MATHEMATICA Policy Research

REPORT

REPORT

APPI Cross-Site Evaluation: Interim Report

March 27, 2015

Margaret B. Hargreaves, Ph.D., M.P.P.
Natalya Verbitsky-Savitz, Ph.D.
Samantha Penoyer
Michaela Vine, M.P.P.
Laura Ruttner, M.P.P.
Alena Davidoff-Gore

Submitted to:
ACEs Public-Private Partnership Initiative (APPI) Leadership Team and Sites

Submitted by:
Mathematica Policy Research
955 Massachusetts Avenue
Suite 801
Cambridge, MA 02139
Telephone: (617) 491-7900
Facsimile: (617) 491-8044

Project Director: Margaret Hargreaves

This report is in the public domain. Permission to reproduce is not necessary.
Suggested citation:
Hargreaves, Margaret B., Natalya Verbitsky-Savitz, Samantha Penoyer, Michaela Vine, Laura Ruttner, and Alena Davidoff-Gore (2015). *APPI Cross-Site Evaluation: Interim Report*. Cambridge, MA: Mathematica Policy Research.

This interim report is available at http://www.appi-wa.org/ or http://www.mathematica-mpr.com/our-publications-and-findings/publications/APPI-Cross-Site-Evaluation-Interim-Report.

This page has been left blank for double-sided copying.

CONTENTS

TABLES

This page has been left blank for double-sided copying.

FIGURES

ACKNOWLEDGMENTS

This interim evaluation report was made possible through the contributions of many individuals and organizations. The Mathematica evaluation team would like to thank the ACEs Public-Private Partnership Initiative (APPI) leadership team and five APPI sites listed below for their considerable time and effort providing direction and feedback to the project. We also appreciate the participation of the many individuals and organizations in the evaluation's site visits in 2013 and 2014. This evaluation also would not have been possible without the generosity and financial support of Casey Family Programs, the Empire Foundation, the Bill and Melinda Gates Foundation, and Thomas V. Giddens, Jr. Foundation. We thank Representative Ruth Kagi and other Washington state legislators for their support of the ACEs work.

In addition, we thank the following Washington State agencies for their permission to use key data sets: the Washington State Department of Social and Health Services Research and Data Division (for CORE-GIS data), the Office of Superintendent of Public Instruction (for student behavior reports), the Department of Health (for Healthy Youth Survey data) and its Center for Health Statistics (for Behavior Risk Factor Surveillance System data), and the University of Washington School of Social Work's Partners for Our Children Data Portal team (for Children's Administration data). We are also indebted to Laura Porter and colleagues at the Foundation for Healthy Generations for the important information they provided regarding the work and research of the Family Policy Council.

Finally, we acknowledge and thank the evaluation team's consultants, Dr. Anthony Biglan, Ms. Patricia Bowie, Dr. Pennie Foster-Fishman, and Ms. Aimee White, for their expert assistance with the design and implementation of the evaluation, including their facilitation and contribution to the December 2013 and July 2014 evaluation retreats with the APPI team, evaluation webinars, and their input on the choice of county-level indicators used in the evaluation's contextual analysis.

APPI Member[a]	Organization
Kathy Adams	Community Public Health and Safety Network
Theresa Barila	Walla Walla County Community Network and Children's Resilience Initiative
Lyndie Case	Skagit County Child and Family Consortium
Paul Cavanaugh	Thomas V. Giddens, Jr. Foundation
Antony Chiang	Empire Health Foundation
Rashelle Davis	Washington State Office of Governor Jay Inslee
Andi Ervin	Okanogan County Community Coalition
Melanie Gillespie	Foundation for Healthy Generations
Marilyn Gisser	Essentials for Childhood
Erinn Havig	Washington State Department of Early Learning
Tory Henderson	Washington State Department of Health
Ron Hertel	Office of Superintendent of Public Instruction
Renee Hunter	Coalition for Children and Families of North Central Washington

APPI Member[a]	Organization
Vicki Lunghofer	Washington Strengthening Families Collective and First 5 FUNdamentals of Pierce County
Sarah Lyman	Empire Health Foundation
Venita Lynn	Early Learning Regional Coalitions and Washington Strengthening Families Collective
Sarah Mariani	Department of Social and Human Services, Division of Behavioral Health and Recovery
Nelly Mbajah	Department of Social and Health Services, Children's Administration
Geof Morgan	Whatcom Family & Community Network
Ron Murphy	Casey Family Programs
Peter J. Pecora	Casey Family Programs and School of Social Work, University of Washington
Debbie Peterson	Washington Strengthening Families Collective and Because It Takes A Village: Child Learning Collaborative
Laura Porter	Foundation for Healthy Generations
Marie Sauter	Bill & Melinda Gates Foundation
Dan Torres	Thrive
Richard Watkins	Thomas V. Giddens, Jr. Foundation
Catherine Roller White	Casey Family Programs
Greg Williamson	Washington State Department of Early Learning
Liv Woodstrom	Thrive
Sam Whiting	Thrive

[a] This table lists both voting and non-voting members of the APPI leadership team who contributed time and effort to the APPI evaluation.

EXECUTIVE SUMMARY

A. Introduction

Family Policy Council legacy. In 1992, the state of Washington enacted legislation creating an interagency Family Policy Council (FPC) to carry out "principle-centered systemic reforms to improve outcomes for children, youth, and families." Additional legislation in 1994 authorized the FPC to create local networks to address specific issues: child abuse and neglect, domestic violence, youth violence, youth substance abuse, dropping out of school, teen pregnancy, youth suicide, and out-of-home placements of children in the child welfare system. In 2001, the FPC began to educate local leaders about the consequences of exposure to toxic stress during child's development, the underlying causes of problem behaviors, and health problems that contribute to intergenerational patterns of problems occurring in communities. In 2002, the FPC began conducting network trainings on findings of the latest epidemiological research on adverse childhood experiences (ACEs), which linked childhood trauma and toxic stress to increased risk of harm to children and adults (Figure ES.1).[1] The networks were encouraged to disseminate the research into their communities, integrate developmental neuroscience and ACEs findings into their work, and adopt a dual-generation approach to reducing the rates of major social problems. After the FPC was defunded in 2011 and the networks lost their FPC funding in 2012, less than half (18 out of 42) of the networks were able to continue their work supported by non-FPC funds.

Figure ES.1. The ACE Pyramid

Source: Centers for Disease Control and Prevention

[1] ACEs are 10 categories of childhood adversity involving child abuse (physical, emotional, and sexual abuse); child neglect (emotional and physical neglect); and growing up in a seriously dysfunctional family (with alcohol or other substance in the home; a mentally ill or suicidal household member; the loss of a parent through separation, divorce, or death; incarceration of a household member; and witnessing domestic violence) (CDC 2014a).

APPI background. In 2013, the ACEs Public-Private Initiative (APPI)—a Washington State consortium of public agencies, private foundations, and community organizations—was formed to reduce children's exposure to toxic stress; ACEs; and their social, health, and economic consequences (APPI 2013a). To advance the study of effective community-based ACEs prevention and mitigation initiatives, APPI awarded three-year grants to five sites: the Coalition for Children and Families of North Central Washington (NCW), Okanogan County Community Coalition, Skagit County Child and Family Consortium, Walla Walla County Community Network, and the Whatcom Family & Community Network.

APPI evaluation. APPI also hired Mathematica Policy Research to conduct a retrospective evaluation of the initiatives. The evaluation was designed to answer a central question: "Can a multifaceted, scalable, community-based empowerment strategy focused on mitigating or preventing ACEs succeed in producing a wide array of positive outcomes in a community, including reduction of child maltreatment and improvement of child and youth development outcomes?" The evaluation is studying (1) the initiatives' contexts, (2) the strategies they used to build community capacity to reduce ACEs and increase resilience, (3) how the sites used their capacity to trigger community change at multiple levels, (4) how these changes are shifting local conditions in ways that may affect ACEs and resilience, and (5) potential lessons about how to increase the effectiveness and cost savings of such initiatives. This interim cross-site evaluation report addresses the first three subjects. The final evaluation report, due in late 2015, will address the final two topics.

B. Contextual Dynamics

The APPI sites are located outside Seattle in rural counties with small core cities bounded by significant geographic features, which influenced the design and operation of the APPI sites (Figure ES.2). Their relative isolation contributed to a sense of agency and self-reliance among the sites, creating a favorable climate for collaboration. The large geographic area and low population density of their counties led two sites to concentrate their activities in the core towns of their regions, while the other three sites targeted their efforts in select areas, such as at-risk neighborhoods or one or two schools, throughout their counties. Local economic realities and political dynamics affected the sites' access to local funding and local policy advocacy efforts. The state's economic downturn in 2009 affected all of the sites; it created a sense of urgency to help affected families, but it also resulted in funding cuts for some prevention services.

Figure ES.2. Map of APPI Sites

Source: Mathematica Policy Research

The APPI initiatives have been trying to shift community conditions in dynamic environments, which also have been changing in ways unrelated to the efforts of the initiatives. To understand these dynamics, the evaluation analyzed state and county trends in 30 indicators of ACEs-related risk and protective factors over a 10-year period (2002 to 2012). For many indicators, county trends were not statistically different from statewide trends, but there were some exceptions (this is not an exhaustive list):

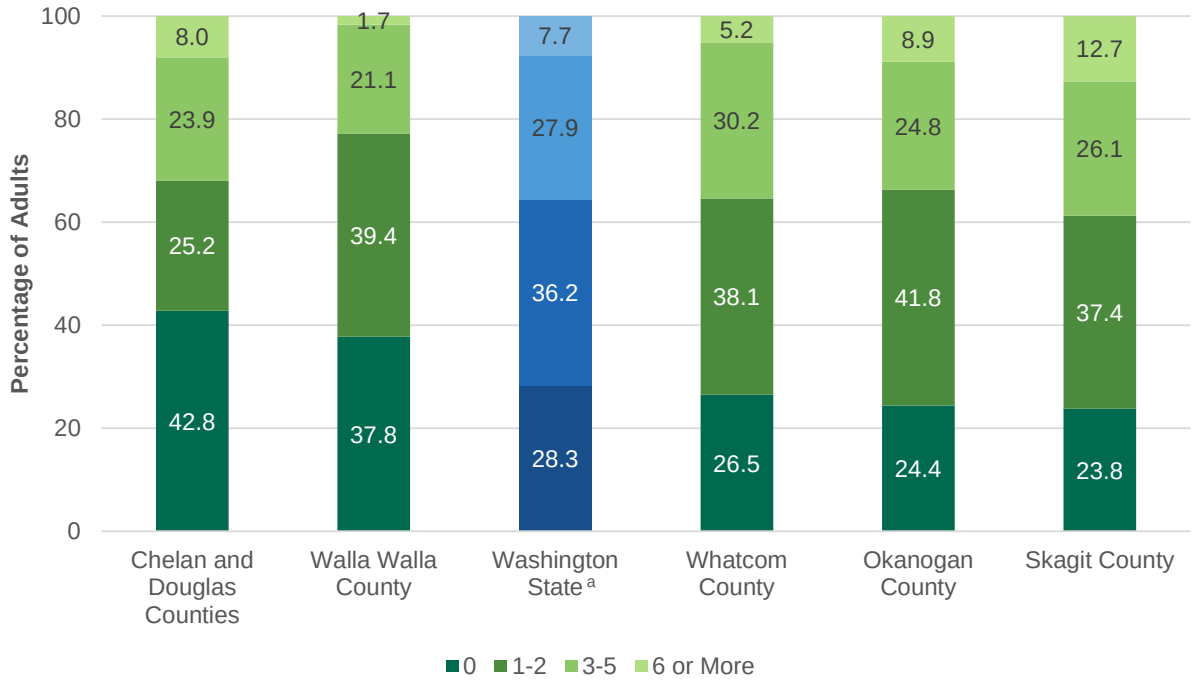
- Chelan and Douglas Counties (NCW) and Walla Walla County had lower prevalence of ACEs among adults (ages 18-54) than the rest of Washington State[2] (Figure ES.3).
- Walla Walla County showed greater decrease in the population rate of alleged victims of child abuse and neglect in accepted referrals than did the rest of the state.[3]

[2] The rest of the Washington State excluded the five APPI sites (Chelan/Douglas, Okanogan, Skagit, Walla Walla, and Whatcom Counties) as well as King County, which is the most populous county in the state and contains the state's largest city, Seattle. King County was excluded because of its differences with the five APPI sites, in terms of urbanicity, demographic characteristics, and availability of resources, among others.

[3] The rate of alleged victims of child abuse and neglect in accepted referrals includes children (age birth–17) identified as alleged victims in reports to Child Protective Services that were accepted for further action. Children

- NCW, Okanogan, Skagit, and Whatcom Counties experienced a slower increase in the rate of hospitalizations due to injury among women (an indicator of domestic violence) than the rest of the state.
- Okanogan County's trends in rates of (a) school suspensions and expulsions and (b) youth arrests for violent crimes also showed greater reductions than did the state trends.

Figure ES.3. Prevalence of Adverse Childhood Experiences (ACEs) in the Five APPI Sites and Washington State Comparison Group Among Adults (Ages 18–54), 2009–2010



Source: Mathematica Policy Research analysis of Washington State Department of Health, Center for Health Statistics, Behavioral Risk Factor Surveillance System (BRFSS), supported in part by Centers for Disease Control and Prevention, Cooperative Agreement U58 DP001996-1 through 2 (2009-2010).

Note: This figure reports the percentage of adults who reported experiencing ACEs. The standard errors range from 1.0 to 7.5 for the APPI sites' estimates and from 0.4 to 0.8 for Washington State comparison group. To improve the precision of the estimates, all statistics are based on a combined sample from the 2009 and 2010 BRFSS surveys.

[a] Washington State statistics exclude the five APPI sites (Chelan/Douglas, Okanogan, Skagit, Walla Walla, and Whatcom counties) as well as King County, which is the most populous county in the state and contains the state's largest city, Seattle.

Although interesting, these differences in trends are not definitive proof of the countywide impacts of the initiatives' efforts for two reasons. First, the APPI counties and the Washington State comparison group differ on a variety of factors including the demographic characteristics of their populations and the programs offered to county residents that are not related to, or

are counted more than once if they are reported as alleged victims more than once during the year. A "referral" is a report of suspected child abuse.

supported by, the APPI sites. Second, using the available data, we were unable to observe shifts in patterns in the above-mentioned indicators coinciding with the start of the ACEs-specific efforts. Therefore, we cannot confirm that that the observed differences between site and state trends are related to the collective impact of sites' ACEs-specific efforts. The question of the impacts of the initiatives' efforts will be explored further in the APPI evaluation's final report.

C. Community Capacity Development

Although the APPI sites vary in the details of their operations, their strategies for building community capacity have been similar in numerous ways:

1. The sites are all using strong, research-based community mobilization and public health prevention frameworks to structure their collaborative efforts (as networks, coalitions, and a consortium).
2. They are engaging a broad spectrum of individual and organizational partners to solve complex community problems at multiple (individual, organization, system, community, and policy) levels.
3. They have integrated ACEs prevention and resilience building principles into their goals and strategies.
4. They are actively engaging community members through ACEs and resilience trainings, public forums, community task forces, focus groups, and other facilitated conversations.
5. They are also using population data from many sources and are developing new ACEs and resilience-related data to identify community problems, develop multifaceted responses, and track their progress.

Most importantly, the sites have been filling critical roles in their communities as neutral conveners of diverse stakeholders and as facilitators of complex community problem-solving processes. Yet in some ways their independent status has created a potential liability for the networks, especially after the loss of FPC funding in 2012. These APPI sites are survivors that have continued operating, in various forms, for 10 to 20 years by leveraging the organizational assets, time, support, and resources of their community partners. However, their staffs are small, many of the site budgets are tiny, and their funding is temporary, putting their long-term sustainability at risk.

D. Multilevel Community Change

The capacity of the APPI sites can be judged by their ability to trigger change in their communities in ways that ultimately reduce ACEs, increase resilience, and enhance community well-being. These community changes can occur at several levels: changing an individual's mindset to see through an ACEs lens, helping community organizations adopt trauma-informed service delivery models, empowering families to improve their neighborhoods, adding more evidence-based programs to a community's continuum of ACEs prevention services, working in cross-sector coalitions to protect youth, or increasing their community's collective impact on ACEs by aligning local policies with funding priorities. Such changes can impact ACEs and resilience by creating more nurturing and protective environments in multiple settings—at home, at school, among peers, and in the community. These types of interventions are designed to

reduce toxic stress, limit opportunities for problem behavior, reinforce prosocial behavior, and develop other protective factors for children, youth, families, and communities, and limit the consequences of childhood ACEs exposure throughout the life course and intergenerational transmission of ACEs.

Child abuse prevention and family support. The APPI sites have initiated and sustained efforts at multiple levels to address the child maltreatment prevention and treatment needs of their communities. Their accomplishments include expanding the availability of evidence-based parenting programs, creating alliances with local child welfare systems to implement population-level child protection projects, increasing the use of trauma-informed practices by social service agencies through training and technical assistance, and helping families directly through parenting classes and training programs. For example, the NCW, Okanogan, and Skagit sites brought several evidence-based child abuse prevention programs to their communities, including the Positive Parenting Program (Triple P), the Strengthening Families program, the Kaleidoscope Play and Learn program, and the Nurse-Family Partnership program. The Whatcom and Walla Walla networks have worked with local child protective services (CPS) to create Family to Family alliances and provide families involved with CPS with peer support through a new Community Navigators program. Two major challenges have been to manage the time-limited grants and staff turnover in these programs.

Trauma-informed health care. Several of the APPI sites also worked with local health care providers to incorporate ACEs and resilience principles in their practices by providing trauma-informed medical care, providing mental health services, and referring patients to appropriate behavioral health programs. The APPI sites made some progress but encountered structural barriers that limited changes in provider practices, such as medical billing procedures that limit clinician time spent on ACEs and resilience-related activities, as well as state reimbursement policies that do not recognize or fund new trauma-informed service delivery models. Some sites have started to challenge these barriers. For example, the Health Center in Walla Walla is working to be recognized by the state as a school-based health clinic. The Okanogan Coalition succeeded in obtaining Medicaid reimbursement billing codes for Triple P services, a time-consuming process that required extensive coordination with the state health care authority.

School climate and student success. The APPI sites targeted school discipline policy and practice as a way to create more nurturing and compassionate school environments. In particular, the Whatcom Network, Walla Walla Network, and Okanogan Coalition have been working with teachers, principals, and staff in targeted elementary, middle, and high schools to shift school policies from punitive approaches to more trauma-informed practices. Their efforts included using evidence-based positive behavior management techniques; training school administrators, teachers, and other staff on ACEs, resilience, and trauma-informed practices; collecting school-level ACEs information through student surveys; changing school suspension and expulsion policies; and adding ACEs and resilience topics to courses. Promising changes have occurred: reducing school suspensions and expulsions, improving student behavior, increasing student retention, and even increasing graduation rates at one high school. The APPI sites' strategy of using successful pilot projects to leverage districtwide policy change has faced more of a challenge. However, with support from school superintendents and school boards, some sites have begun to spread school-specific "wins" to more locations.

Risk behavior reduction and healthy youth development. The APPI sites have been particularly active in the area of risk behavior reduction and healthy youth development. For example, one site (Skagit) have secured grants to hire more prevention and intervention staff in schools and community programs. Two other sites (Whatcom and Okanogan) have facilitated successful cross-sector coalitions involving schools, media, parents, law enforcement, and juvenile justice agencies in prevention efforts to limit opportunities for a range of problem behaviors, including underage drinking, gang violence, and suicide. All of the sites have helped start and operate afterschool activities, youth-led prevention clubs, and community-based programs, such as mentoring programs and a teen center, to provide opportunities for healthy youth development. The sites have also been involved in providing youth with more intensive services, such as mental health treatment services, community truancy boards, and the use of trauma-informed practices in juvenile justice settings.

Community development. Two of the five APPI sites (Whatcom and Walla Walla) have also focused their time and resources on building formal and informal social supports for vulnerable families in targeted neighborhoods. The underlying logic is that by bringing neighbors together to work on community improvement projects, attend public events, and participate in other neighborhood-oriented activities, residents can develop a greater sense of community, become less socially isolated, and be more willing to ask for and offer help when needed, as they move from being consumers of services to active producers of community engagement. The Whatcom Network also helped to bring new services and supports to an isolated community on the eastern side of the county. These development efforts have played a part in reducing neighborhood violence, improving community safety, creating more attractive park space and other amenities, and improving housing conditions for some families. Such efforts are designed to help meet basic needs, reduce toxic stress, and increase social capital among at-risk families.

Policy advocacy. Until the state FPC office was defunded in 2011, FPC networks—including the Walla Walla and Whatcom networks—were typically involved in policy advocacy at the state level as FPC partners, working with FPC staff, state House and Senate representatives, the Governor's Office, the Office of Superintendent of Public Instruction, and other state agencies. The FPC networks submitted formal reports and policy recommendations, participated in rule making processes, and advocated for changes in state programs and budgets. In addition, the NCW Coalition, the Okanogan Coalition, and the Skagit Consortium have had their own histories of state-level political engagement and policy advocacy as independent community coalitions. After 2011, the Walla Walla and Whatcom networks have become more active independently on state policy issues by, for example, supporting a state budget proviso that allowed more flexible use of juvenile court funds for ACEs-informed continuous improvement efforts. However, the APPI sites have had mixed success on some issues for a range of reasons, including the fact that they did not use hired lobbyists or have legislative allies to champion their causes. Indeed, the loss of previous FPC legislative champions has left a gap at the state level. Recently, two APPI sites (Walla Walla and Whatcom) have become involved in Collective Impact processes to align local policy priorities and resources. Such efforts could influence the networks' future state policy work.

E. Limitations of this Report and Plans for Future Reports

This report presents substantial qualitative evidence of the capacity and efficacy of the APPI initiatives and uses quantitative county-level data to describe the dynamic contexts of the sites. However, more quantitative data are needed at the subcounty level to track the initiatives' processes, products, and impacts at individual, organizational, and cross-sector levels.

In the final 2015 phase of the APPI evaluation, the evaluation team will work with the sites to gather more quantitative information examining subcounty impacts of specific activities in all four domains—(1) child abuse prevention and family support, (2) school climate and student success, (3) risk behavior reduction and healthy youth development, and (4) community development. The APPI sites have already provided some documentation of subcounty outcomes that are reported in local program evaluations and other site-specific analyses (not included in this report). These reports will be reviewed systematically and incorporated into the findings of the evaluation's final report. As part of the implementation study, the evaluation will also collect new information regarding the sites' capacity for collaboration using a community network survey that will assess the alignment of goals among coalition members, the intensity and sustainability of collaboration among members, and other indicators of network capacity. Finally, we will conduct the APPI evaluation's cost savings study. The findings from these data collection activities will be included in the evaluation's final report, due at the end of 2015.

LIST OF ACRONYMS

ACEs	Adverse childhood experiences
APPI	ACEs Public-Private Initiative
BMAC	Blue Mountain Action Council
BRFSS	Behavioral Risk Factor Surveillance System
C2C	Commitment to Community
CASA	Court-appointed special advocate
CCD	Community Capacity Development model
CDC	Centers for Disease Control and Prevention
CHIP	County Health Improvement Plan
CIS	Communities in Schools program
CORE-GIS	Community Outcome and Risk Evaluation Geographic Information System
CPS	Child Protective Services
CRI	Children's Resilience Initiative
CTC	Communities That Care model
DBHR	Washington State Department of Social and Health Services, Division of Behavioral Health and Recovery
DCFS	Washington State Department of Social and Health Services, Division of Children and Family Services
DSHS	Washington State Department of Social and Health Services
ECEAP	Early Childhood Education and Assistance Program
FFT	Functional Family Therapy
FPC	Family Policy Council
GBG	Good Behavior Games
MOOV	Most of Okanogan Valley
MOU	Memorandum of understanding
NCW	Coalition for Children and Families of North Central Washington
NFP	Nurse-Family Partnership
OSPI	Office of Superintendent of Public Instruction
Project SUCCESS	Schools Using Coordinated Community Efforts to Strengthen Students
SAMHSA	Substance Abuse and Mental Health Services Administration
SFP	Strengthening Families Program
SPF	Strategic Prevention Framework
RTL	Readiness to Learn
Triple P	Positive Parenting Program
VIP	Valley Intervention Program
VOICE	Voicing Our Ideas, Challenging Everyone
YCCY	YMCA's Community Center for Youth

This page has been left blank for double-sided copying.

I. INTRODUCTION

A. Family Policy Council Networks

In 1992, the state of Washington enacted the Family Policy Initiative (RCW 70.190), creating an interagency Family Policy Council (FPC) to carry out "principle-centered systemic reforms to improve outcomes for children, youth, and families."[4] Additional legislation enacted in 1994 authorized the development of local FPC affiliates, called Community Public Health and Safety Networks (FPC networks). The FPC networks—quasi-governmental public/private collaboratives—were charged with addressing a set of complex problems targeted by the state: child abuse and neglect, domestic violence, youth violence, youth substance abuse, dropping out of school, teen pregnancy, youth suicide, and out-of-home placements of children in the child welfare system.[5] The FPC networks were funded to (1) assess community strengths and challenges; (2) review existing local programs, laws, and regulations; (3) research effective strategies; and (4) build on local assets to develop and implement solutions addressing local concerns.[6]

Since 1994, the FPC networks have been implementing individual and family-based interventions addressing a broad spectrum of problems, particularly child maltreatment. The FPC networks have been active at many levels, including implementing community awareness campaigns, facilitating cross-sector coalitions, training local service providers, organizing neighborhood development efforts, and supporting a range of evidence-based and promising programs and practices for vulnerable children and families. However, the FPC networks lost state support when authority and funding for the FPC ended on June 30, 2011. A reduced amount of state funding remained for the FPC networks through June 30, 2012.[7] Since then, many of the FPC networks have become inactive. However, 18 (out of 42) FPC networks continue to operate, relying on other funding sources for their support, including grants from state and local agencies and private foundations.[8]

[4] The council included five state agencies—(1) the Department of Social and Health Services, (2) the Department of Commerce, (3) the Employment Security Department, (4) the Department of Health, and (5) the Office of the Superintendent of Public Instruction—and representation from the four caucuses of the legislature and the Office of the Governor.

[5] This information was gathered from the Washington State Family Policy Council website which is no longer functioning but was available when accessed in November 2013 at [http://wsldocs.sos.wa.gov/library/docs/FPC/SL_FPC2004_000001.htm]. For more information about the RCW 70.190, Washington State's statute authorizing Family Policy Council, see [http://apps.leg.wa.gov/rcw/default.aspx?cite=70.190]. Accessed on February 25, 2015.

[6] The FPC networks signed formal contracts specifying network activities, short and long term outcomes, and methods for monitoring their achievements based on local planning processes, research and local or cultural wisdom.

[7] In 2011 some of the Family Policy Council work and staff transitioned to the Washington State Department of Social and Health Services (DSHS), Office of ACEs Partnerships; this office continued to be responsible for the contracts of the FPC networks in the final year. After 2012, the FPC networks retained their legislative authority but received no FPC funding.

[8] Before it closed, the FPC sought broader public and private support for the networks and sought to document evidence of the networks' efficacy, through articles such as Hall et al. 2012.

The FPC became aware of the Adverse Childhood Experiences study (ACE study), conducted by Kaiser Permanente with the Centers for Disease Control and Prevention (CDC), soon after its publication in 1998 (Felitti et al. 1998). ACEs are 10 categories of childhood adversity or trauma involving child abuse (physical, emotional, and sexual abuse); child neglect (emotional and physical neglect); growing up in a seriously dysfunctional family (with alcohol or other substance abuse in the home); a mentally ill or suicidal household member; the loss of a parent through separation, divorce, or death; incarceration of a household member; or witnessing domestic violence (CDC 2014a). The study showed evidence of the association between ACEs and increased risk of further harm to children and adults (Felitti et al. 1998). For example, childhood trauma and toxic stress are associated with slowed language development, attention problems, aggressive behavior, and social conflict, all of which put children at risk for early use of alcohol and drugs, school failure, truancy, delinquency, and entry into the juvenile justice system (Figure I.1; Stambaugh et al. 2013).

Figure I.1. The ACE Pyramid

Source: Centers for Disease Control and Prevention

In 2002, based on the ACEs research, the FPC initiated a series of statewide network trainings on the impact of early trauma and toxic stress on the brain development in children. The trainings also emphasized the roles that nurturing environments, protective factors, and resilience can play in preventing or mitigating the effects of childhood trauma, based on nurturing environments and resilience research (Biglan et al. 2012; Cohen et al. 2010; O'Connell et al. 2009). Nurturing environments foster successful development and prevent the development of psychological and behavioral problems. Many children and youth, including those who have experienced trauma or adversity, are able to avoid or mitigate negative outcomes more readily than are others. Their characteristics and skills are strongly associated with protective factors at the individual, relationship, and community levels. These protective factors include caring relationships, high expectations for youth, and opportunities for youth participation and/or contribution (Brownlee at al. 2013; Development Services Group 2013). These ideas have since

been developed into a broader cluster of concepts involving neuroscience, epigenetics, ACEs, and resilience called NEAR science (Porter 2014).

The FPC adopted a public health approach to the complex problem of ACEs by encouraging FPC networks to develop their own communitywide responses to the problem (Anda et al. 2010). The FPC networks were encouraged to attend the FPC trainings, disseminate the ACEs and resilience information in their communities, integrate developmental neuroscience and ACEs findings into their work, and adopt a dual-generation approach to reducing the rates of major social problems. For many of the FPC networks, this information confirmed the direction and scope of the prevention-oriented work that they were already doing. The emphasis on ACEs and resilience helped deepen the networks' commitment to prevention and sharpened the focus of their network activities.

B. Adverse Childhood Experiences Public-Private Initiative

After state support for the FPC networks ended, a new Washington State consortium of public agencies, private foundations, and community organizations, called the ACEs Public-Private Initiative (APPI 2013a), was formed in 2013.[9] Its mission is to reduce children's exposure to toxic stress; ACEs; and their social, health, and economic consequences. The initiative has two objectives: (1) to study effective interventions that use neuroscience and population-level data about childhood adversity to inform policies and practices to prevent and mitigate ACEs and (2) to facilitate learning and dialogue with the broader community on these topics.

To advance the study of effective network-based ACEs prevention and mitigation efforts, APPI sought to fund a rigorous, mixed-methods evaluation of multifaceted community-based initiatives in five communities across the state (APPI 2013b). In 2013, APPI used a competitive process to select and award three-year grants to five community-based organizations. The flexible funds ($25,000 per year) were designed to support the sites' cost of participating in the mixed-methods evaluation and help the sites to (1) advance their work of developing cross-sector, multidisciplinary partnerships; (2) engage and align diverse community resources in the prevention and mitigation of ACEs and toxic stress; and (3) develop the communities' capacity to evaluate and continuously improve their collective efforts.

Through this process, APPI selected two sites in northwest Washington, north of Seattle (the Skagit County Child and Family Consortium and the Whatcom Family & Community Network); two sites in the north central region of the state (the Okanogan County Community Coalition and the Coalition for Children and Families of North Central Washington [NCW]); and one site in the southeast corner of the state (the Walla Walla County Community Network, see Figure I.2).

[9] For more information on the ACEs Public-Private Initiative (APPI), see APPI website [http://www.appi-wa.org/]. Accessed on March 17, 2015.

Figure I.2. Map of APPI Sites

Source: Mathematica Policy Research

II. APPI EVALUATION GOALS AND METHODS

A. Evaluation goals, questions, and conceptual framework

In 2013, APPI contracted with Mathematica Policy Research to conduct a rigorous, mixed-methods evaluation of these five community-based initiatives. The evaluation seeks to answer a central question: "Can a multifaceted, scalable, community-based empowerment strategy focused on mitigating or preventing ACEs succeed in producing a wide array of positive outcomes in a community, including reduction of child maltreatment and improvement of child and youth development outcomes?" The evaluation's goals are to (1) understand the APPI sites' goals, target populations, strategies, and theory of change and how they evolved over time as the sites developed and incorporated ACEs and resilience concepts into their work; (2) examine the extent to which the initiatives developed effective coalitions, created collaborative cross-sector partnerships, and helped implement local programs, policies, and practices to accomplish their goals; (3) assess the evidence of the impact these efforts may have had on short- and longer-term ACEs-related outcomes at the county and subcounty levels; and (4) identify cost savings that may have accrued, or may accrue, through these initiatives.

As part of the design process, the evaluation team developed a research-based conceptual framework to focus the following set of five research questions (see Figure II.1; Biglan et al. 2012; Child Welfare Information Gateway 2014; Flaspohler et al. 2008; Hargreaves 2010, 2014; Luthar and Cicchetti 2000; National Research Council 2009). The first three questions are addressed in this report; the last two questions will be addressed in the final report.[10]

1. In what contexts did the APPI sites operate? In what ways might local community characteristics have influenced the sites' goals, capacity, choice of interventions, and effectiveness?
2. What strategies have the APPI sites used to increase their communities' capacity to address ACEs and increase community resilience (adopting an effective model of community problem solving; raising awareness of ACEs and resilience concepts; developing sustained leadership and collaborative structures; leveraging funding and other resources; engaging network members and community partners in their efforts; and using data for learning, evaluation, and adaptation)?
3. How have the APPI sites used their increased capacity to trigger community change at multiple levels (changing individuals' mindsets and perceptions, implementing effective programs, adjusting organizational practices, increasing community partnerships, and adopting new policies)?
4. How have these community changes shifted local conditions in ways that reduce or mitigate ACEs and increase resilience (by reducing toxic stress, limiting opportunities for problem

[10] Due to the limited budgets, the sites strategically targeted their activities to select areas or populations within their counties. Our main impact analyses will, therefore, examine whether the sites' activities shifted their outcomes at the subcounty level; the results of these analyses will be described in the final report. In 2014, however, we examined whether it is feasible to detect any impacts of the sites' activities at the county levels. The methodology for and results of these feasibility analyses are presented in Appendix C.

behavior, reinforcing prosocial behavior, increasing psychological mindfulness, and influencing other protective factors)?

5. Have the APPI sites been able to build and sustain community capacity at sufficient scale to produce intended impacts? What general lessons can be learned about the development and implementation of effective, scalable, community-based initiatives addressing ACEs and increasing resilience?

Figure II.1. APPI Evaluation Conceptual Framework

Source: Adapted from Hargreaves et al. 2014.

B. Evaluation overall approach and components

The evaluation began in November 2013 and is scheduled to finish in December 2015. The evaluation team includes Mathematica researchers and analysts as well as expert consultants Ms. Patricia Bowie, Dr. Pennie Foster-Fishman, and Dr. Anthony Biglan. The evaluation is organized and contracted in three phases: (1) a six-week evaluation planning and site orientation phase in November and December 2013; (2) a retrospective evaluation of the community initiatives' efforts and county-level outcome trends over a 10-year period (between 2002 and 2012) conducted in 2014; and (3) a final round of data collection and analyses in 2015 to gather site activity updates, to conduct network survey of network members and partners, and to obtain and analyze quantitative data on site cost savings and subcounty-level outcomes.

The APPI evaluation's design followed four principles:

1. A developmental evaluation approach. The evaluation team worked closely with the APPI leadership and sites to prioritize evaluation questions, develop methods that match the information needs of the sites and the evaluation goals of the APPI team, discuss preliminary findings and their interpretation with the leadership and sites, and adjust evaluation methods in response to evolving information needs (Patton 2011).
2. A mixed-methods design. Using the platinum evaluation standard of methodological pluralism and appropriateness (Patton 2014), the evaluation team consulted with topic and evaluation experts on the conceptual framework and other key design decisions, including the selection of ACEs-related population indicators.
3. A multilevel framework. The evaluation's design was informed by prevention and implementation science frameworks as well as systems concepts and a multilevel framework to capture the complex dynamics in which the sites operate (Blodgett 2013; Hargreaves 2010, 2014; Institute of Medicine 2002).
4. A capacity-building approach. The team's cadre of experts in community capacity building (Ms. Patricia Bowie and Dr. Pennie Foster-Fishman), prevention science (Dr. Anthony Biglan), and local evaluation technical assistance (Ms. Aimee White) worked with the APPI sites on a range of evaluation topics, including ACEs' root causes, theories of change, and the evaluation of evidence-based prevention programs and practices.[11]

The APPI evaluation's design was structured as three studies: a qualitative study, a quantitative study, and a cost savings study.

Qualitative study. Guided by background information collected in the evaluation's site orientation visits in 2013, the evaluation team conducted implementation study site visits in spring 2014. During these visits, two-person (researcher and analyst) teams interviewed 15 to 20 site staff and community partners about the history and timeline of their community-based initiatives, including the sites' increase in focus on ACEs and resilience. The interviews focused on the sites' goals, theory of change, leadership, structure, resources, network membership, use of data, and modes of community engagement (see Appendix B for the interview protocol).

[11] APPI evaluation capacity-building activities included day-long events in December 2013 and July 2014, webinars in March and April 2014, and a conference workshop in September 2014.

In 2015, the evaluation team will update site activities, collect subcounty outcome data, and examine evidence of cost savings accrued as a result of network efforts. The evaluation's 2014 findings are summarized in this interim cross-site evaluation report, based on five preliminary site case studies. The final case studies and final report are scheduled for publication in late 2015.

Quantitative study. The quantitative study has three objectives: (1) to assess trends in county-level ACEs-related indicators over the last 10 to 15 years while the sites have been active; (2) to assess whether it is feasible to detect impacts of the APPI sites' activities, before and after the sites incorporated an ACEs perspective into their work at the county level; and (3) to document results of the sites' efforts at the subcounty level. Because of the retrospective nature of the quantitative study, the evaluation relied on existing survey and administrative data. The quantitative study assessed a total of 30 indicators from five state data sets: (1) Community Outcome and Risk Evaluation Geographic Information System (CORE-GIS) data from the Washington State Department of Social and Health Services (DSHS) Research and Data Analysis Division, (2) Student Behavior Reports from the State of Washington Office of Superintendent of Public Instruction (OSPI), (3) child welfare data from the Partners of Our Children data portal, (4) Healthy Youth Survey data from the Washington State Department of Health, and (5) Behavioral Risk Factor Surveillance System (BRFSS) data from the Washington State Department of Health's Center for Health Statistics. Appendix C describes the measure selection process.

To address the first two objectives, the evaluation team evaluated county-level trends in the 30 indicators. To understand the dynamics of the environments in which the APPI sites have been operating, we examined the direction or slope of the trends in these 30 indicators over time; we assessed whether the trends remained steady, increased or decreased over time. We also compared the direction of the trends in the APPI sites to a Washington State comparison group.[12] The results of these analyses are presented in the report's context section. In addition, the evaluation team conducted an assessment of the feasibility of detecting impacts of the site-specific ACEs-related efforts at the county level. The evaluation examined whether localized efforts to combat ACEs, increase resilience, and improve child and adult well-being could be detected at the county level. The methodology and results are presented in Appendix C. In 2015, the evaluation team will examine more closely the impact of the sites' efforts on specific programs or organizations. We also plan to collect and analyze quantitative measures of the sites' network capacity and efficacy. These will be presented in the final report and case studies.

Cost savings study. In 2015, the evaluation will document, where possible, the public costs that were shifted or saved through the changes in programs, policies, and practices initiated by the APPI sites. The cost study will estimate the savings accrued to date and their potential impact in the future. During the 2015 site visits, the teams will also gather qualitative information about

[12] When feasible, the Washington State comparison group excluded the five APPI sites (Chelan/Douglas, Okanogan, Skagit, Walla Walla, and Whatcom counties) as well as King County, which is the most populous county in the state and contains the state's largest city, Seattle. King County was excluded because of its differences with the five APPI sites, in terms of urbanicity, demographic characteristics, and availability of resources, among others.

the savings accrued from the organizations involved in the site visits. The findings will be reported in the study's final report.

C. Report roadmap

This report provides preliminary findings from the retrospective cross-site evaluation. In the next sections, we review (1) the local contexts in which the APPI sites have been operating, (2) the community capacity built by the sites, and (3) the sites' community changes in the four domains referenced earlier. The report closes with a summary of preliminary findings and their implications for the APPI leadership, sites, and other stakeholders. For consistency, the report will refer to the five sites collectively as the APPI sites. However, when the report discusses a specific site, its official title will be used (such as the Skagit Consortium or the Okanogan Coalition).

This page has been left blank for double-sided copying.

III. APPI SITE CONTEXT

Place-based initiatives operate within and are influenced by the physical geography, population demographics, cultural politics, and economics of their communities (GEO 2014). Evaluators recognize that the results of place-based initiatives cannot be assessed in isolation of these contextual forces. We start this section with a summary of the geographic, social, political, and economic contexts in which the APPI sites have been operating.

▲ **View of the Columbia River: Coalition for Children and Families of North Central Washington (Chelan and Douglas counties)**

Community-based initiatives also operate in dynamic environments. With sufficient reach and impact, community-based initiatives may be able to shift their environment, but the environment may also change in ways that have nothing to do with the local initiative (GEO 2014). To understand the dynamics of the environments in which the APPI sites have been operating, we summarize county-level trends in ACEs and four domains of resilience-related risk and protective factors: (1) child abuse prevention and family support, (2) school climate and student success, (3) risk behavior reduction and healthy youth development, and (4) community development.

A. Contextual factors

Geographic boundaries. The five APPI sites share certain geographic traits. All are located outside the Seattle metropolitan area, in counties characterized by small core cities surrounded by rural areas. All APPI sites are also bounded by significant geographic features. These physical features tend to separate and isolate them, contributing to a sense of independence, self-reliance, and close-knit nature of the APPI communities.

- Whatcom County is in the northwest corner of the state, bordered by the Pacific Ocean on the west, Mount Baker and the North Cascade mountain range on the east, Skagit County on the south, and the international border with the Canadian province of British Columbia on the north.
- Just south of Whatcom County is Skagit County. Skagit County is located approximately 70 miles north of Seattle and 26 miles south of Bellingham, Whatcom's county seat. Skagit also shares the geographic boundaries of the Pacific Ocean on the west and the Cascades on the east.
- Okanogan County is a large rural county, the size of Connecticut. It is located in the north central part of the state and stretches over the western portion of the Colville Indian Reservation.

- South of Okanogan are largely rural Chelan and Douglas counties served by the NCW.
- The Walla Walla site in the southeastern part of the state serves the Walla Walla Valley, encompassing the city and county of Walla Walla. This area is bordered by the Blue Mountains on the east, the Columbia River farther west, and the Oregon state border on the south.

APPI target populations. In consideration of the large geographic size, low population density, and limited resources of their counties, two APPI sites have focused their efforts on their core communities. The Okanogan Coalition serves the greater Omak area, whose population of 8,229 is one-fifth of the county population (see Table III.1 for the size of the total population in each APPI county). The NCW Coalition is targeting the city of Wenatchee, the commercial hub for Chelan, Douglas, Grant, and Okanogan counties. Wenatchee's population of 32,701 is less than a third of the combined populations of Chelan and Douglas counties. The scope of the other APPI sites is countywide.

Many of the APPI sites are ethnically diverse. Four of the five APPI sites (all but Whatcom) are located in areas with relatively large Latino populations (Table III.1). In these counties, the proportion of young Latinos (under age 18) is almost twice the proportion of the overall Latino population, which increases the need for culturally and linguistically appropriate services for children, youth, and families. In addition, although less than one percent of the state's population is American Indian, 15 percent of Okanogan County residents are American Indian.

Table III.1. Overall and Latino Populations in APPI Sites and Washington State, 2011–2013

	All ages		Children under 18 years of age	
	Total population (Count)	Latino population (Percentage)	Total population (Count)	Latino population (Percentage)
Chelan County	73,609	26.9	17,865	45.4
Douglas County	39,187	29.6	10,451	45.8
Okanogan County	41,260	18.5	9,658	33.5
Skagit County	118,225	17.4	27,178	31.7
Walla Walla County	59,481	20.6	12,930	36.9
Whatcom County	204,880	8.4	41,941	15.4
Washington State	6,971,406	11.9	1,596,184	20.2

Source: Washington State estimates are based on U.S. Census Bureau's 2013 One-Year American Community Survey data; county-level estimates are based on U.S. Census Bureau's 2011-2013 Three-Year American Community Survey data.

Local culture and politics. The "small town" nature of the APPI sites has played an important role in the development of professional relationships and local politics. Four APPI sites (Whatcom, Skagit, Okanogan, and Walla Walla) reported on the high level of collaboration, reputation for innovation, and progressive mindset among the foundations, service providers, advocacy groups, and colleges and universities in their areas. However, they also noted a

political divide between liberal and conservative voters in their communities that may have limited public sector leadership and funding for ACEs-related reforms. The NCW region is notably more politically conservative than the other sites, although one interviewee commented that the area is becoming more diverse, which may eventually shift the balance of local politics.

Economic root causes. The APPI sites pointed to individual and community-level economic challenges as important local determinants of childhood adversity. The sites reported significant pockets of poverty concentrated in particular neighborhoods and communities. For example, the Skagit Consortium noted that affordable housing was an issue for many residents. The Okanogan Coalition reported on the high levels of poverty, homelessness, and unemployment in the area, including on the nearby reservation. These factors have contributed to high rates of substance abuse and suicide in the region. Some sites have targeted troubled neighborhoods for community development. For example, the Whatcom site has worked with neighborhood associations to increase formal programming and social supports in several lower-income neighborhoods. The Walla Walla Network worked with a local foundation and other partners to revitalize several diverse, low-income neighborhoods, including one near the state penitentiary.

The APPI sites also reported on the impact of the economic downturn after 2009, which led to significant state and local budget cuts that affected a range of prevention programs. For example, the schools in Skagit County lost many of their prevention specialists through recession-related budget cuts. In 2011–2012, state funding was cut for several programs that supported ACEs-related prevention work. Specifically, funding was eliminated for the FPC and its networks and decreased for the Readiness to Learn (RTL) program.[13]

In summary, several contextual factors influenced the design and operation of the APPI sites. Their geographic locations contributed to a sense of agency and self-reliance among the sites, creating a favorable climate for collaboration. The large geographic size and low population density of their counties led two sites to focus their activities in core towns within their regions. Local economic and political dynamics likely affected the sites' choice of policy advocacy efforts and access to public funds. The state's economic downturn affected all of the sites; it created a sense of urgency to help affected families, but it also resulted in funding cuts for some local prevention services.

B. Prevalence of adverse childhood experiences

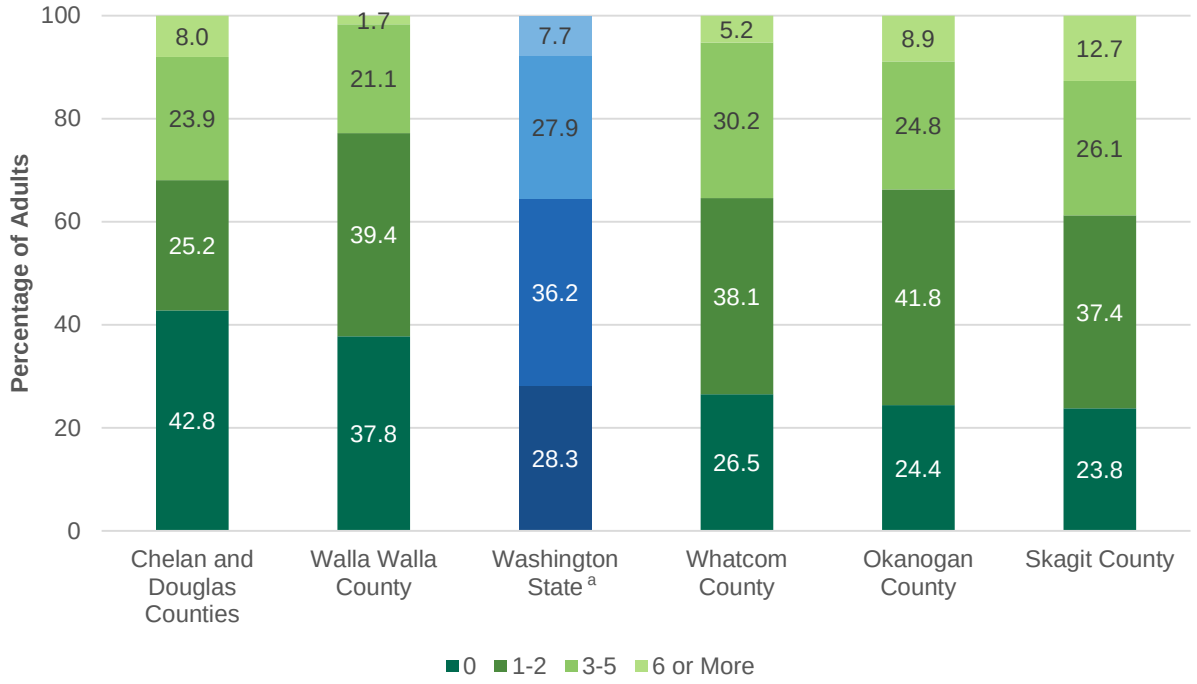
Knowing the prevalence of ACEs in the counties where the APPI sites are located provides insight into the magnitude of the problems they are addressing. To examine the prevalence of ACEs in each community, the evaluation examined the percentage of adults (ages 18 to 54 years old) reporting no ACEs, the percentage reporting a large number (three or more) of ACEs, and the percentage reporting a very large number (six or more) of ACEs.[14] The analysis found:

[13] RTL is a program that addresses the nonacademic reasons for academic failure. The program is no longer state funded but is funded at the discretion of local school districts.

[14] Because exposure to a high number of ACEs is associated with increased mortality risk, we restricted our analysis of the prevalence of ACEs in the community to adults ages 18 to 54. The source of the ACEs data is the Washington State's 2009–2010 BRFSS data.

- In three out of five sites (Okanogan, Skagit, and Whatcom), the prevalence of ACEs was high but similar to the Washington State comparison group. In particular, roughly one out of 3 adults (28.3 percent) reported experiencing no ACEs during their childhood. However, one out of 3 (35.6 percent) reported experiencing large number of ACEs and one out of 13 (7.7 percent) reported experiencing a very large number of ACEs (Figure III.1 and Table C.4 in Appendix C).
- However, two sites (NCW and Walla Walla) had lower prevalence of ACEs than the Washington State comparison group. For example, more adults in NCW than in the Washington State comparison group reported experiencing no ACEs (42.3 percent, $p = 0.02$). In Walla Walla County, fewer adults than in the Washington State comparison group reported experiencing a large number of ACEs (22.8 percent, $p = 0.01$) or a very large number of ACEs (1.7 percent, $p < 0.01$).

Figure III.1. Prevalence of Adverse Childhood Experiences (ACEs) in the Five APPI Sites and Washington State Comparison Group Among Adults (Ages 18–54), 2009–2010



Source: Mathematica Policy Research analysis of Washington State Department of Health, Center for Health Statistics, Behavioral Risk Factor Surveillance System, supported in part by Centers for Disease Control and Prevention, Cooperative Agreement U58 DP001996-1 through 2 (2009-2010).

Note: This figure reports the percentage of adults who reported experiencing ACEs. The standard errors range from 1.0 to 7.5 for the APPI sites' estimates and from 0.4 to 0.8 for Washington State comparison group. To improve the precision of the estimates, all statistics are based on a combined sample from the 2009 and 2010 BRFSS surveys.

[a] Washington State comparison group excludes the five APPI sites (Chelan/Douglas, Okanogan, Skagit, Walla Walla, and Whatcom counties) as well as King County, which is the most populous county in the state and contains the state's largest city, Seattle.

C. Trends in child abuse prevention and family support

It is also important to understand the sites' trends in child maltreatment and family well-being to determine whether the APPI sites have been working in communities that are relatively high risk for children and families. The evaluation examined three indicators related to child abuse prevention: (1) rate of hospitalizations due to injury or accident among children, (2) rate of alleged victims of child abuse and neglect cases in accepted referrals,[15] and (3) percentage of cases with an out-of-home placement that were closed within 24 months because of the reunification of the family. We also analyzed two indicators of family support: the rate of hospitalizations due to injury or accident among adult women (an indicator of potential domestic violence) and the level of family rewards for a child's prosocial behavior (such a praising a child for a job well done).[16] We found the following:

- **The rates of injury and accident hospitalizations among children remained steady or slightly decreased in the five sites and were similar to the rates in the Washington State comparison group (Figure D.1 in Appendix D, Table C.5 in Appendix C).** In all sites, between 2.5 and 6 percent of child hospitalizations were due to injury and accidents between 1990 and 2012. These figures are comparable to the percentages in the Washington State comparison group.

- **Although in four sites the rate of alleged victims of child abuse and neglect in accepted referrals remained steady, it decreased by more than 60 percent in Walla Walla County (Figure D.2, Table C.5).** Between 1998 and 2012, three sites (Okanogan, Skagit, and Whatcom counties) had similar rates of alleged victims of child abuse and neglect in accepted referrals as the Washington State comparison group, reporting between 30 and 60 cases per 1,000 children under 18 years old. Combined, Chelan and Douglas counties reported lower rates of alleged victims of child abuse and neglect in accepted referrals, ranging between 23 and 35 cases per 1,000 children. The trends for all of these groups were steady over time.

  However, in Walla Walla County, the rate of alleged victims of child abuse and neglect in accepted referrals decreased from a high of 100 (out of 1,000 children) in 2001 to about a third of that (36 out of 1,000 children) by 2010, with an average annual decrease of roughly 4 out of 1,000 children between 1998 and 2012 ($p < 0.01$). At this time, we do not have an explanation for this decrease.

- **The rates of children exiting out-of-home care to reunification within 24 months decreased or remained steady but were similar in the five sites and the Washington State comparison group (Figure D.3, Table C.5).** The percentage of children exiting out-of-home care to reunification within 24 months remained steady in the Washington state

[15] The rate of alleged victims of child abuse and neglect in accepted referrals includes children (age birth–17) identified as alleged victims in reports to Child Protective Services that were accepted for further action. The rate is calculated by dividing the number of children reported as alleged victims by the population of children (age birth–17) and multiplying by 1,000. Children are counted more than once if they are reported as alleged victims more than once during the year. A "referral" is a report of suspected child abuse.

[16] The family rewards for prosocial involvement scale from the Healthy Youth Survey consists of four items: 1. My parents notice when I am doing a good job and let me know about it. 2. How often do your parents tell you they're proud of you for something you've done? 3. Do you enjoy spending time with your dad? 4. Do you enjoy spending time with your mom? Possible scale scores range from 1 to 4, with higher values indicating more family rewards.

comparison group between 2000 and 2012 ($p = 0.07$). The trends in the five APPI sites were similar to those observed in the Washington state comparison group.

- **The rates of injury and accident hospitalizations among adult women—a primary indicator of potential domestic violence—increased in the Washington State comparison group and the five APPI sites (Figure D.4, Table C.5).** Between 1990 and 2012, the rate of hospitalizations due to injury or accidents among adult women more than doubled, increasing from roughly 8 to 18 percent, with an average annual increase of 0.4 percentage points ($p < 0.01$) in the Washington State comparison group. However, four sites (NCW, Okanogan, Skagit, and Whatcom) experienced a slower rate of increase than the rest of the state.
- **Average scores for youth-reported family rewards for their prosocial involvement scale were high and remained steady or slightly decreased in all five sites and the Washington State comparison group (Figure D.5, Table C.5).** In all sites, 6th grade students reported high levels of family rewards for the student's prosocial behavior (an average of about 3.5 on a 4-point scale) between 2002 and 2012. This was similar to the levels in the Washington State comparison group.

D. Trends in school climate and student success

The school environment is an important source of risk and protection for children. Students spend a great deal of time in school interacting with adults who can potentially serve in caring and nurturing roles and with peers who can potentially bully or support their classmates. School discipline policies and classroom management practices can also affect a school's climate and level of student engagement by being punitive or by rewarding positive student behavior. To measure ACEs prevention factors at the primary and secondary school levels, the evaluation team examined two short-term indicators of student behavior (the rates of unexcused absences and the incidence of suspensions and expulsions from school); one indicator of student commitment to school;[17] and one positive indicator of school climate (the level of school rewards for students' prosocial behavior[18]). We also looked at two critical end-of-school outcomes: the high school cohort dropout rate and the high school extended graduation rate.[19]

- **Rates of unexcused absences among elementary and middle school students in all APPI sites and the Washington State comparison group remained steady (Figure D.6,**

[17] The low school commitment scale from the Healthy Youth Survey consists of five items: 1. How often do you feel the schoolwork you are assigned is meaningful and important? 2. How interesting are most of your courses to you? 3. How important do you think the things you are learning in school are going to be for you later in life? 4. Think back over the past year in school. How often did you: a. Enjoy being in school? b. Hate being in school? c. Try to do your best work in school? 5. During the last 4 weeks, how many whole days of school have you missed because you skipped or "cut"? Possible scale scores range from 1 to 5, with higher values indicating lower level of commitment to school.

[18] The school rewards for prosocial involvement scale from the Healthy Youth Survey consists of four items: 1. My teacher(s) notices when I am doing a good job and lets me know about it. 2. The school lets my parents know when I have done something well. 3. I feel safe at my school. 4. My teachers praise me when I work hard in school. Possible scale scores range from 1 to 4, with higher values indicating more rewards.

[19] Extended graduation rate is defined as the percentage of students who graduate; it includes on-time graduates as well as students who stay in school and take more than four years to complete their high school degree.

Table C.6). Between 2004 and 2013, four APPI communities (Okanogan, Skagit, Walla Walla, and Whatcom) reported roughly five unexcused absences for every 1,000 potential school days; students in Chelan and Douglas counties had about half the number of unexcused absences (between 1.0 and 2.5 per 1,000 potential school days). However, the rates remained steady in all APPI sites and the Washington State comparison group.

- **Except for Okanogan, the rates of suspensions and expulsions among enrolled students either remained steady or increased in the APPI sites and the Washington State comparison group (Figure D.7, Table C.6).** The rate of school suspensions and expulsions increased in the Washington State comparison group from about 35 to 55 per 1,000 enrolled students between 2005 and 2013. The rates in four APPI sites (NCW, Skagit, Walla Walla, and Whatcom) remained steady but were indistinguishable from the Washington State comparison group due to high degree of variability. However, the rate of suspensions and expulsions decreased in Okanogan during the same period (average annual rate of change = -3.6, $p < 0.01$).
- **Both average scores for student-reported low school commitment and school rewards for prosocial involvement scales were similar and remained relatively steady over time for all groups (Figures D.8 and D.9, Table C.6).** The average score for low school commitment scale in the five APPI sites and the Washington State comparison group was similar (roughly 2.5 on a 5-point scale) and remained steady between 2002 and 2012. In addition, the average score for school rewards for prosocial involvement scale was similar (roughly 2.5 on a 4-point scale) across the five APPI communities and the Washington State comparison group and remained steady between 2002 and 2012.
- **Except for Okanogan County, the APPI sites and Washington State comparison group were either stable or saw improvements in their two end-of-school indicators—high school cohort dropout and high school extended graduation rates (Figures D.10 and D.11, Table C.6).** In particular, between 2006 and 2012, the high school cohort dropout rate remained stable or decreased in the Washington State comparison group and Chelan, Douglas Skagit, and Whatcom counties. However, in Okanogan County the high school cohort dropout rate increased by about five percentage points during the same period. Similar patterns were observed for the high school extended graduation rates.

E. Trends in risk behavior reduction and healthy youth development

To assess county trends in youth risk behaviors, the evaluation team focused on the onset of substance use and substance use in the last month among youth and involvement with the justice system among youth and adults. The team specifically examined the percentage of 10th grade students who reported (1) never having more than a sip or two of alcohol, (2) never drinking alcohol regularly (more than once or twice per month), (3) never using marijuana, (4) not using alcohol in the last 30 days, (5) not using marijuana or hashish in the last 30 days, and (6) not using illegal drugs (other than alcohol, tobacco, or marijuana) in the last 30 days. The team also looked at arrests among youth and adults for (1) alcohol-related violations, (2) drug-related violations, and (3) violent crimes. To measure healthy youth development, we focused on four indicators: (1) youth quality of life,[20] (2) seriously considering or planning a suicide as reported

[20] Youth quality of life scale from the Healthy Youth Survey consists of 11 items: 1. I feel I am getting along with my parents or guardians. 2. I look forward to the future. 3. I feel good about myself. 4. I am satisfied with the way

by 10th grade students, (3) overall health as reported by adults, and (4) mental health as reported by adults. We found the following:

- **Based on both self-reported and administrative indicators, alcohol use in the APPI communities and Washington State comparison group decreased over time among both youth and adults (Figures D.12, D.13, D.15, D.18, and D.19, Table C.7).** The rates of alcohol use initiation and alcohol use in the past 30 days among youth decreased between 2002 and 2012 in the Washington State comparison group and the five APPI sites. Except for Walla Walla County, the arrests for alcohol-related violations among both youth and adults also declined between 1990 and 2012. In Walla Walla County, however, the arrests for alcohol-related violations remained relatively stable among youth and adults. This is likely the result of the low arrest rates in Walla Walla County during the early 1990s.

  One of the largest decreases was observed in Whatcom County, where arrests for alcohol-related violations among youth decreased from about 30 arrests (per 1,000 adolescents) in 1990 to about 5 arrests (per 1,000 adolescents) in 2012. In contrast, arrests for alcohol-related violations among youth in the Washington State comparison group dropped from about 10 arrests to 3 (per 1,000 adolescents) during the same time period. One potential reason for the reduction in youth arrests in Whatcom is the long-term collaboration between the Whatcom Network, local law enforcement, and juvenile justice agencies on gang and youth substance abuse prevention issues. In 1990, the community created a community coalition for youth substance abuse prevention, of which the Whatcom Network became a part, to change the community culture of drinking and driving and general youth alcohol use through youth leadership development and youth-led prevention projects. This work has expanded over 24 years and has become the Whatcom Prevention Coalition, coordinated by the Whatcom Network.

- **The rate of marijuana and other illegal drug use was similar across the five APPI communities and the Washington State comparison group (Figures D.14, D.16, D.17, D.20, and D.21, Table C.7).** For example, between 60 and 72 percent of 10th grade students reported never using marijuana between 2002 and 2012. The rate remained steady in the Washington State comparison group and the five APPI sites. In general, we observed a similar pattern across the Washington State comparison group and the five APPI sites for the three self-reported measures (never using marijuana, not using marijuana or hashish in the past 30 days, not using other illegal drugs in the past 30 days) and the two administrative indicators of drug use (arrests for drug law violations among adolescents and adults).

- **With one exception, rates of arrests for violent crimes among youth and adults were similar for the APPI communities and the Washington State comparison group (Figures D.22 and D.23, Table C.7).** Between 1990 and 2012 the rates of arrests for violent crimes decreased or remained steady in the Washington State comparison group and the five

my life is now. 5. I feel alone in my life. 6. Compared with others my age, my life is .... 7. There are adults in my life who really care about me. 8. In the last month, how often have you felt that: You were unable to control the important things in your life? 9. In the last month, how often have you felt that: You dealt successfully with irritating life hassles? 10. In the last month, how often have you felt that: You were effectively coping with important changes that were occurring in your life? 11. In the last month, how often have you felt that: You were on top of things? Possible scale scores range from 0 to 100, with higher values indicating a better quality of life.

APPI sites. However, the decreasing trend in arrests for violent crimes among both youth and adults in Okanogan County was more pronounced than the rest of the state.

- **The two indicators of healthy youth development were generally consistent across the five APPI communities and the Washington State comparison group (Figures D.24 and D.25, Table C.7).** In particular, the quality of life as reported by youth slightly improved or remained steady in the Washington State comparison group and the five APPI sites between 2002 and 2012. During the same period, the percentage of youth reporting suicidal thoughts or plans remained steady in four APPI sites (NCW, Okanogan, Walla Walla, and Whatcom) and was similar to the trend in the Washington State comparison group. However, this rate slightly increased in Okanogan County during the same period.
- **The percentage of adults reporting good mental and overall health was generally consistent across the APPI sites and the Washington State comparison group (Figures D.26 and D.27, Table C.7).** The percentage of adults reporting good mental health remained stable over time in the five APPI sites and was similar to the trend observed in the Washington State comparison group. With the exception of Whatcom, the trends for the percentage of adults reporting "good" or better overall health were similar between four APPI sites and the Washington state comparison group. However, while this trend was worsening in the rest of the Washington state between 1995 and 2010, it remained steady in Whatcom County during the same period.

F. Trends in community development

To assess county trends in community-level social norms and connections, the evaluation team examined two indicators: (1) community rewards for prosocial involvement as reported by youth[21] and (2) the degree to which adult residents reported having their social and emotional meets met. We found:

- **The indicator of community rewards for prosocial involvement was consistent in the five APPI sites and the Washington State comparison group (Figure D.28, Table C.8).** The average score for community rewards for prosocial involvement scale as reported by 6th grade students decreased for all groups. Although statistically significant, this decrease is not substantively important (0.02 points per year or 0.1 points in five years on a 4-point scale, $p < 0.01$).
- **The percentage of adults reporting having emotional and social support remained steady in the APPI sites and was comparable to the Washington State comparison group (Figure D.29, Table C.8).** In particular, between 77 and 85 percent of adults reported having their emotional and social needs met "usually" or "always" between 2005 and 2010. These figures were similar across the five APPI sites and the Washington State comparison group.

[21] Community rewards for prosocial involvement scale consists of three items: 1. My neighbors notice when I am doing a good job and let me know. 2. There are people in my neighborhood or community/neighborhood who encourage me to do my best. 3. There are people in my neighborhood who are proud of me when I do something well. Possible scale scores range from 1 to 4, with higher values indicating more rewards.

Summary. In summary, the findings from the review of county-level trends in ACEs-related indicators found similar patterns among the APPI sites and in comparison with state-level trends, with some exceptions (this is not an exhaustive list):

- Chelan and Douglas Counties (NCW) and Walla Walla County had lower prevalence of ACEs among adults (ages 18-54) than the Washington State comparison group.
- Walla Walla County showed greater improvement in the population rate of alleged victims of child abuse and neglect in accepted referrals than did the rest of the state.
- NCW, Okanogan, Skagit, and Whatcom Counties experienced a slower increase in the rate of hospitalizations due to injury among women (an indicator of domestic violence) than the rest of the state.
- Okanogan County's trends in rates of (a) school suspensions and expulsions and (b) youth arrests for violent crimes also showed greater reductions than did the state trends.

Although interesting, these differences in trends are not definitive proof of the countywide impacts of the initiatives' efforts for two reasons. First, the APPI counties and the Washington State comparison group differ on a variety of factors including the demographic characteristics of their populations and the programs offered to county residents that are not related to, or supported by, the APPI sites. Second, using the available data, we were unable to observe shifts in patterns in the above-mentioned indicators coinciding with the start of the ACEs-specific efforts. Therefore, we cannot confirm that that the observed differences between site and state trends are related to the collective impact of sites' ACEs-specific efforts. The question of the impacts of the initiatives' efforts will be explored further in the APPI evaluation's final report.

IV. BUILDING COMMUNITY CAPACITY

The APPI sites worked hard to develop their communities' capacity to initiate change at several levels: changing people's views on ACEs, implementing evidence-based and promising programs, motivating agencies to change their organizations' practices, aligning goals and activities across sectors, and advocating successfully for changes in state and local policies. The sites increased community capacity in seven areas: (1) adopting or developing an effective community-based prevention model; (2) incorporating ACEs and resilience concepts into their work; (3) creating collaborative structures (networks, coalitions, and a consortium); (4) providing ongoing leadership to the networks; (5) sustaining their work through ongoing funding; (6) using data for learning, evaluation, and improvement of local efforts; and (7) engaging network members, other local organizations, and community residents as collaborative partners.

A. Prevention framework

The FPC charged its networks with addressing a range of complex problems, including child abuse and neglect, domestic violence, youth violence, youth substance abuse, dropping out of school, teen pregnancy, and youth suicide. Unlike simple technical problems with known solutions, complex problems are characterized by "multiple root causes, unclear solutions, and require orchestrated action by diverse stakeholders, who may not agree about the nature of the problem and how it should be addressed" (Cabaj 2014, p 110). Complex problems typically require comprehensive solutions that involve the alignment and coordination of multiple programs, policies, and practices (GEO 2014). These solutions also often require "bold thinking, tough conversations and experimentation, planning that is iterative and dynamic, and … [a focus on] learning-by-doing" (Cabaj 2014, p. 111).

▲ **NCW ACEs Training by Laura Porter**

Aware of the complexity of the task, the FPC did not impose a specific prevention model that included a pre-set menu of programs, policies, or practices but encouraged its networks to educate their communities about ACEs and resilience and to advocate for change appropriate to the needs of their residents (Blodgett 2013). At FPC-sponsored ACEs trainings, Dr. Robert Anda, the CDC co-author of the ACE study, resisted requests to recommend a menu of ACEs prevention practices and instead encouraged FPC networks to develop their own community-based responses. Dr. Christopher Blodgett's 2013 review of community efforts to mitigate and prevent ACEs and childhood trauma confirmed that "there are no ACEs-specific evidence-based prevention practices" (p. 4). As an alternative, he recommended the development of a trauma-informed public health model for the prevention and mitigation of ACEs (Blodgett 2013).

Sites' origins and evolution. Most of the APPI sites did not create entirely new coalitions in response to the FPC's request for network proposals. Three of the five APPI sites (Skagit, Okanogan, and NCW) modified an existing group to become formally recognized as an FPC network. One site (Whatcom) used an existing group to create the network and then eventually merged the two. Only Walla Walla created a new community-based network (the Walla Walla County Community Network) with FPC funding.

To some extent, the structures and goals of the APPI sites reflect their origins. The Skagit and NCW sites started as social service collaboratives, focused on improving the coordination of their continuum of local services. Supported by Community Mobilization and Drug-Free Communities grants, the Okanogan Coalition focused on drug prevention and healthy youth development. In 1994, the Whatcom Network started with a broad community-building focus, convening local efforts to address youth suicide, youth substance abuse, youth violence, unintended teen pregnancy, child abuse, and school dropout prevention. The site began to focus more on substance abuse prevention when it received its first state grant in 2006 and federal grant in 2010. Less influenced by non-FPC agendas than other sites, the Walla Walla Network's mission has focused more on ACEs and resilience, especially through the activities of its Children's Resilience Initiative (CRI), described in more detail below (see Table IV.1).

- *Whatcom.* In 1990, a local pediatrician founded the Whatcom Commission on Children and Youth to create a comprehensive response to the needs of children in the area. In response to the FPC call to create local community networks, the commission helped organize and staff the Whatcom County Community Network in 1994 to address the needs of families and eventually merged and renamed the two organizations as the Whatcom Family & Community Network in 2000. The group's mission is to build the capacity of communities and organizations in the county to "support children, youth, and families so that they can develop the skills and opportunities they need to lead healthy and productive lives."
- *Skagit.* In Skagit County, a group of social service organizations that had been working together to coordinate local case management services became the advisory board to the school district's RTL program in 2001. This shifted the group's focus from education to prevention. In 2003, the group became the Skagit County Child and Family Consortium, and then was formally recognized as an FPC network in 2008. The group's mission remains service-oriented, to "promote and strengthen a seamless continuum of support and services to foster safe and healthy children and families."
- *Okanogan.* Started as the Meth Action Team in 1999 to prevent the production and abuse of methamphetamines, the group broadened its focus to youth drug and alcohol prevention as the Drug-Endangered Children Team in 2001 and then as the Okanogan County Community Coalition in about 2005, after it began receiving Community Mobilization funding. A separate FPC network operated in the county until the FPC network funding ended in 2012. Since then, the Okanogan County Community Coalition has added a complex trauma lens and ACEs concepts to its mission of "effectively addressing the problems of youth substance use and violence."
- *Chelan/Douglas.* The Chelan/Douglas Children's Interagency Council was originally created in the mid-1980s. It consisted of representatives from local social service agencies, school districts, and nonprofit organizations. In 2006, this group developed into a 35-agency

Partnership for Children and Families of North Central Washington to "enhance existing resources and develop community resources." In 2010, the group changed its name to the Coalition for Children and Families of North Central Washington (NCW) and refined its mission, which is to "promote an environment that enhances, develops, and implements a network of services that will support all of our children and families."

- *Walla Walla.* In 1994, the county started the Walla Walla County Community Network, an FPC affiliate. Since hiring its current coordinator in 1998, the network has helped create a number of programs, work groups, and alliances. Notably, in 2009, the network created Children's Resilience Initiative (CRI), which formally started in 2010. After the network learned about ACEs, it incorporated ACEs and resilience concepts into its mission to increase the community's capacity to address local problem behaviors. The network's mission concerns "mobilizing the community through dialogue to radically reduce the number of ACEs while building resilience and a more effective service delivery system."

▲ **Walla Walla Network's Children's Resilience Initiative**

Community-based prevention of ACEs. The APPI sites are using community mobilization and public health prevention frameworks to organize their efforts. Three sites (Skagit, NCW, and Okanogan) are using the Communities That Care (CTC) model (CTC n.d). CTC is a community change process designed to help communities plan, implement, and evaluate proven prevention strategies to promote healthy youth development and reduce problem behaviors (Quinby et al. 2008, Shapiro et al. 2013, CTC 2014). The CTC model outlines a five-step process of activating a small group to organize a formal board that conducts a formal community profile to identify local risks and strengths, create a community action plan, and implement and evaluate programs and policies. Some of the sites have also incorporated elements from the Strategic Prevention Framework (SPF), which also has five steps—(1) assess needs, (2) build capacity, (3) plan, (4) implement, and (5) evaluate—which are guided by two principles of sustainability and cultural competence (Substance Abuse and Mental Health Services Administration [SAMHSA] 2014).

The Whatcom Network is using the Community Capacity Development (CCD) model, created by the FPC in 2009 (see Figure A.1 in Appendix A). Skagit also incorporated elements of the CCD Model into its work. The model offers an iterative process for cross-sector, cross-cultural, and cross-disciplinary leadership at three levels (family, community, and state) to (1) help communities come together, identify, and act on issues that matter most to the community and (2) create opportunities to learn from collaborative efforts, which then (3) increase the community's capacity to make further change. The Skagit Consortium also included elements from the CCD model into its work. The Walla Walla Network has taken a more eclectic approach, incorporating elements from both the CTC and CCD models, as well as principles from other research on systems change, asset-based community capacity development, and community organizing frameworks (Flaspohler et al. 2008).

The APPI sites have also developed site-specific theories of change that articulate their own strategies for achieving their goals (see Figures A.2 to A.6 in Appendix A). Although tailored to their local communities, the sites' theories of change share two key elements. First, the models target change at multiple levels (policy advocacy, community awareness and engagement, cross-sector collaboration, evidence-based programs, organizational practices, and shifts in individual mindsets and behaviors). Second, all of the sites have also incorporated an ACEs and resilience narrative into their work, from making community members aware of the concepts to assigning new teams or work groups to address the issues.

- The *Skagit Consortium* is using six strategies (community forums, education, networking, outreach, access to services, and common metrics) to increase community involvement, create effective partnerships, enhance focus on priority areas, and identify and use meaningful data to ultimately reduce ACEs.

- The *Okanogan Coalition* is working across sectors with key partners (health care providers, social service agencies, schools, public health staff, and behavioral health workers) to implement evidence-based programs (such as Triple P and the Good Behavior Game [GBG]) to increase resilience and to prevent or mitigate ACEs. These efforts are supported by a mass media campaign and other collective prevention efforts to address underage drinking.

- The *Whatcom Network* is using a range of capacity-building strategies, including convening resident meetings, piloting family support programs, and facilitating strategic partnerships. The site is also using community organizing strategies to improve social connections, enhance family activities, and empower individuals and communities. These efforts are designed to reduce community problems and increase community equity and well-being.

- The *NCW Coalition* is using an ACEs lens to assess community gaps, evaluate local systems, foster key relationships, improve communication, and raise public awareness and advocacy to build coordinated service systems that support local children and families.

- The *Walla Walla Network* is using three reform pathways (engaging priority constituents, conducting a community awareness campaign, and developing new service delivery models) to ensure that children are resilient, parents can nurture them and raise them with consistency, and the community has the capacity to foster this resilience.

B. Site infrastructure

The overall health of a community network can be evaluated by its infrastructure (leadership, governance structure, and processes); resources (material resources needed for sustained operation); and the advantages or benefits it brings to a community (Taylor et al. 2014). Strong, sustainable networks have:

- **Capacity** to maintain the ongoing operations of their executive boards, work groups, and committees,

- **Staff** with the leadership skills and experience to manage complex community engagement, strategic planning, and project implementation processes, and

- **Funding** to continue activities started through seed funding or start-up grants and to scale up effective programs and practices.

In terms of sustainability, the FPC networks are known for both their longevity and fragility (Blodgett 2013). Although many have been in existence for decades, the loss of state FPC funding in June 2012 left many of its networks at risk of closure. In fact, only 18 of the 42 FPC networks are still in operation. Subsequently, other local coalitions have sometimes taken on the goals and activities left by inactive FPC networks. This happened, for example, in Okanogan County. In this section, we assess the health of the APPI sites and compare their relative strengths and potential weaknesses in three areas: their organizational structure, leadership, and resources.

Site structure. With some local variation, the APPI sites share a structure inherited from their days as FPC networks. The APPI sites typically have a board of approximately 25 members, divided among fiduciary members (public sector organizations, nonprofit agencies, and local foundations) and nonfiduciary members (community residents). Originally, members' terms were for three years, but as appropriate replacements became harder to find, some of the APPI sites relaxed their rules, allowing members to remain on the board as long as they were willing to contribute. While one site (Skagit) maintains a strict membership attendance policy, others have been less strict. In the site visit interviews, the evaluation teams learned that there were very high member retention rates. Some members have retired from their community leadership positions as agency heads or program administrators but continue to attend sites' meetings and serve on leadership groups.

As the APPI sites have matured, some have added more work groups, alliances, and task forces. Two sites (Whatcom and Walla Walla) both illustrate their networks' relationships to these other entities as a "network of networks" constellation of community groups and alliances. Over time, four of the APPI sites have obtained 501(c)(3) status as independent, tax-exempt nonprofit organizations. The exception is the Walla Walla Network; its fiscal agent is a local community college. The Skagit Consortium has obtained 501(c)(3) status but uses a fiscal agent (the local hospital) for larger grants.

Site leadership. Members are loyal to these sites in part because of the quality and longevity of their leadership. In two sites, the leadership consists of a single coordinator, Lyndie Case (Skagit) and Renee Hunter (NCW). In the other three sites, the coordinator or director—Geof Morgan (Whatcom), Teri Barila (Walla Walla), and Andi Ervin (Okanogan)—started part-time, but moved to full-time status. As funding has allowed, they have also worked with a second team member to share the responsibility of leading site activities. Although the coordinators at three of the APPI sites have served as paid staff for a relatively short time (three years in NCW, four years in Skagit, and five years in Okanogan), they have all had previous experience as network members or even as their network's chair, and thus were already familiar with and trusted by their network colleagues. The Whatcom Network's executive director helped start his network 20 years ago. The Walla Walla Network's coordinator has served in that role for 16 years. However, the Whatcom and Walla Walla leaders are now of an age to begin planning for their retirement. Their boards are working on transition plans to ensure the sustainability of their networks.

Site resources. The APPI sites are staffed and resourced at two levels. The two APPI sites (NCW and Skagit) with the smallest budgets (between roughly $30,000 and $60,000 per year) are staffed by part-time coordinators (see Table IV.1). The NCW site operates from the annual dues of its members. The majority of the Skagit coordinator's salary comes from a grant administered by the consortium. The rest of her salary is covered through a non-consortium grant, for which she is required to assume some non-consortium duties that take up a portion of her time. These sites report that their funding is inadequate, but both are challenged to find other resources.

In contrast, at the other three APPI sites, the coordinators have moved to full-time status and have begun managing other grant-funded programs. The two APPI sites with the largest budgets (Okanogan and Whatcom) have prevention staff supported primarily by federal Drug-Free Communities grants. The third site (Walla Walla) has just started adding staff to work on a school expansion project funded by a private donor. However, before 2014, the Walla Walla Network had been struggling to find enough resources to cover the coordinator's salary. The site also created and started selling ACEs training curriculum materials as a small entrepreneurial effort to reach out to a much larger audience. In addition, the coordinator began accepting paid speaking engagements outside the Walla Walla Valley. To find a longer-term solution, she helped restart a defunct local Investors Group in 2012, which is now working to find ongoing public (non-grant) funding to help maintain the Walla Walla Network.

Table IV.1. APPI Site Characteristics

APPI site (Current name)	Year started	2014 budget	2014 FTEs	Leader
Coalition for Children and Families of North Central Washington	2006	$29,000	0.25	Renee Hunter
Okanogan County Community Coalition	1999	$335,698	2.5	Andi Ervin
Skagit County Child and Family Consortium	2001	$61,200	0.7	Lyndie Case
Walla Walla County Community Network	1994	$93,000	1.5	Theresa Barila
Whatcom Family & Community Network	1990	$302,000	2.8	Geof Morgan

C. Use of data

Through their efforts to address ACEs, the APPI sites developed capacity in several areas that are considered "essential public health functions" (CDC 2014b). Specifically, the sites have improved their ability to (a) monitor population health status to identify community health problems; (b) diagnose and investigate community health problems; (c) inform, educate, and empower people about health issues; (d) mobilize community partnerships to identify and solve health problems; (e) develop policies and practices supporting individual- and community-level health; (f) evaluate the quality and effectiveness of individual- and community-level health efforts; and (g) research innovative solutions to community health problems. In this section, we examine the APPI sites' capacity in three areas: monitoring community health status, investigating community health problems, and evaluating and improving the effectiveness of their efforts. The following section summarizes the sites' efforts to mobilize community partnerships and to inform and engage community members in the work of the sites.

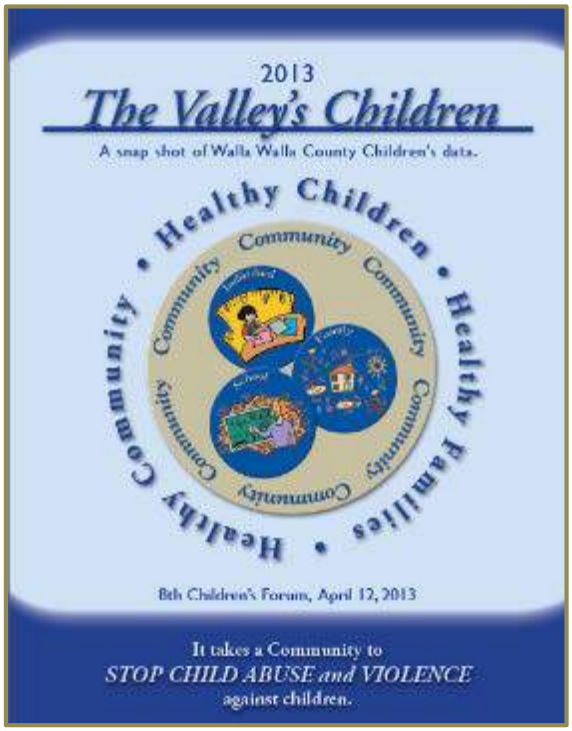
Monitoring community health status. The APPI sites vary in their capacity to organize and analyze local population trend data. Two sites (Walla Walla and NCW) helped to develop extensive trends reports and websites. One site (Okanogan) created a collective database of local court, law enforcement, and liquor board data trends in drug and alcohol-related activity. The other sites (Whatcom and Skagit) routinely review data analyzed by the county health department.

- The Walla Walla Network helped to develop a compendium of children's indicators for its first Children's Forum in 1998. Updated for each biennial forum, these data books have tracked major indicators of children's well-being in four domains: individual, family, school, and community (Children's Forum 2013). The Walla Walla Network has also monitored community health status data in its strategic planning, needs assessments, and other community studies.
- The NCW Coalition has collaborated with Eastern Washington University on its Chelan Douglas Trends website, which includes local statistics on topics such as health, education, the environment, transportation, and public safety (Chelan Douglas Trends 2014). Data for the website come from the United States Census; the Washington State Department of Health's Healthy Youth Survey; and other state, county, and school data sources.
- In 2010, the NCW Coalition collaborated with the Community Choice Healthcare Network of NCW and other community organizations to conduct a community needs assessment of Chelan and Douglas counties. Hospitals are required to conduct a community needs assessment every three years per the Affordable Care Act requirement.
- Through a 2012 pilot project with the Pacific Institute of Research and Evaluation, the Okanogan Coalition developed an Excel spreadsheet with data from Omak police records, court data, crash records, and Liquor Control Board monthly compliance check data. Data are updated regularly and used for planning, communication, and evaluation purposes.
- The Whatcom Network uses data to support its planning activities, working with the county health department and other data sources, such as the Children's Administration, Kids Count, the state Office of the Superintendent of Public Instruction, and the Office of Juvenile Justice, and to assess annual population trends on key indicators of child abuse and maltreatment; family health and well-being; community support and social capital; and measures of healthy youth development, risk behaviors, and school success.
- The Skagit Consortium analyzes the county's Healthy Youth Survey data every other year. Members hope to gain some additional data analysis assistance from the county's health department to better understand the county's greatest needs.

Investigating community health problems. In 2009, Washington was one of the first five states to add an ACEs module of questions to the state's BRFSS surveys. Since then, the APPI sites have supported the collection of other ACEs-related survey data to fill local information gaps and needs.

- In 2010, the Whatcom County Health Department and Walla Walla Network paid for a local oversample of the state's 2010 BRFSS survey to obtain more accurate and reliable data on the incidence of ACEs among their counties' adult populations.

- As part of its 2012 community health assessment, the Okanogan Coalition conducted a survey of community perceptions toward underage drinking and marijuana use. Omak middle school students annually complete the ACTUALITY survey to assess their 30-day drug and alcohol use and perceptions of parental disapproval. Also, each month, all 9th through 12th grade students complete a survey on their perceptions of alcohol and tobacco use.
- To gather more accurate trend data on the incidence of ACEs among local students, the Whatcom Network collaborated with the Shuksan Middle School in Bellingham to add ACEs questions to the school's Risk and Resilience Survey three years in a row (2011–2013), implemented the survey, and analyzed the data to help the school identify potential areas for improvement. Student ACEs data are also tracked at Walla Walla's Lincoln High School.



▲**Walla Walla Children's Forum Data Book**

Evaluation of network efforts. The FPC did not require its networks to collect network implementation and outcome data in a standardized format that would facilitate cross-site analysis (Blodgett 2013). As a result, they developed their own site-specific evaluation methods. However, none of the sites has had the funding to support an ongoing evaluation function, which has limited their own strategic learning cycles, or to facilitate the evaluation of collective actions taken with their partners.

Two sites (Okanogan and Whatcom) have conducted coalition self-assessment surveys on a periodic basis, as required of coalition grantees by the DSHS Division of Behavioral Health and Recovery (DBHR). The DBHR assessment report compares individual coalition scores to high and low state assessment scores on a range of topics, including the coalition's vision, mission, and goals; structure and membership; outreach; meetings and communication; effectiveness of planning and implementation; relationship to local government and other community partners; ability to collect, analyze, and use data; cultural competence; funding; and understanding of and commitment to environmental change strategies.

- One site (Walla Walla) is developing a range of ACEs and resilience-related measures to evaluate individual changes in student resilience, organizational spread of trauma-informed practices, and program-level outcomes.
- Once a year, the Okanogan Coalition uses the DBHR coalition assessment tool to measure its overall effectiveness and improve coalition functioning. The Coalition's 2014 assessment report showed that on numerous measures, its scores were near the state's top ratings.

- In 2009, the NCW Coalition sought member feedback on its own capacity and progress towards its goals. The coalition conducted a membership survey using Survey Monkey that was completed by 37 members. The survey assessed members' perceptions of the coalition's level of collaboration, communication, and performance and its benefits to partner organizations and the community.
- In 2013, the Walla Walla Network collaborated with former FPC researchers as consultants to develop and implement a resilience survey evaluating the impact of shifts in school discipline policies implemented at Lincoln High School. This is one example of numerous evaluation projects that the Walla Walla Network has conducted, including an evaluation of its Friends mentoring program and an evaluation of its Community to Community program.
- In 2014, the Walla Walla Network developed a common metric for network partner organizations to use as pre-post measures of their activities. The measures are used for quality improvement purposes and to demonstrate collective impact across organizations. The indicators measure two protective factors (parental resilience and children's social/emotional competency) from the Strengthening Families framework (Strengthening Families 2014).
- In 2013, the Walla Walla Network developed a qualitative measure of the organizational practices of network members: the number of organizations that have signed a memorandum of understanding (MOU) detailing their commitment to embed ACEs and resilience principles into specific organizational practices.
- The SAMHSA-funded Safe Schools/Healthy Students grant provided the Skagit Consortium with funding for an evaluator who helped the consortium to evaluate its progress and engage in strategic planning. When the grant ended, the funding for this activity was not sustained.
- The Whatcom Network compiles local program data to identify annual trends across multiple programs, which included the Strengthening Families program ([SFP], implemented in 12 sites), the Communities in Schools (CIS) program (serving 3,000 students annually), the Lummi CEDAR program (serving 100 tribal youth annually), Youth Prevention clubs (supporting more than 500 students annually), and the Dispute Resolution Center (reaching 340 youth annually).

D. Collaborative partnerships

The power of the APPI sites to leverage communitywide change depends in part on their collaborative capacity, that is, their ability to (1) make decisions and take action with other organizations within and across sectors, (2) develop new partnerships to advocate for and influence the funding and implementation of new programs and policies, and (3) create more effective service systems through the integration and coordination of service networks (GEO 2014). In this section, we assess the collaborative capacity of the APPI sites by reviewing the characteristics of their memberships and quality of collaboration among network partners.

Network members. The sites' membership lists are comprehensive; they touch almost every sector in their communities and involve public and private sectors, including education, juvenile justice, social services, municipal and tribal governments, and private foundations. Although all of the sites included similar groups (see Figure IV.1 for a compilation of the sites' members and partners), there is some variation among the sites. For example, the membership of

the Walla Walla Network includes more businesses because of its strategic outreach to that community. The Whatcom, Skagit, and Okanogan sites include more tribal partners because of their proximity to tribal communities. Notably, the networks have included a relatively small number of individual community members. They typically engage community members through other means, including trainings, community conversations, focus groups, and public events.

Figure IV.1. Site Members and Community Partners

- Early childhood education
  - Child care associations
  - Early intervention and developmental disabilities programs
  - Early learning coalitions and collaboratives
  - Head Start and preschool programs
- K–12 education
  - Educational Service Districts
  - Elementary, middle, and senior high schools
  - School districts, school superintendents, and school boards
- Postsecondary education
  - Community colleges
  - Private colleges
  - State universities
- Law enforcement and justice system
  - City and tribal police
  - Community truancy boards
  - County sheriff and state patrol
  - County prosecutors and public defenders
  - Court-appointed special advocates
  - Dispute resolution centers
  - Juvenile courts and detention centers
  - State penitentiary
  - Victim advocacy groups and violence prevention coalitions
- Public health and health care
  - Community health centers
  - County and tribal public health agencies
  - Family medical practices and primary care providers
  - Hospitals and health systems
  - Health care alliances
  - Mental and behavioral health practices and counselors
  - School-based health clinics
  - State Health Care Authority
- Social services
  - Catholic Charities and Children's Home Society
  - Department of Social and Health Services, including Children's Administration Division of Children and Family Services
  - Family support and counseling centers
  - Homeless shelters and residential housing services
- Community nonprofits
  - Youth mentoring and service agencies
  - YWCA, Girls and Boys Clubs, Scouts, 4H, county extension
  - Community action program agencies
  - Job Corps, AmeriCorps, and Volunteers of America
  - United Way
  - Workforce development and training services
- Local and tribal public agencies and private foundations
  - County board and city council members
  - Tribal councils and governments
  - City, regional, and rural libraries
  - Community foundations and family trusts
- Businesses and other community partners
  - Churches and faith-based organizations
  - Media—local broadcasting and newspaper outlets
  - Local employers
  - Chamber of Commerce
  - Kiwanis and Rotary clubs

Across the sites, medical and behavioral health providers are generally underrepresented. One NCW member explained that the level of engagement with the medical community has been low because it is an "encounter-driven system" in which the ability to bill for services is critical. The presumption is that because ACEs-related behavioral health issues are not typically treated through primary care, medical providers have less incentive to get involved in the networks. If this is the case, it is unclear why there are not more behavioral health providers serving on

network boards and committees. Evidence-based trauma-focused psychotherapy interventions such as Alternatives for Families–Cognitive Behavioral Therapy, Child-Parent Psychotherapy, and the Attachment, Self-Regulation, and Competency Framework are evidence-based models that could be part of a community's continuum of ACEs-related services (National Child Traumatic Stress Network 2014).

Several factors contribute to the diversity of the networks' memberships. For example, the site coordinators have been developing these relationships for decades, not only through the networks but also through other social, school, and family connections.

Other reasons are more network specific. For example, diverse coalition representation has been a condition of some of the grants the sites have received, such as the federal Drug-Free Communities grants. The members also cite other factors that support the size and diversity of their memberships:

- **Community context.** The sites serve small, rural communities and therefore do not have many similar groups or organizations competing for members' attention.
- **Lack of territorialism.** Members prefer to work together, instead of alone, to maximize the impact of their efforts and to avoid duplication of their activities.
- **Inclusive structure.** The sites seek input from their members on which issues to pursue, rather than dictating the goals of the group. Through flexible grants, they are also able to work on multiple, interconnected issues.
- **Shared passion.** The sites rally their members around a common set of interconnected issues, which attracts a diverse set of stakeholders motivated to get involved in issues that they might not otherwise have taken on.

Several network members also noted that relationships among their network's members deepened after the site began incorporating ACEs and resilience concepts into their work. One Skagit member explained, "ACEs language is frequently brought up during consortium meetings and ACEs concepts are related to all topics." When the Okanogan Coalition began to seek 501(c)(3) status, one member noted increased interaction among the members: "I see a lot more dedication from a lot of different folks, which is nice." The breadth of network memberships also brings other advantages to the APPI sites. For example, member diversity increases a network's ability to maximize its reach. Members bring their network's mission into their daily activities within their respective organizations. Members also provide "bridging capital" by linking their network to a broader set of organizations and agencies that are potential partners and allies.

These connections benefit members as well. Keeping abreast of what is going on in their community helps to advance their work within their respective organizations. Another network benefit is the ability to foster informal relationships. A Skagit Consortium member explained that not only do members become aware of the other services available in their county, they also learn whom to contact when they need help. Hearing about other organizations' work also helps members to understand the mechanics of how services are delivered in their county.

Member collaboration. Network relationships often differ by their type of activity. For example, the Walla Walla Network's Investors Group involves more government and business

leaders because of its emphasis on local investments. In contrast, the network's Youth Alliance includes more housing agencies and youth programs interested in providing shelter for homeless youth. These member relationships can also be used to spur friendly competition. For example, in the Walla Walla Network's CRI meetings, members are asked to report on the recent steps they have taken to embed trauma-informed principles into their operations. This has created some friendly peer pressure among network members to "walk the talk" as change agents. The Walla Walla Network has also instituted a more formal mechanism for ensuring that members are contributing to CRI efforts. In 2013, the network's CRI members were asked to sign an MOU confirming their commitment to implement ACEs and resilience principles into their organizational practices. Thus far, 24 organizations have signed the MOU, which was then used to demonstrate local collaborative strength when presented to the Walla Walla City Council in October 2013 and October 2014 to receive official designation as Children's Resilience Month.

Network members' level of collaboration also appears to differ by type of activity. We asked the APPI sites' members to rate the collaborative level of their interactions, using an eight-point scale (from low to high, 1–2 = networking, 3–4 = cooperation, 5–6 = coalition, and 7–8 = collaboration; Hargreaves et al. 2013). Across the APPI sites, most network members indicated that their core leadership or executive board operates at the highest level of *collaboration*. General network meetings function at a lower level as members share information about how to *coordinate* their activities. On joint projects, members work more intensively, working together (at a *coalition* level) to share decisions and resources. For example, a Skagit work group is deciding how to distribute local dollars earmarked for mental health services. The funding is set aside from a special county "1/10th of one percent" sales tax. As one member said, "You can get a lot more collaboration and a lot more movement in a subgroup than in the overall consortium itself."

Skagit Consortium members also work together to bring program resources to their county, to implement projects, and to advocate for policy change. They try to collaborate rather than compete for grant funding and do not apply for a grant if they believe that someone else in the community could do a better job. They also try not to seek funds that would create redundant programs, preferring to build on existing capacity. Sometimes the consortium uses its meetings to provide advice to individual members on programs under development. Finally, the consortium actively looks for new funding sources. Members also write letters of support when one member or a group of members is applying for a particular grant.

Despite these successes, recent cuts in funding for many service-oriented organizations in some communities have affected the ability of at least one APPI site (NCW) to maintain its coalition's membership. At that site, the local public health department's staff has been reduced in recent years from 60 to 30 employees, which has limited the ability of remaining employees to devote in-kind time to the coalition's efforts. One coalition member noted that "people, even those that are left, have lost a lot of steam for doing this type of work. They're gun-shy and overworked. People are wearing five, six, seven, eight hats, and when you look at how our region is spread out, we cover long distances, so it is a lot of work."

E. Community engagement

The APPI sites view community engagement as an essential strategy in the prevention and mitigation of ACEs and are working to raise awareness of ACEs and resilience principles among many segments of their communities. Through increased awareness, the sites hope to (1) motivate service providers to change their professional practices, (2) gain political support from local policymakers and private funders to allocate more local resources for trauma-informed services and supports, and (3) help local families understand their own traumatic experiences so they can use that insight to make changes in their own lives and in the lives of their children.

ACEs education. The sites have been using a variety of approaches to provide ACEs education to local service providers, educators, policymakers, funders, parents, youth, and other residents. The strategies are tailored by each site:

- ***Whatcom***. The Whatcom Network staff were trained in 2004 as ACEs experts and, together with board members, Health Department staff, and national trainers, they have disseminated information on ACEs to more than 2,000 community members and professionals, including community agencies, schools, parents, and neighborhood residents. Network staff offer five to six trainings per year. A group of network board members volunteer as "staff extenders," providing ACEs presentations to their respective sectors, including meetings of health providers; early learning community professionals; and staff working in social services, substance abuse and mental health, juvenile detention, and law enforcement agencies.

  These community events show attendees how to calculate their ACEs, reduce their stress, and work with others to prevent and mitigate ACEs in their community. The trainings take from 60 minutes to three hours and are tailored to local audiences. The Whatcom Network regularly partners with other agencies to bring national trainers such as Dr. Anda, Dr. Felitti, and Ms. Laura Porter to the community to expand and deepen the community's use of the research.

- ***Skagit***. The consortium was first introduced to ACEs through a FPC training provided by Dr. Anda in 2007 but did not begin to use an ACEs lens to think about its work until 2009. In 2010, the consortium decided to focus on ACEs and began hosting regular "ACEs 101" trainings at least once a year. Between 50 and 100 people have attended each training session. In general, each training targets a specific type of attendee (for example, the most recent training targeted educators), but all trainings are open to anyone in the community. The trainings have historically been provided at no cost to attendees.

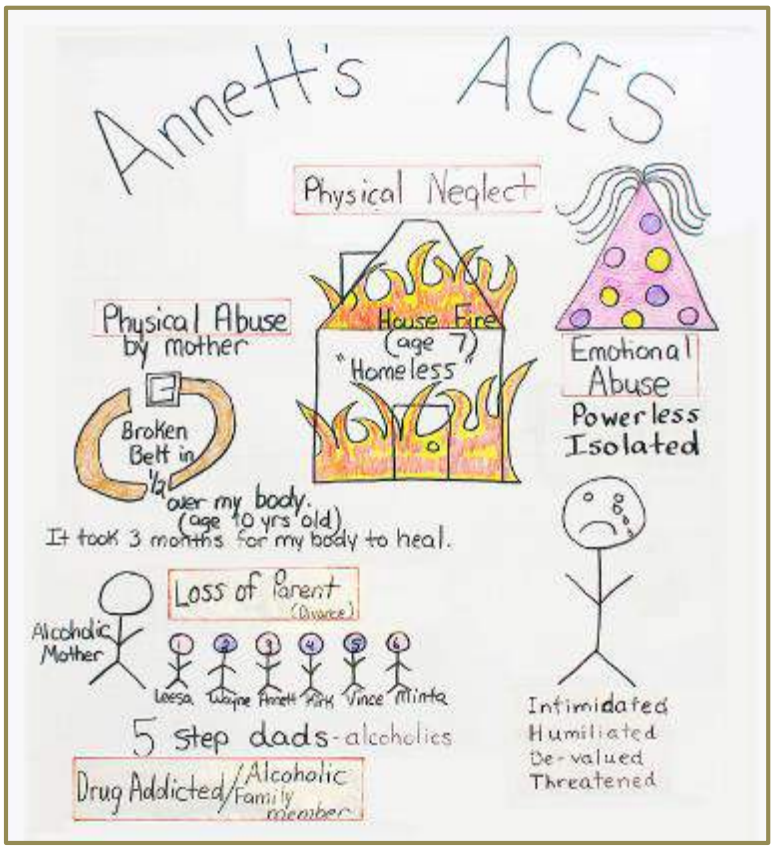
- ***Okanogan***. In March 2011, the Coalition partnered with the Support Center, the Family Health Policy Network, Family Empowerment, and the Educational Services District to facilitate a three-hour ACEs 101 training at the Okanogan Public Utility District. This training, attended by 120 community members, focused on what ACEs are and why the community should be aware of them. Because of these efforts, some coalition members believe that the ACEs concept and related terminology have become more visible in the community in the past three to four years.

  The ACEs 101 training served as a catalyst to the formation of the Okanogan Coalition's ACEs subcommittee in the summer of 2011. The group developed a logic model and

strategic action plan to reduce the prevalence of ACEs and foster resilience. The plan included the training and implementation of evidence-based programs, including the Triple P, designed to prevent child maltreatment, and the PAX GBG, a classroom practice to support and reinforce prosocial student behavior. In addition, the coalition organized follow-up ACEs training, scheduled for February 2015, on how to move from general awareness of ACEs to implementation of additional evidence-based practices proven to foster resilience to trauma.

- ***NCW***. In May 2010, the coalition hosted a two-day conference, entitled Hurt to Hope: Discovering Approaches to Strengthening Community Resilience and Supportive Learning Environments, which was attended by 162 people from multiple sectors of the community. The conference included an overview of ACEs as well as presentations from Dr. Robert Anda and Ms. Natalie Turner, a Washington State University research associate whose work focuses on children's mental health, family violence, and complex trauma. Since then, the coalition has continued its ACEs outreach through workshops, attended by a total of 90 participants from multiple sectors, including education, child welfare, health, family planning, mental health, early intervention, child care, and drug and alcohol prevention. In addition, in November 2014, Laura Porter gave a presentation on "ACEs and Resilience" to more than 250 community members, school staff, medical providers, social service staff, and members of the business community.

- ***Walla Walla***. In spring 2008, the Walla Walla Network brought Dr. Anda to Walla Walla to give a presentation on ACEs for 165 community members. One resident who attended the event was Ms. Annett Ridenour, who realized that she had all 10 ACEs—she had experienced every adversity during her childhood. She shared this awareness at the event and eventually became involved in the CRI as the lead parent representative. She reported, "Something happened." Before, she had just been "going through the motions" but now reported, "I am in the middle of it; I am involved."



▲**Annett's ACEs Presentation Poster**

Since then, the Walla Walla Network has given more than 700 presentations to service providers, community groups, individual agencies, businesses, neighborhood forums, and

parent groups. The presentations typically cover up to five topics: the original ACE study; brain development; resilience strategies and models; trauma-informed practices and tools for parents; and examples of what communities can do to respond to ACEs and improve resilience. The trainers sometimes use videos and resilience graphics and materials to enhance the trainings. The network staff has also spoken at national and regional conferences and provided technical assistance to other Washington communities and other states. The network uses multiple media to broaden the outreach of its ACEs/resilience message, including radio shows and newspaper stories. CRI also created a website (www.resiliencetrumpsaces.org), which has received more than 20,000 visitors since its creation in 2012.

The Walla Walla Network's efforts have increased local awareness of ACEs significantly in the last decade. In July 2014, the County Health Department administered a community survey at four public events (in a park, at a health fair, at a community fair, and at a National Night Out event). Of the 700 people who answered the survey's ACEs question, 40 percent reported that they were "somewhat familiar" or "familiar" with the concept of ACEs.

Other activities. The APPI sites have also used other capacity-building strategies to engage community members, including convening community meetings, hosting public events, and creating opportunities for peer learning through network projects. For example, the Whatcom Network holds community café events called "Conversations that Matter" in which "people listen to others' points of view and have an honest dialogue and get community consensus to move forward on specific issues." The network also supports community events, including an annual Community and Family Night at Shuksan Middle School. The event draws 400 neighborhood residents, families, and school district staff into the school. Participants share a free dinner, take part in planning sessions, and hear presentations on drug prevention and other youth development topics.

The Whatcom Network also works with neighborhood association members and Western Washington University student volunteers to host an annual National Night Out celebration in Bellingham's Roosevelt Park. Finally, the network has hosted an annual Community Building Awards celebration for the past 15 years that has recognized more than 300 individuals and groups for their extensive community-building efforts.

The Squalicum Health Alliance is a group of high school students and leaders that each year creates their own community projects to raise awareness of the value of healthy youth development and the risks of youth substance use. They had done some community assessments and had raised awareness about social norms about drinking and smoking in the area. They then discussed the problem that the grounds at the local Lynden Fair were mostly available for smoking. They approached the Fair Board about shifting the policy to a non-smoking focus with a few designated smoking areas. The Fair Board members were receptive and approved the policy change. The students then changed the smoking and non-smoking signs at the 2014 Fair. Working in partnership with the County Health Department and the Whatcom Network, these youth leaders successfully changed the smoking policy at the County's largest fair. For their leadership, the group received a Whatcom Community Builder award in 2014.

Impact on community awareness. As a result of these efforts, network members in all of the APPI sites believe that ACEs concepts and terminology have become more visible in certain sectors of their communities. Although most members of the general public are still unlikely

to have heard of ACEs, over the last several years many local service providers, educators, counselors, and other professionals have attended ACEs trainings, workshops, or conferences and are familiar with the concepts. As one Walla Walla community provider explained, "We all use ACEs language." Another local program manager explained, "There are now more direct conversations about ACEs. We had always talked about trauma and resilience, but now we are actually using the word ACEs."

Still, some network members highlight the need for ongoing ACEs and resilience training and other public awareness strategies. New staff orientations are needed to address employee turnover. More targeted events are needed to reach new groups, including employers and rural communities. More advanced training is needed to reinforce topics covered in introductory presentations. Culturally and linguistically appropriate messages are needed for different racial/ethnic groups. Respondents advocate for more use of radio, websites, community papers, and other media to increase the visibility of ACEs and resilience issues among local target populations.

▲**Whatcom Community Build Award Winners: Squalicum Health Alliance**

Summary. Although the APPI sites vary in the details of their operations, their strategies for building community capacity are similar in several respects. The sites are all using evidence-based community mobilization and public health prevention frameworks to structure their organizations and collective efforts. They are engaging a broad spectrum of individuals and organizational partners to solve complex problems at multiple levels. They have incorporated an ACEs prevention and resilience-building narrative into their work. They use data to identify community problems and track their progress. Most importantly, they have filled a unique role in their communities as neutral conveners of diverse stakeholders and facilitators of community problem-solving processes. In some ways, their independent status has been a vulnerability for

the networks, especially after the loss of FPC funding in 2012. These APPI sites are survivors that have continued operating, in various forms, for 10 to 20 years, but their staffs are small, their budgets are tiny, and their funding is temporary, putting their long-term sustainability at risk.

This page has been left blank for double-sided copying.

V. TARGETED COMMUNITY CHANGE

Community capacity development is not an end in itself but the means to a much larger goal of communitywide change. Community capacity is "the ability of public, private, nonprofit, and civic organizations to create effective and lasting change through their relationships and actions. It includes myriad elements, including the ability of community organizations and individuals to collaborate, advocate, communicate, collect, and use data and implement programs that are effective for the community" (GEO 2014, p 9). Community capacity is also recognized as "the interaction of human, organizational, and social capacity existing within a given community that can be leveraged to solve collective problems and improve or maintain the well-being of a given community" (Chaskin 1999, p. 4).

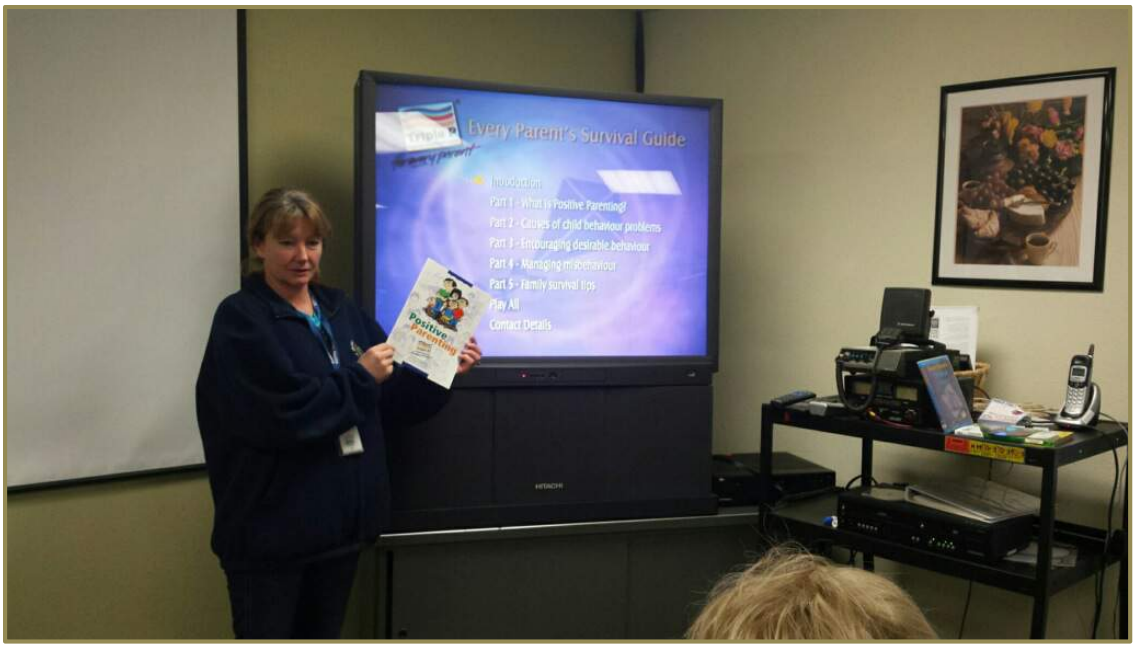
The capacity of the APPI sites should then be judged by their ability to trigger change in their communities in ways that ultimately reduce ACEs, increase resilience, and enhance community well-being. These community changes can occur through multiple levels: changes in individual perceptions or mindsets, adoption and implementation of evidence-based or promising programs, shifts in organizational practice, action through communitywide alliances, and the passage and implementation of new state or local policies. Such changes can impact ACEs and resilience by creating more nurturing and protective environments in multiple settings (at home, at school, among peers, and in the community) that have less toxic stress, fewer opportunities for problem behavior, more support for and reinforcement of prosocial behavior, and other protective factors, such as increased psychological flexibility and mindfulness (see Figure II.1). This section of the report reviews the efforts and accomplishments of the APPI sites in leveraging change in these four domains: (1) child abuse prevention and family support, (2) school climate and student success, (3) risk behavior reduction and healthy youth development, and (4) community development.

A. Child abuse prevention and family support

The APPI sites have initiated and sustained efforts at multiple levels (individual, organization, cross-sector, community, and policy) to address the child maltreatment and treatment needs of their communities. Their accomplishments include expanding the availability of evidence-based parenting programs and developing new programs, creating alliances with local child welfare systems to implement population-level child protection projects, increasing the use of trauma-informed practices by social service agencies through training and technical assistance, and helping families directly through parenting classes and training programs. For example, the Skagit, NCW, and Okanogan sites brought several evidence-based child abuse prevention programs to their communities, including the Triple P, SFP, the Kaleidoscope Play and Learn program, and the Nurse-Family Partnership (NFP) home visiting program. In their communities, the Whatcom and Walla Walla networks have worked with local CPS to create Family-to-Family alliances and to provide families involved with CPS with peer support through a new Community Navigators program. The challenge has been to manage the time-limited grants and staff turnover of these programs.

Positive Parenting Program (Triple P). In keeping with the Okanogan Coalition's aim to reduce physical and emotional abuse and neglect, the group has sought to provide support for parents through several evidence-based programs. Most notably, the coalition implemented the

Triple P in Omak in 2012 through a state grant from the DBHR[22] to engage primary care providers with substance abuse prevention work. Triple P is an evidence-based parenting and family support system for families with children ages 12 and under.[23] By training local medical and behavioral health providers in the use of Triple P, the coalition aims to normalize the concept of parental support among families and providers. Under the DBHR grant, the coalition arranged for local providers to be trained on Triple P. In 2012, the coalition used mental health block grant funding to expand its Triple P work in the community. By 2014, more than 30 local medical and behavioral health providers (most of the providers in the Family Health Center and in Okanogan Behavioral Health Care) as well as staff from Okanogan Public Health, Tribal Health, and the Okanogan County Dispute Resolution Center have been trained and accredited to use Triple P practices. However, since the Triple P training, almost all of the trained providers have left their positions, creating significant staff turnover. Without ongoing DBHR funds to support the training and accreditation of incoming providers, the coalition is concerned about sustaining the community's Triple P services.



Okanogan's Positive Parenting Program (Triple P) Training for Providers▲

It has also been challenging to change practices in some of the community's other sectors. In particular, some social workers have resisted adopting Triple P because they are used to referring parents to a different parenting class, where parents typically receive a standard dosage of didactic instruction. In contrast, Triple P dosage should be individualized and family specific to

[22] DBHR is part of the DSHS Behavioral Health and Service Integration Administration, which provides funding, training, and technical assistance to community-based providers for prevention, intervention, inpatient treatment, outpatient treatment, and recovery support services to people who face challenges with substance abuse and/or mental illness.

[23] Triple P is an evidence-based parenting program that gives parents simple and practical strategies to help them confidently manage their children's behavior; prevent problems developing; and build strong, healthy relationships. More information about Triple P is available at http://www.triplep.net/. Accessed January 18, 2015.

ensure that parents receive the level of support they require. One coalition member reported, "We thought if we just got the word out and got the agencies on board, then families would be referred to the program—that 'if you build it, they will come.' But even if they build it [the program], they [the families] don't know they have it."

Strengthening Families. Strong relationships between youth and their parents can serve as protective factors for youth. Originally developed through a collaboration between the University of Utah and Iowa State University, SFP is another evidence-based child maltreatment prevention program used in several APPI sites. The SFP targets middle school-age children and their families and is designed to help build better relationships between parents and children. The program consists of meetings that include a dinner with the families followed by activities to support parent-child relationships. The Whatcom Network and the Skagit Consortium have funded the SFP in their counties since 2003 and 2010, respectively.

▲**Skagit Strengthening Families Program**

The NCW Coalition helped to implement the ***Play and Learn Program,*** which consists of facilitated play groups for parents and caregivers of children ages birth to five years (Kaleidoscope 2014). The groups are run by the local Catholic Family and Child Services agency and are supported by state funds, private grants, and in-kind contributions from Child Care Aware of Central Washington and the United Way. Cited as a promising practice in the University of Washington's 2013 inventory of evidence-based, research-based, and promising practices, the program focuses on preventing and mitigating physical and emotional abuse and neglect by offering parents and caregivers the opportunity to learn about and engage with their children with guidance from a trained facilitator (Washington State Institute of Public Policy 2013). The program's efficacy is assessed on an annual basis through a caregiver survey and an annual program evaluation.

Nurse-Family Partnership. Home visiting has been shown to help prevent child abuse and improve the well-being of children and families. One of the Skagit Consortium's most significant efforts has been its involvement in NFP. This evidence-based home visiting program employs nurses who visit women during pregnancy and the first two years of their children's lives to help the women develop parenting skills. The consortium secured funding for NFP through a Safe Schools/Healthy Students grant from SAMHSA. When funding through that grant ended, the county reduced the size of the NFP program. However, the program has recently grown again after receiving federal funding through the Health Resources and Services Administration Maternal, Infant, and Early Childhood Home Visiting program. The consortium now serves as the community advisory board for the program. This funding is currently in place for only a three-year period, but the group hopes to keep NFP in the county by finding other funding sources for it if necessary.

Skagit Nurse-Family Partnership Program▲

Parenting classes and parent support services. The NCW Coalition also supports parenting classes offered by Washington State University, which currently facilitates several classes for parents, including (1) Children Cope with Divorce, a four-hour, court-mandated parenting class for divorcing parents who have children under the age of 18; (2) Strengthening Families 10–14, a seven-session program for families with children between the ages of 10 and 14 to reduce alcohol and drug use and strengthen communication and empathy between family members; and (3) Resilient Families Inside and Out, a program through a local drug and alcohol in-patient program that combines parenting education with yoga for stress management. In addition, for the last 20 years, NCW has also supported another parenting program called Love and Logic Parenting (see next section for more details). In the last three years, the program has included an ACEs education component.

The Okanogan Coalition has supported and expanded upon ***Love and Logic Parenting*** trainings that have been available in the community since the late 1990s (Love and Logic n.d.).

The free 12-hour group training, offered to community members through the coalition and the Okanogan County Local Planning Area once a year, is designed to teach parents practical parenting skills. Several coalition members, including the coalition director, have been trained to teach Love and Logic Parenting classes, which usually have about 40 students. Knowledge gained by participants is measured through process evaluations completed after each class. In addition, the coalition measures change in community awareness of parental supports through its annual community survey. Although these classes are not evidence based, coalition members report that parents who have participated in them have found them very useful.

▲NCW - Play and Learn Program

The NCW Coalition supports the ***Valley Intervention Program*** (VIP), a behavioral program that trains families on positive behavior management skills in both bilingual classroom and one-on-one settings (Valley Intervention Program n.d.). These trainings aim to help parents regain control of their responses to their children's behaviors and train children in social skills needed to successfully adjust to school. The VIP program is sponsored by Catholic Charities and supported by Medicaid, grants, donations, and annual fundraising. The NCW Coalition also publishes a social services directory on a monthly basis; this directory includes links to resources and information for children and family support services and is available on the coalition's website.

Catholic Charities has also played an important role in the work of the Walla Walla Network. When the Catholic Charities director started his position in 2008, he had the opportunity to meet the Walla Walla Network's coordinator, who took him to ACEs and resilience trainings. He joined the network board and became involved in several collaborative projects, including the Youth Alliance and the organization of a local Opportunity Conference to examine and address the issue of local poverty. The agency provides a range of services, including senior chore services, senior housing, immigration, counseling, and emergency assistance services as well as senior companions and kinship navigators. The agency is focusing on ACEs and resilience principles in its counseling activities. The agency has also made the commitment to serve as the licensing applicant for the one-stop comprehensive youth center that is being developed by the network's Youth Alliance (described later). Catholic Charities will also operate the shelter.

In Walla Walla, the coordinator of the Children's Home Society's parenting classes and ***Home Team Parent Aide*** parent mentoring program first learned of ACEs as a graduate student at Western Washington University. She attended ACEs trainings that were provided by the Walla Walla Network, joined the network's CRI team in 2010, and embedded ACEs and resilience

principles into her parenting classes and parent mentoring program. The agency has also started to collect data on the ACEs score and child welfare involvement of parenting program participants for programming purposes. The reach of these parenting classes is limited mostly to 60 parents per year who are involved with the local CPS system. However, the agency also provides ACEs and resilience trainings for the community members who volunteer as parent aides (mentors) in the agency's Home Team program. The program serves a caseload of 50 families who are not involved in CPS.

Child welfare services. In Walla Walla, the supervisor of the Children's Administration's local Division of Children and Family Services (DCFS) office was first introduced to the network in 2007. She was given a one-year assignment to manage the agency's ***Family to Family*** project, an initiative funded by the Annie E. Casey Foundation to build partnerships between child welfare agencies and the community. In that role, she met the Walla Walla Network's coordinator, who connected her to local community groups and service organizations.

After returning to her DCFS duties, she incorporated ACEs, resilience, and trauma-informed principles and practices into the work of her social workers, caregivers, and contracted service providers. They received training on how to provide more effective, sensitive, and trauma-informed responses to parents and children. One CPS respondent noted that "the staff is trying to be more aware of the emotional states of clients and children because when they are under a certain amount of stress, they are in a reactive role, not a thinking mode. It is about bringing the conversation back to a safe and calm state." The staff is also taught self-care skills to prevent secondary trauma resulting from working so closely with traumatized clients. In addition to the trainings, the agency is providing ACEs and resilience information to parents in information packets.

In 2007, the Whatcom Network began working with the administrator of its Bellingham DCFS office to implement the Family to Family program in its area. DCFS and the network cohosted monthly meetings where representatives of school districts, local nonprofits, and foster parents worked together to keep foster children connected to their communities and schools and to engage families in Family Team decision-making meetings, where placement decisions are made about whether to put children in foster care or remain with their families. The area administrator and network staff also developed neighborhood-based pilot projects, such as a neighborhood resident family connector and a resident-led neighborhood time banking program.

As an offshoot of the Family to Family project, in 2008, Whatcom Network staff worked with the DCFS administrator, a regional program manager, and multiple community partners to develop and pilot a new ***Community Navigators*** program. This program demonstrated how DCFS could partner more directly with local communities to provide informal services to children and families involved in CPS that would prevent child removal from the home and reduce barriers to family reunification. The Whatcom Network also collaborated with Walla Walla's CPS staff and the Walla Walla Network to become the second site in the state to work with the Family to Family program and have a Community Navigator program. Designed to "build a village around the families involved in CPS," the Whatcom program hired parents who had been through CPS in the past to help connect families currently involved with CPS to local services and supports. Staffed by the Whatcom Network program manager and four part-time

navigators, the program operated successfully for six years until September 2014, when its state funding was cut.

The Family to Family project has provided an opportunity to think more about what it takes to be a thriving community, and the Community Navigators program has increased respect for parents both previously and currently involved with CPS among some CPS staff, especially CPS staff who have attended ACEs trainings. The Family to Family partnership continues to meet monthly in different parts of Whatcom County, and each year the team selects a new geographic site in which to convene local partners and address local issues of child abuse and neglect.

Brigid Collins is a nonprofit organization providing services that include children's advocacy centers (a multidisciplinary team approach to child abuse investigations) and parenting education programs in Whatcom and Skagit counties. The Skagit Consortium supported a training program run by the Brigid Collins Family Support Center called ***Stewards of Children***. This training helps adults identify signs of child sexual abuse and to address them. This training can be provided to parents or to anyone who works with youth. The program had been provided in neighboring Whatcom County for years before the consortium helped bring it to Skagit in 2012. The program is still operating, although no longer funded by the consortium.

After learning about ACEs through the Whatcom Network, the executive director of the Brigid Collins Center shifted from teaching staff to follow specific procedures of particular program models to helping staff to develop stronger relationships with their clients through motivational interviewing, dialogue, and trauma-informed strategies, including positive parenting approaches. As a result, the agency reported reduced staff turnover and increased staff professional development, which allowed the center to implement more evidence-based practices and improve behavioral outcomes among children receiving services.

Trauma-informed health care. Several APPI sites also worked with local health care providers to incorporate ACEs and resilience principles in their practices by providing trauma-informed medical care, providing mental health services, or referring patients to appropriate behavioral health programs. The APPI sites made some progress but encountered structural barriers that limited changes in provider practices, such as medical billing procedures that limit clinician time spent on ACEs and resilience-related activities, as well as state reimbursement policies that do not recognize or fund new trauma-informed service delivery models.

For example, in Walla Walla, a local pediatrician, who realized that students were going without medical care, helped to establish ***the Health Center*** adjacent to the campus of Lincoln High School. Opened in 2009, the clinic provides free medical, mental health, and social-support referral services to students. The services are provided in a professional, confidential setting designed as a safe, nurturing environment to help keep students connected to school. The students report multiple challenges, including physical and/or sexual abuse, serious neglect or homelessness, an incarcerated or drug-abusing parent, a mentally ill or addicted family member, and caretaking responsibilities for younger siblings. While seeking routine medical care, students also commonly seek counseling services to address substance use, depression, and thoughts of suicide. The Health Center will be one of the anchor tenants in the new one-stop comprehensive youth services center, which is under development by the Walla Walla Youth Alliance, as part of its 10-year strategic plan to address the needs of homeless youth.

Funded by private grants, donations, and the services of AmeriCorps members, the center was able to expand its services to the Blue Ridge Elementary School in 2014 by reallocating its staff and staff hours among the two schools. Funding constraints prevent the center from hiring more staff. A private nonprofit 501(c)(3) organization, the health center does not fit the legal definition of a school-based health clinic, a primary care provider, a federally qualified health center, or a Medicaid certified health care provider. Consequently, its services are not reimbursable by public or private health insurance. To correct this, the center is working with its state legislator to expand the state's definition of a school-based health clinic to include the center's service model.

The Okanogan Coalition had more success gaining state approval for ***Medicaid reimbursement for Triple P*** services. Through the coalition's efforts to expand the availability of Triple P services, the community's Family Health Care has institutionalized Triple P practices in the health clinic's well-child exams/visits, and providers can now bill for Triple P services through the Medicaid Healthy Option Benefit. Although obtaining billing codes for Triple P services was a major success for the coalition, it was a time-consuming process that required a great deal of coordination with the state health care authority. Having a champion at DBHR was also important because the department helped the coalition put together the mental health block grant funding for the second round of Triple P implementation activities.

The Health Center at Lincoln High School in Walla Walla▼

The Whatcom Network has had less success directly reaching the medical community. In 2012, through a DBHR grant (mentioned below), the Whatcom Network brought Dr. Vincent Felitti, the ACE study co-principal investigator, to talk with the Whatcom medical community about how to incorporate ACEs screening into their practice. Medical community representatives had low attendance at the training. However, a number of the physicians and nurses who were in attendance are working with the network to find useful ways for the medical community to use the ACEs research. At present, financial disincentives limit the network's collaboration with the private medical community. As one Whatcom Network member noted, "ACEs will have to have billing codes, performance measures, and benchmarks for physicians and lawmakers to hold onto the issue. A new funding model is needed!"[24] She noted that such a change may happen quickly, however, if

[24] The Walla Walla Network received a similar response from the medical providers who attended ACEs training presented by Dr. Felitti, a co-author of the original ACE study, at the two major hospitals in town. Doctors reported that they needed billing codes to incorporate ACEs and resilience concepts into their medical practice.

the state issues an Accountable Care Organization RFP providing financial incentives to health care organizations that focus on community health improvement.

The Whatcom Network looked for other ways to gain traction by working with individual medical providers to add ACEs to a patient's intake history for consideration in their medical assessment and treatment. In 2012, when the health department received a $25,000 DBHR grant to work with primary care physicians, the network worked with the staff at the ***Interfaith Community Health Center*** in Bellingham to consider using a 10-question ACEs screening questionnaire to "look at the bigger picture" when treating their patients. Although the clinic did not adopt the ACEs screening tool, the network implemented a patient ACEs survey, presented a report to the staff, and facilitated a discussion about the implications that their patients' lives were impacted by ACEs. This led the leadership staff to consider further integrating the clinic's behavioral health, substance abuse, and mental health services.

B. School climate and student success

The APPI sites targeted school discipline policy and practice as a means to create more nurturing and compassionate school environments. In particular, the Whatcom Network, Walla Walla Network, and Okanogan Coalition have been working with teachers, principals, and staff in targeted elementary, middle, and high schools to shift school policies from punitive approaches to more trauma-informed practices. Their efforts included using evidence-based positive behavior management techniques; training school administrators, teachers, and other staff on ACEs, resilience, and trauma-informed counseling topics; collecting ACEs information through student surveys; changing school suspension and expulsion policies; and adding ACEs and resilience topics to courses. These changes have yielded important results: reducing school suspensions and expulsions, improving student behavior, increasing student retention, and at one high school, increasing graduation rates. The APPI sites' strategy of using successful pilot projects to leverage districtwide policy change has been more of a challenge; however, support from school superintendents and school boards has begun to spread school-specific "wins" to more locations in some sites.

Whatcom Network: Shuksan Middle School. In 2011, a new principal, Jay Jordan, started working at the Bellingham School District's Shuksan Middle School. The Whatcom Network immediately began working with him to incorporate ACEs-related, trauma-informed policies into the school's practices. The principal, who served as the Whatcom Network's board president in 2013 and 2014, implemented a positive behavior approach to school discipline, replacing the middle school's previous "zero tolerance" policy of suspensions and expulsions. The principal and network staff also added ACEs and resilience questions to the school's annual Risk and Resilience Survey of 6th, 7th, and 8th grade students to track the incidence of ACEs among the student population and correlate it to other risk behaviors, grades, and resilience factors.

Even though the student demographics have not changed over the last three years, as a result of the change in discipline policy, the school has experienced a 90 percent reduction in school expulsions; 50 to 80 percent reductions in school suspensions; and similar reductions in substance abuse, aggressive behaviors, and fighting among the students. The Whatcom Network received grants from two foundations to continue this survey at Shuksan Middle School each year. To support and enhance these achievements, in 2014, the state's OSPI awarded the school a

five-year $1.3 million grant to work with the Whatcom Network, the Bellingham school district, and Western Washington University's College of Education to implement a 21st Century Community Learning Center to provide before-school, after-school, and summer learning programs and help students develop leadership skills.

◄Shuksan Middle School, Bellingham School District

These changes have also had an effect beyond the middle school. One network member reported that the school system was beginning to take up the issue of ACEs: "A lot of teachers and counselors are beginning to identify ACEs and see it as a potential tool to explain and help tough kids." In 2012, the Bellingham School District adopted a board policy to reduce school suspensions and expulsions to zero. In 2014, the Shuksan principal received the school district's Bellingham Promise award as Leader of the Year (Bellingham Schools 2014). Based on this experience, the Whatcom Network staff is now working with the Bellingham, Ferndale, Lummi, and Mt. Baker districts' schools to develop training and prevention plans for mitigating and reducing ACEs. In 2014, Whatcom County, the Whatcom Network, and the Whatcom Prevention Coalition were also awarded $65,000 from the state to expand mental health supports and youth suicide prevention efforts in Bellingham and Ferndale elementary schools based on their work at Shuksan.

Walla Walla: Lincoln High School. Lincoln High School is an alternative high school, serving about 180 of the school district's 2,200 high school students. After the school's principal attended an ACEs trainings sponsored by the Walla Walla Network,[25] he changed the school's discipline policy in 2010, shifting from a punitive disciplinary approach to more empathetic, student- and situation-specific responses. The new,

> The high school principal described the impact of the change in the school's climate on one student, "Having lunch with a Lincoln alumnus, we were talking about the amazing changes he had made in his life. I asked him about when exactly he decided to make the changes. He shared that when he came to Lincoln, it saved his life. Things weren't going well for him and he didn't see much hope for his future. He had decided to give Lincoln a chance and if it didn't work out, he planned to end his life. I asked him what happened at Lincoln that put him on the life path and joy that he is now experiencing. He shared, "When I came to Lincoln, you (staff) loved me."

[25] The ACEs training presentations were given by John Medina, a developmental molecular biologist, and Natalie Turner, a trauma-free school expert. Turner works for the Washington State University Extension's Area Health Education Center (AHEC), directed by Christopher Blodgett.

trauma-informed approach focused on making the school a safer, more supportive setting for students by asking students what was wrong when they acted out and assigning them to in-school suspension rather than sending them home. With network support from a one-year grant from the Gates Foundation, the school also brought in 30 community members from all community sectors to deliver ACEs/resilience trainings to the general student population, in student health classes, and to parenting teens. The school also created a popular ACEs life skills course, as an elective class, to help students learn how to manage their lives around ongoing trauma. As part of the school's staff meetings, school teachers and staff also changed their approach to discipline issues by identifying and following up individually with students who were having problems.

The result was a significant reduction in school suspensions and expulsion rates in one academic school year. School suspensions dropped by 83 percent, from a total of 798 days out of school in the 2009–2010 school year to 135 days out of school in the 2010–2011 school year. School expulsions also dropped by 40 percent, from 50 to 30 expulsions during this period, and the number of graduations almost tripled (increasing by 185 percent) from 20 to a total of 57. A documentary of the shift in policy, *Paper Tigers*, was filmed by James Redford.[26] The principal has since retired from the school and currently consults on other network projects, including the expansion of the Walla Walla Network's ACEs and resilience work in three other district schools.

Lincoln High School Student Art Contest: What does Resilience Mean to You? ▲

The Walla Walla Network had been working with Walla Walla's local Early Learning Coalition to train local Head Start and Head Start/Early Childhood Education and Assistance Program (ECEAP) staff on the Head Start Trauma Smart model and was interested in doing more to support trauma-informed healthy child development programs. Based on the success at Lincoln High School, the Walla Walla Network approached the school district's leadership in 2014 about ***extending trauma-informed practices into three elementary schools***, Green Park

[26] The film, Paper Tigers, held a sneak preview in November 2014, and will be released to the public in 2015. The trailer for the film is available at: http://www.acesconnection.com/blog/paper-tigers-trailer-a-peek-into-documentary-about-lincoln-high-school. Accessed January 18, 2015.

Elementary, Edison Elementary, and Blue Ridge Elementary, and into the Head Start/ECEAP program housed in the Blue Ridge school.[27]

The district's superintendent approved the project but then left the district for another position during summer 2014. Unaware of the agreements that had been made, the new interim superintendent had to be brought up to speed on the expansion project at the start of the fall 2014 school year, which slowed its development for a few months. In the first year of the three-year project, the Walla Walla Network is working with preschool and elementary teachers and staff to develop the curriculum. The curriculum will include classroom strategies and tools for building positive learning environments.[28] The curriculum also includes trauma-informed materials and other self-care and self-regulatory practices, such as meditation and deep breathing, to prevent secondary traumatic stress among teachers.

The Walla Walla Network also advocated for change in the school district's discipline policy. In 2011, the school board voted unanimously to close all schools for a half-day ACEs/resilience training for all school district staff, from bus drivers to school teachers, when Dr. John Medina, a developmental molecular biologist, was brought to town for the Children's Forum event.[29] The school board later requested that trauma-informed language be included in district policies and that the district support the expansion of the network's activities into three elementary schools. Without the strong support of school board members, the network would not have had the leverage to achieve these policy gains at the school district level.

◄ Okanogan PAX Good Behavior Game Afterschool Activity

The Walla Walla Network has also started working with other schools in the region to change their disciplinary practices. In ***Vista Hermosa***, a planned agricultural community for migrant farm workers, the school revamped its policies and practices as a result of the technical assistance provided. The school is reporting a reduction in behaviors that previously would have resulted in school suspensions. The ***Jubilee Leadership Academy***, a residential boarding school for troubled boys aged 13 to 18, shifted from a traditional punitive method of discipline to a three-tiered, trauma-informed discipline model of safety, relationship, and skill building. The school later reported fewer school violations and

[27] While Head Start is funded by the federal government, and ECEAP is funded by Washington State, both programs provide to eligible families free early learning preschool, family support and parent involvement, and child health coordination and nutrition services.

[28] These include Safe Zone (where students can go when feeling overwhelmed), the Safe Pocket System (teaching children to check in about their feelings), Blaustein and Kinniburgh's ARC Model and implementation lessons learned from the Lincoln High School project, and the writings of Bruce Perry, Dan Siegel, Becky Bailey, Heather Forbes, Susan Cole, Ken Ginsburg, Brooks and Goldstein, and other teachers.

[29] Dr. Medina, known for his work in child brain development its impact on education, authored Brain Rules (2014).

fewer students sent back to their home states as "failures." In 2014, the school won a national Hope Award for Effective Compassion for its disciplinary changes.

Other APPI sites have also been working on school climate issues. In 2013, the Okanogan Coalition helped implement the ***PAX Good Behavior Game*** (GBG) in several Omak schools (PAX n.d.). The GBG is an evidence-based classroom management program that rewards students for appropriate, on-task behaviors during instruction. As of May 2014, two coalition members have received formal training on GBG techniques and have begun to train others in the community. Currently, GBG is used in the Omak afterschool program for grades K–12, and one teacher is evaluating the piloting of GBG in her 3rd grade classroom at East Elementary School. A formal assessment of the GBG program will be conducted through a partnership with school district staff. The coalition will conduct classroom observations and the school will provide rates of in-school suspension and standardized test results for participating schools. The GBG program has helped improve behavior among some students: in the 3rd grade classroom, negative behaviors observed within a 15-minute period declined from a total of 413 incidents to only 4 after the GBG program was implemented.

In addition, the district's student assistant specialist uses some GBG techniques in middle school life skills classes, which focus on teaching students social and practical life skills, and in the high school's 9th grade Project SUCCESS classes. Although other elementary and high school teachers have expressed interest in the GBG program and the coalition plans to train staff at several additional schools, the coalition initially had difficulty expanding the program because extensive state testing requirements left teachers with little time for topics not related to testing.

Other ACEs and resilience-related efforts. The Skagit Consortium has been involved in a variety of programs designed to help youth succeed in school. One of its primary activities was its role as an advisory board for the county's ***Readiness to Learn*** (RTL) initiative. RTL provided resources in schools and the community to help families reduce their students' nonacademic barriers to learning. The consortium advocated for sustained funding for this program. However, after state funding cutbacks, the county program ended in 2013. The Skagit Consortium has also been working to (1) prevent high school students from dropping out of school through its ***Building Bridges*** grant, (2) help youth involved in the juvenile justice system or substance abuse treatment transition back to the school system, and (3) tutor children at a neighborhood police station in Kulshan Creek. The tutoring program stopped temporarily when its SAMHSA Safe Schools/Healthy Students grant ended, but the school district has since revived the program.

The Skagit Consortium has also focused on providing mental health services by starting the Skagit County ***Behavioral Health Program***. It provides certified mental health workers in all K–8 schools in the county. The mental health workers in this program help families to problem-solve student mental health issues and can provide mental health care for children at school or in families' homes. These services are now funded by the county using funds from a "1/10th of one percent" sales tax. Through the Safe Schools/Healthy Students grant, the county expanded its ***At-Risk Intervention Specialist*** program, by hiring additional staff, including bilingual and bicultural staff. Through this program, specialists in seven school districts provided mental health and family stabilization services to at-risk youth in their schools. The funding for the program was not sustained by the county after the grant funding for it ended in 2009. Other mental health programs in which the consortium has been involved include providing early

childhood development specialists for young children, mental health programs that target Spanish-speaking families, and the provision of Functional Family Therapy (FFT) services[30] in the county.

The Okanogan Coalition has worked closely with the Omak Middle and High Schools to raise awareness about ***ACEs trainings*** among teachers and school staff. For example, the coalition director gave a brief ACEs presentation for all the county school counselors that explained how knowledge of ACEs is critical to school staff. In addition, several teachers and most administrators in the Omak School District have attended training sessions through the state's Compassionate Schools Initiative; these sessions raise awareness among staff about how to support and teach students chronically exposed to stress and trauma.

In 2007, the Whatcom Network convened an education task force to help bring the ***Communities in Schools*** program to the county. CIS is a nonprofit organization that operates an afterschool program in Shuksan Middle School to increase Latino family engagement in school. CIS also works in eight other schools in three of the county's seven school districts, providing wraparound dropout prevention case management services tailored to each school's needs. CIS programs currently provide case management services to 1,200 students and distance services to 3,500 students. The Whatcom Network's ACEs training reinforced the CIS executive director's belief that high-risk students with multiple ACEs needed extra attention and support. He then trained his CIS staff on ACEs, which was a "wake-up call" for many staff, motivating them to use a more sensitive approach in their work as mentors and case managers. To improve student outcomes, CIS is also shifting to earlier, more intensive case management services at the elementary and middle school levels.

C. Risk behavior reduction and healthy youth development

The APPI sites have been particularly active in the area of risk behavior reduction and healthy youth development. For example, one site (Skagit) have secured grants to hire more prevention and intervention staff in schools and community programs. Two other sites (Whatcom and Okanogan) have facilitated successful coalitions involving schools, media, parents, law enforcement, and juvenile justice agencies in prevention efforts to limit opportunities for problem behaviors, such as underage drinking, gang violence, and suicide. All of the sites have helped start and operate after-school activities, youth-led prevention clubs, and community-based programs, such as mentoring programs and a teen center, providing opportunities for healthy youth development. The sites have also been involved in providing more intensive services for youth, such as mental health treatment services, community truancy boards, and the use of trauma-informed practices in juvenile justice settings.

Community coalitions. Supported since 2007 by state, federal, and county health department funds and staffed by the Whatcom Network's coordinator, the ***Whatcom Prevention Coalition*** has been working with area high schools and middle schools on prevention activities, including convening Conversations that Matter on prevention topics; conducting social norming

[30] FFT is an evidence-based family counseling intervention targeted toward at-risk youth. Increasingly being used in child welfare, FFT consists of 12 to 14 therapy sessions over the course of three to four months, during which a clinician meets in the home with the juvenile and his or her family. More information available at: [http://www.fftllc.com/].

campaigns on alcohol and tobacco use; conducting ACEs trainings in school and community settings; disseminating prevention literature; supporting school dropout prevention, gang prevention, and suicide prevention activities and Parents Matter groups; providing group facilitator trainings; and partnering with other organizations and agencies on community-building and youth prevention activities.

The FPC required its networks to conduct programmatic reviews of targeted local services. In 2005, the Walla Walla Network started a two-year research project, conducted by a Whitman College professor and student, on the status of unaccompanied minors in the Walla Walla Valley. The study, which was extended and became ongoing, highlighted the need for shelter and other services for homeless youth living in the area. This issue brought together a new group of stakeholders, including the network, Catholic Charities, the YWCA, the Blue Mountain Action Council (BMAC), and other local organizations, to develop and implement a coordinated communitywide strategy for addressing the needs of this particularly vulnerable group. Named the ***Walla Walla Youth Alliance***, the group is developing a plan for a one-stop services center for at-risk and homeless youth and is raising funds for the $2.2 million construction cost.

The Okanogan Coalition has also worked closely with community partners on its ***Most of Okanogan Valley (MOOV),*** a community positive norms campaign that highlights positive behavior and sets clear standards regarding alcohol use and underage drinking. As part of the campaign, the coalition used marketing techniques targeting middle school students, high school students, and adults. The guerrilla marketing at Omak High School (OHS) was organized by the Omak Key Club, which used the message "8 out of 10 OHS students do not use alcohol." The middle school marketing was focused on marijuana and its message was "9 out of 10 Omak Middle School Students are Positively Not Smoking Pot." The adult MOOV campaign used the message "9 out of 10 Omak adults do not approve of underage drinking." Moving forward, the coalition may shift the leadership of this group to the local Kiwanis club; as a branch of the Kiwanis Builder's Club, the group will focus on community service but will retain ties with the coalition. The coalition has also worked with local businesses to disseminate and display the MOOV logo and to clean up graffiti-covered buildings and cover them with murals containing healthy youth development messages.

Community-based youth support programs. One of the first spin-off programs created by the Walla Walla Network in 1999 was ***Friends of Children of Walla Walla***, a nonprofit 501(c)(3) organization that provides mentoring services to help children in the Walla Walla Valley "engage in safe, child-focused friendships with adults." The director explained the resilience principles behind the program: "According to all of the resilience research, the primary building block is a caring relationship with a safe, consistent adult, and that is what we do." Funded primarily by businesses, clubs, foundations, trusts, organizations, and individuals, the program struggled financially for a few years after the current director was hired in 2008. To pay for part of his salary, he worked four hours a week for the Walla Walla Network in 2009 as part of the network's Sherwood Trust and Gates Foundation grants to increase local awareness of ACEs and resilience principles.

A second program spun off by the Walla Walla Network in 1999 was the ***Community Center for Youth***. The center experienced ongoing issues of staff turnover (14 directors since 1999) until 2013, when it merged with the Walla Walla YMCA and became the Walla

Walla YMCA's Community Center for Youth (YCCY; Ponti 2013). The YCCY currently provides a wide range of recreation programs for at-risk youth, including white-water rafting, survival skills, basketball, participating in service projects such as a bike shop, essay competitions, and a monthly movie night. The organization operates with four staff and three to four volunteers, including an AmeriCorps volunteer. The director explained the goal of the center: "We want to have a positive effect and mold these kids and be that stable base they need." Since the merger, youth engagement in the center increased, averaging more than 40 children per day in 2013. The Walla Walla Network's ongoing role in the center is to provide ACEs and resilience training to center staff. The network has since supported youth programing in other ways, including afterschool programs (homework support and recreation), parent training, a soccer team, a basketball team, and other activities. The network's interest in youth involvement eventually led to the start of the Commitment to Communities project, described later in the report.

The Skagit Consortium's programs to promote healthy youth development emphasize providing prosocial activities to youth. The consortium has more recently provided mini-grants for prosocial activities, such as a movie night in Kulshan Creek and a mosaic glass art project for youth. The consortium also helped to create the ***Voicing Our Ideas, Challenging Everyone*** (VOICE) Youth Coalition, which offers several activities, including dances and social service projects. Although the program was meant to be countywide, transportation difficulties limited it to Sedro-Woolley, a community of roughly 10,000 people.

▲Skagit Varsity for Volunteerism Activity. Photo Courtesy of United Way of Skagit County.

When that group began to decline, it was replaced by the ***Varsity in Volunteerism*** program. This program provides students with a varsity letter if they participate in volunteer activities. To receive a varsity letter, students must complete a minimum of 100 hours of community service during the school year. The program helps students gain leadership skills, gives them an opportunity to help others in their communities, and helps them gain recognition for positive activities. The program especially benefits students who do not belong to other clubs, music groups, or sports teams. The program has expanded, serving more than 90 high school students in Sedro-Woolley, Burlington, and Concrete, a town with fewer than 1,000 people (United Way of Skagit County n.d.). The program is now being evaluated by SAMHSA as part of its Service to Science program.

Since 2010, the Whatcom Prevention Coalition has supported and helped form 12 ***youth-driven prevention clubs*** or teams to support healthy youth development activities, including leadership team building, health promotion efforts to promote healthy habits and anti-drug messages, drug prevention groups, and "finding your passion" (finding your gift and how to offer it) opportunities. The teams or clubs have adopted positive names, such as the Natural High Club and the School and Health Alliance. The youth also attend an annual youth prevention summit in Yakima. In 2014, the Prevention Coalition organized its own summit and hosted 50 youth locally for a two-day leadership retreat. At the request of teachers and counselors, these clubs have expanded to a dozen high schools and middle schools around the county. School counselors report that these clubs are a success, especially among struggling students who are given leadership opportunities.

To support youth leadership in the clubs, the Whatcom Prevention Coalition also started a youth council led by three high school students. The council has completed community service projects, personality testing, digital storytelling, and leadership training on topics that include using resilience-related practices to create a sense of belonging and prevent bullying, substance abuse, and youth suicide. The Whatcom Network has also brought in staff from the local conflict resolution center to teach conflict resolution skills to youth leaders, youth at Shuksan School, the Lummi tribal community, and the Sterling Meadows (a multifamily affordable housing development for farm workers and their families).

In fall 2013, the Whatcom Prevention Coalition worked with two parents on the Bellingham School District Superintendent's Parent Advisory Committee to create ***Parents Matter***, a parent group that now serves as a subgroup to both the prevention coalition and the school district's parent advisory committee. The group meets each month with a coalition of community members (including the county health department and state patrol), parents, and school staff to find ways for parents to get more involved in community prevention work and to help connect families with community partners and activities that address such issues as relationships, drugs, and alcohol use. One of the first activities of the group was to create a parent education series that included ACEs/resilience training led by Whatcom Network staff.

Youth risk prevention activities. The Okanogan Coalition has partnered with the local school district on a range of alcohol and substance abuse prevention activities. At the Omak Middle School, 6th graders attend ***Project Northland***, a program that aims to increase student knowledge of the risks associated with underage drinking and improve student leadership and support. In high school, Omak 9th graders attend ***Project SUCCESS (Schools Using Coordinated Community Efforts to Strengthen Students)***, a drug and alcohol prevention initiative funded by the local education service district. Based on the SAMHSA substance abuse prevention model, the program provides a range of substance abuse prevention and early intervention services. Through this program, students learn about skills for drug resistance, relaxation techniques, and community resources. The program includes the classroom curriculum used in the high school as well as individual and small-group curricula that the student assistance specialist uses with students who have been identified as drug or alcohol users or those coming out of treatment.

Under the SAMHSA ***Safe Schools/Healthy Students*** grant, the Skagit Consortium led a number of targeted substance abuse prevention programs, such as Students against Destructive Decisions. The consortium was also involved in the Student Assistance Prevention and Intervention Services program, which funded intervention specialists in schools. More recently, the consortium has created the Power in Numbers social norms campaign to reduce alcohol and drug use, formed a substance abuse prevention committee, and participated in advocacy activities and public forums about alcohol and marijuana laws. Under the Safe Schools/Healthy Students grant, the consortium also worked on several gang violence prevention projects, including creating an intra-local agreement to improve communications between police and social service agencies, hosting extensive gang awareness stakeholder meetings, developing school assessment teams to prevent school shootings, and writing a strategic plan to address gang violence communitywide. Much of this work has been sustained after the grant and may spread because other localities have inquired about the work.

From 2004 -2009, the Skagit Consortium participated with the county's seven school districts, social services, law enforcement agencies, and other partners in the $7.9 million SAMHSA-funded Safe Schools/Healthy Students Initiative, which was administered by Northwest Educational Services District 189. The initiative increased violence prevention and mental health services for children from birth through high school and their families. Through the initiative, school prevention-intervention specialists served more than 7,000 children. Early childhood behavior specialists served more than 2,000 children. The Strengthening Families program served more than 100 families, and more than 6,700 participants were reached through community events. When the grant ended in 2009, the Consortium was asked to facilitate county efforts to continue key elements of the grant.

In 2012, the Whatcom Prevention Coalition helped start a ***Youth Suicide Prevention Task Force.*** Several Bellingham High School youth met with parents and coalition staff to talk about what could be done to prevent suicide among their friends and peers. In response, the Prevention Coalition, school district prevention specialists, and several mental health counselors worked with the students to form a youth suicide prevention task force that was active for about a year and a half, holding meetings to develop a training and peer support program. The group incorporated the topic of suicide into school trainings and teacher trainings, created a video for all schools in the district, and gave a presentation at the 2013 Youth Spring Forum. Counselors reported that six students sought help as a result of the awareness the task force brought to the school. During the 2013–2014 school year, more than 50 youth went through the prevention training. In 2014–2015, the training will be offered to all students, school staff, and parents in the county, using $25,000 that the coalition received as part of a larger mental health grant.

In 1994, the Whatcom Network started working with the Ferndale and Lummi Nation schools, the Lummi tribal government, Ferndale law enforcement, and the juvenile detention center in Bellingham to develop and implement a ***gang prevention*** plan targeting native and Latino youth as well as other gang prevention efforts. In response to the resurgence of gang activity in the community, in 2008 the network formed the Gang Prevention Team, working with the Bellingham police, Shuksan Middle School (considered a "hotbed" of gang activity), the Sheriff's department, community agencies, and Sterling Meadows. Facilitated by the network's director, the group holds bimonthly partner meetings and weekly meetings with 8 to 10 at-risk youth to provide mentoring and community service activities. One project involved painting over graffiti on the outside of a local restaurant, which led to a job for the youth to paint the entire restaurant.

Whatcom Gang Prevention Team with Local Law Enforcement Officers▲

Law enforcement partnerships. The Okanogan Coalition has worked closely with the Omak Police Department to ***enforce underage drinking laws*** through party patrol efforts and investigations to identify people supplying alcohol to minors. The coalition has also used its connections with local businesses to support these efforts. For example, when the coalition heard that a 12-year-old had shoplifted a fifth of Captain Morgan rum from a local Walmart and gone into a coma for three days in 2012, the group worked with the local radio station to publicize reports of liquor thefts at Walmart. As a result, Walmart redesigned its liquor department so that liquor must be paid for in that department rather than in the general checkout area of the store.

The coalition began partnering with Okanogan County Sheriff's Department in fall 2010 to implement semiannual prescription drug take back events. The effort was expanded to offer five different semiannual take-back sites in 2011. In 2012, the Omak Police Department installed a permanent take-back depository. Currently there are three separate permanent take-back sites at Omak Police Department, Oroville Police Department, and Twisp Police Department. Since the Drug Enforcement Administration discontinued offering its semiannual take-back events, the coalition will partner with the three police departments who house permanent take-back depositories and the North Central Regional Drug Task Force to properly incinerate collected medicines at an approved incinerator in Spokane, Washington.

In 2014, the coalition also worked with the Omak High School, local media, and five local law enforcement jurisdictions, including tribal police, to preempt underage drinking and drug use on Senior Skip Day.

In Walla Walla, local law enforcement leaders have also been active partners in the prevention of youth delinquency. The former chief of police was a leader in the creation of the Community Center for Youth and instrumental to many other youth development projects. Although retired, he continues to serve as a network member. The new chief of police in Walla Walla has become an active participant in the meetings of the Youth Alliance and Investors Group. The sheriff has also been a supporter of the Walla Walla Network's activities.

In 2014, the Okanogan Coalition learned that several Omak high school students were "taking orders" for alcohol and marijuana for the upcoming Senior Skip Day planned over the Memorial Day weekend in an area campground. In response, the community used existing resources and connections coordinated by the Coalition to mobilize five law enforcement jurisdictions, the high school principal (the Coalition's board president), and local media, to prevent potential underage drinking and related risks. The day before the event, the Coalition taped 300 posters in school bathrooms, met with the students suspected of taking orders, and began patrolling local campgrounds. As a result, the event occurred without incident; there were no reported car collisions, physical or sexual assaults, or students caught in possession of alcohol or drugs. The poster later became a local billboard.

▲**Okanogan Senior Skip Day Poster and Billboard**

Juvenile justice interventions. One of the first ACEs-related projects implemented by the Walla Walla juvenile detention center was a survey of the juvenile detention population that showed adjudicated youth had high rates of ACEs. The juvenile justice center subsequently implemented a series of trauma-informed practices. For example, the center provided ***trauma-informed practice training*** to the juvenile detention center staff. After the training, the center director revamped the center's behavioral approach. The center also shifted its discipline policy from a punishment and demerit-based system to a more empathetic, positive response system. As part of this shift, the center has added a mental health counselor who works inside the detention center. The detention center's teacher has added trauma-informed practices to the center's classroom, including the use of a stationary bike, which students can ride during class to calm themselves, and other practices. As a result, behavior problems have been reduced and the center has been able to keep more youth offenders at the center rather than send them to adult corrections.

The Walla Walla Network has also worked to change the policies of the local juvenile justice center's program of volunteer ***court-appointed special advocates*** (CASAs). Community

volunteers are trained to serve as advocates in court for abused or neglected children to ensure they receive appropriate educational and social services and, if necessary, are placed into a safe and permanent home. The network's CASA member has been instrumental in embedding ACEs and resilience principles into the CASA program, which changed its group orientation training for CASA volunteers to include ACEs and resilience topics. CASA volunteers are incorporating trauma-informed language and concepts into their court reports. CASA volunteers also introduced the Family Treatment Court program to their trauma-informed approach.

The Okanogan Coalition was a cofounder of the ***Omak School District Community Truancy Board*** instituted for the 2014–2015 school year. The coalition partnered with the Okanogan County Juvenile Court and Omak School District superintendent to implement a truancy board for the district after learning about similar work in other counties. The truancy board, which includes the juvenile court officer; school staff; mental health providers; and representatives from the coalition, the community action council, and the Family Empowerment agency, helps to resolve barriers to school attendance and identify supports to help students improve their attendance. The coalition has also worked with the Okanogan County Prosecutor's Office (which employs several coalition members) to support parents of children in grades 6 through 12 involved with the juvenile justice system through ***Functional Family Therapy (FFT)***.[31]

The NCW Coalition is also working with the Children's Home Society and Chelan County Juvenile Court to implement a community truancy board for its school district. The board, which will complement the local RTL program by identifying barriers to school attendance, is intended to decrease truancy rates in Chelan County.

In 2007, the Whatcom Network contacted the county juvenile court administrator to discuss ACEs and found that the concepts of trauma-informed practice, ACEs, and resilience were not new for juvenile court administrator and judges but informed an approach that they had been using for a number of years to reinforce ***restorative justice principles.*** The court administrator required all staff to attend Whatcom Network ACEs trainings and to use their skills in aggression replacement therapy and FFT to switch from a punishment-based deficit approach to an asset-based encouragement model of care. The juvenile justice system also replicated a fiscal policy originally created in Pierce County to decategorize more than $250,000 in court funding for restorative justice purposes. In addition, the juvenile court administrator instituted a new policy of conducting rapid intake assessments of youth sent to detention. Students who did not belong were sent back to their schools. This initially created some tension between the court and the schools, which had used detention as a student punishment, but over time the schools became aligned with the restorative justice philosophy and "the new policy became the norm."

Other ACEs-related efforts. The Omak School District also has been an instrumental partner in collecting data on student drug and alcohol use. Since winter 2013, all Omak High School students have completed a monthly survey on their use of alcohol and tobacco as well as on their perceptions of use among their peers. The coalition developed the survey, provides and collects survey materials, and analyzes the survey data. The high school survey has subsequently

[31] FFT is an evidence-based family counseling intervention targeted toward at-risk youth. More information available at: [http://www.fftllc.com/].

indicated significant drops in 30-day alcohol use among students. Middle school students also complete the annual ACTUALITY survey, also developed by the coalition, which assesses their attitudes toward their school, their use of substances and their perceptions about use among their fellow students, and their familiarity with slogans used as part of the school's social norms campaign. To provide an adult perspective on substance use among local youth, the coalition also conducts a biannual survey of Omak community members on their perceptions of underage drinking and support for enforcement of underage drinking laws.

Although the NCW Coalition has historically done less work around youth development, recently the coalition has been working with the West Side Alternative High School to focus more on ACEs, trauma, and resilience. As part of this work, the coalition conducted an ***ACEs survey*** at one of the high school's feeder elementary schools. The survey revealed that more than half of all 5th graders in the school had a score of four or more ACEs. Moving forward, the coalition hopes to conduct the ACEs survey at the other two feeder elementary schools for the alternative high school and to use that information to inform school policy and practice change.

D. Community development

Two of the five APPI sites (Whatcom and Walla Walla) have focused their time and resources on building formal and informal social supports for vulnerable families in targeted neighborhoods. The underlying logic is that by bringing neighbors together to work on community improvement projects, attend public events, and participate in other neighborhood-oriented activities, residents can develop a greater sense of community, become less socially isolated, and be more willing to ask others for help and reciprocate, when needed, as they move from being consumers of services to active producers of community engagement. The Whatcom Network also helped to bring new services and supports to an isolated community on the eastern side of the county. These development efforts have played a part in reducing neighborhood violence, improving community safety, creating more attractive park space and other amenities, and improving living conditions for some families. Such efforts are designed to help meet basic needs, reduce toxic stress, and increase social capital among at-risk families.

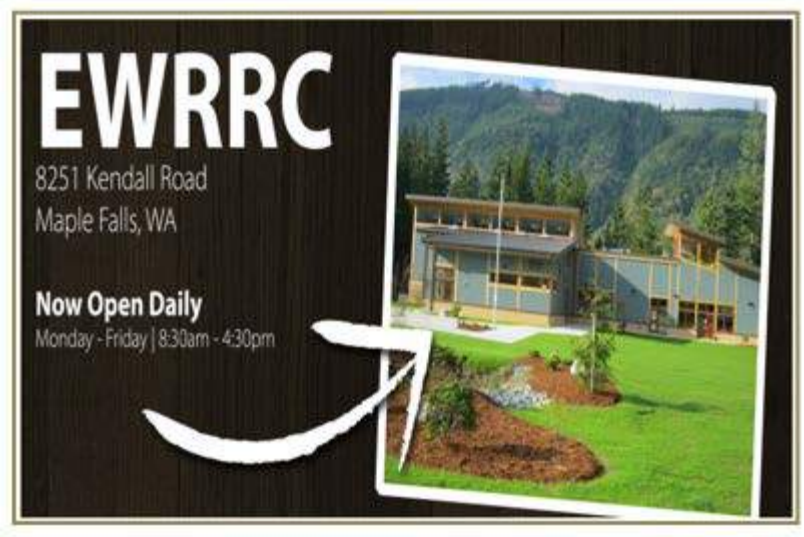
Whatcom neighborhood development. Since 1997, the Whatcom Network has worked on several projects designed to empower parents and other community members at the neighborhood level. The approach of the network has been to "lean in and help and then pull back from" neighborhood associations, when needed. The primary work has been in the Roosevelt and Birchwood neighborhoods in Bellingham and in the smaller communities of Ferndale, Kendall, and Acme. The network's efforts have been a visible improvement to these areas. These and other activities, for example, have contributed to the turnaround of the Roosevelt neighborhood that has occurred over the last six years. Since 2010 in particular, there have been fewer reports of violence in the area, and fewer children have been removed from their homes and placed into foster care.

Bellingham's 2014 Roosevelt Park National Night Out Celebration▲

To accomplish these changes, the network contracted with the president of the ***Roosevelt Neighborhood Association*** to coordinate the new neighborhood resource center and to hold monthly meetings and other activities to bring neighbors together to make the neighborhood more community minded and supportive of its residents. The network also supported the work of Whatcom Dream, a nonprofit organization providing financial literacy classes at the Roosevelt Resource Center. The Community Navigator program hosted monthly family dinners at the resource center for families involved with CPS, which enabled them to connect, network, and provide mutual support. The network also helped organize the now annual National Night Out celebrations in Roosevelt Park. It also sponsored and supported other community-building activities in the neighborhood, including the Read Aloud group, a summer reading program started by a neighborhood parent, regular neighborhood clean-up activities, supervised visits at the center, and a Dads group started by a father, formerly involved with CPS, who had been helped by the Community Navigator program.

In Kendall, a small but rapidly growing community in an isolated area 45 minutes from Bellingham referred to as East County, the Whatcom Network funded a resident in 1999 to help organize her neighbors. Over the next 10 years, the residents partnered with the county and state to reduce methamphetamine labs in the area, build connections with the large local Russian-Ukrainian population, and build a neighborhood resource center. This created a space for many service providers and programs to reach out to the isolated community. In 2011, a new East Whatcom Regional Resource Center was opened to provide early childhood education (a preschool program); family support and health services; transportation, and other assistance, including translation services for the Russian and Ukrainian immigrants in the area.

There is now community internet access, Whatcom Transit Authority bus service, and increased police presence in the community. In 2012, the Family-to-Family group began meeting in Kendall, bringing together several more organizations to support the isolated East County families. The organizations included the Whatcom Network's Community Navigator program, the Prevention Coalition, the Opportunity Council, local churches and parents, CPS, the county health department, the county sheriff, the Collins Center, and the Mt. Baker School District. As a result of their efforts, significant new resources have flowed into this rural area and a surge of energy is helping mobilize local residents to come together to create new parent and youth programs.



East Whatcom Regional Resource Center

Walla Walla Commitment to Community program. In early 2004, the Walla Walla Network's coordinator helped to create and then lead a neighborhood safety and stabilization initiative that led to Commitment to Community (C2C), an ongoing program funded by the Sherwood Trust and other funders. The goal of the program has been to build social capital by working directly with four targeted neighborhoods: Jefferson Park, Edith-Carrie, Washington Park, and Blue Ridge. The neighborhoods were selected because of their relatively high rates of poverty, crime, need for intensive social services, and disconnected residents.

The program has sought to reduce social and cultural isolation and empower neighbors to come together to address their concerns. With funding from the Sherwood Trust, C2C launched many activities, such as clean-up efforts in the neighborhoods and family events, such as potlucks and Children's Day; and it brought in a community building expert from the Pomegranate Center to lead these community improvement projects. For example, in 2006, after the BMAC (under which the C2C program operates) purchased and removed 11 dilapidated structures in the Edith-Carrie neighborhood, the community worked with the Pomegranate Center to clean up the area and create a Gathering Place that is well maintained and well used. In 2012, the city also completed a significant infrastructure repair and replacement project in the neighborhood.

▲**Walla Walla's Edith-Carrie Gathering Place Event. Photo courtesy of Pomegranate Place**

The C2C program has also made major improvements in other target neighborhoods, working with residents to improve their physical environment while teaching them how to advocate on their own behalf. For example, the Pomegranate Center also helped engage youth and neighbors in a second revitalization project in Washington Park, where a "plaza" style gathering center was designed and constructed in collaboration with the city and park neighbors. C2C also supported the rejuvenation of Jefferson Park in Walla Walla. One network board member commented, "Jefferson Park has made a very big transformation." Once avoided by the community, the park is now celebrated as a welcoming space. Another board member explained, "The community took back Jefferson Park. They cleaned up their neighborhood, made connections with city council members, and developed a relationship with the police department. They learned how to function well without the need for a backbone organization like C2C."

Walla Walla business development. The Walla Walla Network has also been working to increase awareness of ACEs in the local business community by including businesses in community ACEs/resilience trainings. The thinking behind this strategy is that employers can use trauma-informed business practices to support employees and families who may be struggling with ACEs-related issues. By acting with more compassion and understanding of the ACEs that may be contributing to employee performance issues, employers can play a powerful role in helping parents prevent and mitigate ACEs in their own families.

Several businesses, such as the Columbia Rural Electric Association, helped to promote special training events to enhance businesses' understanding of the connection between ACEs and employment and to develop a business leadership group to engage local business leaders in the integration of ACEs/resilience principles into their organizations. Another important business

in the community, the Opp-Seibold Construction Company, has joined the Investors Group to advance the policy work of the Walla Walla Network.

One of the largest employers in Walla Walla with over 200 staff, Valley Residential Services provides residential services to developmentally disabled and homeless veteran populations. The network trained the director and staff on ACEs and resilience topics. Since then the director has worked with staff to use more trauma-informed approaches with their clients and is working directly with some of her agency's disabled veterans to use an ACEs lens to understand their own experiences with post-traumatic stress.

Private nonprofit organziations are also part of the network's business development strategy. BMAC, a Community Action Program, provides a range of services to help meet the basic needs of low-income individuals and families, leveraging community services and supports to help families become more self-sufficient. A member of the network board, BMAC staff have been involved in several projects, including the C2C project to renovate targeted neighborhoods, the development of a Youth Alliance to improve services for homeless youth, and the resurrection of the local Investors Group to find more public and private (non-grant) resources to power the network's activites.

E. State and local policy change

Until the state FPC office was defunded in 2011, the FPC networks—including the Walla Walla and Whatcom networks—were typically involved in policy advocacy at the state level as FPC partners, working with FPC staff, state House and Senate representatives, the Governor's Office, the Office of Superintendent of Public Instruction, and other state agencies. The networks submitted formal reports and policy recommendations, participated in rule making processes, and advocated for changes in state programs and budgets. In addition, the NCW Coalition, the Okanogan Coalition, and the Skagit Consortium have had their own histories of state-level political engagement and policy advocacy as independent community coalitions. After 2011, the Walla Walla and Whatcom networks have become more active independently on state policy issues by, for example, supporting a state budget proviso that allowed more flexible use of juvenile court funds for ACEs-informed continuous improvement efforts. However, the APPI sites have had mixed success on some issues for a range of reasons, including the fact that they did not use hired lobbyists or have legislative allies to champion their causes. Indeed, the loss of previous FPC legislative champions has left a gap at the state level.[32] Recently, two APPI sites (Walla Walla and Whatcom) have become involved in Collective Impact processes to align local policy priorities and resources.[33] It is not clear whether this model is considered a more effective policy approach, or has attracted the attention of local policymakers for other reasons. Such efforts could influence the networks' future state policy work.

Policy advocacy. Since 2000, the NCW Coalition has hosted an ***annual legislative forum*** to provide an opportunity for state and local legislators to hear from the Coalition on topics of

[32] For example, one former champion left the state legislature to become the Mayor of Bellingham.

[33] Collective Impact is a structured form of collaboration that involves creating a common understanding of a problem, shared measurement, mutually reinforcing activities, continuous communication, and a backbone organization. The phrase was coined by Kania and Kramer (2011).

interest to the community. At these events, local program representatives and clients share information about the impact that programs have had on them and talk about the potential impact of the loss of funding. Although the forums have generally been well attended by community organizations, recent funding cuts across the state have reduced the number of agency representatives who can attend. However, the forums have been well received by legislators and have increased political accountability on critical social service issues. In recent years, the forum has included formal presentations from coalition members on their collective activities and on the importance of ACEs. Although network members believe that the forums have positively impacted the political climate around ACEs-related issues, it is difficult to objectively measure the success of this work. As one respondent said, "I believe it's got to help. It certainly can't hurt, but it's real hard to attribute something specific and concrete."

The Okanogan Coalition has been active in several state and local policy advocacy initiatives. For example, coalition staff sit on the state's Prescription Drug and Opioid Abuse Committee, which is charged with evaluating state policy and legislative priorities regarding the misuse and abuse of prescription drugs and opioids. The coalition also has an active advocate of youth-oriented policies related to the state's 2012 legalization of the recreational use of marijuana. The coalition advocated for youth prevention-oriented strategies to be incorporated into the Washington State Liquor Control Board's new rules regarding marijuana use. The coalition has also advocated for limiting the opening of recreational marijuana outlets in Omak and advising the County Commissioners' Land Use Commission on the need for conditional land use permits for all marijuana businesses in the county. The coalition also sought to limit the size of the acreage allowed for marijuana cultivation. Their efforts contributed the reduction in acreage limits that was subsequently adopted by the Commission, but not at the magnitude recommended by the Coalition.

Okanogan Coalition Testimony at Land Use Commission Meeting▲

Although state policy advocacy is not a main focus of its work, the Skagit Consortium has advocated to ***maintain funding for evidence-based programs*** in the county and has recently begun advocating about new alcohol and marijuana related laws in the state. Advocacy activities have included meeting with state legislators locally and in Olympia, writing joint letters advocating in support of certain positions, and encouraging members to write to their legislators. Network members indicated that the joint letters can be particularly effective because they are signed by a broad spectrum of people from many agencies in the county.

Since the elimination of the state FPC office in 2011, two sites (Whatcom and Walla Walla) have increased their policy advocacy activities. Before 2012, the Whatcom Network held an annual legislators forum before the state legislative session to communicate with legislators about local priorities and issues. The network also attended several state-level meetings of the Children's Administration to brief state officials on their Community Navigators program. However, since 2011, both sites have started advocacy efforts to change ACEs-related policy at the state level. The Whatcom Network began working with other FPC networks to develop a ***network-level FPC policy agenda***. This proved to be a challenge because other networks gravitated to local activities, more interested in local community capacity building than in setting a statewide policy agenda. With the help of a state legislator, who later became Bellingham's mayor, a state budget proviso was approved in 2011 that authorized the expansion of the Community Navigator program. Efforts to expand the program ended, however, when it was defunded by the state in 2014.

In 2013, the Walla Walla Network's coordinator worked with the Lincoln High School principal and others to advocate for changes in ***state high school graduation requirements***. Current graduation standards require that students pass high-stakes mathematics assessments to graduate. Passing this exam has been a challenge for students with math cognition deficits. Because youth with ACEs-related trauma may not have the executive functioning skills to deal with the abstract thinking required for advanced math, they may be less able to pass the state's high-stakes test. Although the Walla Walla Network was not able to change state policy on this issue, it was an important lesson for the network on the challenges of policy advocacy work.

Local policy advocacy. The Whatcom Network has become more involved in county public health policy advocacy through its relationship with the county's health department. In 2010, the health department cosponsored Dr. Anda's presentations in the community on the ACE study and talked about its policy implications. In 2010, the health department also agreed to fund the ACEs oversampling for the county for the state's implementation of BRFSS, the annual state health survey. Every three years, the health department conducts a community health assessment as part of its population health planning and community mobilization function. During the 2011 assessment process, the topic of ACEs resurfaced and was incorporated into the final assessment report. This prompted an analysis of the county's relatively high rates of poverty and substance abuse. As a result, the department focused its 2013 ***Whatcom County Health Improvement Plan*** (CHIP) on addressing the problem of "the uneven start of children" based on economic and racial/ethnic inequities.

The 2013 CHIP identified four overarching principles: (1) building community connectedness and resilience, (2) enhancing child and family well-being, (3) promoting healthy active living, and (4) improving health care access and service delivery. At the same time, the department and advisory board became interested in the trauma-informed "compassionate community" model.[34] In October 2013, the Whatcom County Council approved the CHIP and passed a resolution endorsing a "call for a compassionate approach to public health-related

[34] This is a variation of the "compassionate schools" model developed by Ray Wolpow, a professor at Western Washington University's School of Education.

services." The department is currently working with local funders and foundations to start a Collective Impact process to align local grant-making priorities with the 2013 CHIP report.

Over the last several years, the Walla Walla Network has been working to broaden the policy implications of its work by implementing new strategies to increase awareness of ACEs and resilience principles among local policymakers and to shift local policies and funding priorities toward trauma-informed services and "creating a more compassionate community for vulnerable children and families." In addition to asking CRI members to sign MOUs committing them to change organizational policies, the Walla Walla Network helped to restart a local ***Investors Group***. Originally created in the mid-1990s, the first Investors Group included key community leaders, including the chief of police and the school superintendent. However, as grant opportunities declined, the group disbanded. Nevertheless, in 2012, after the local FPC networks were defunded, the network coordinator convened several of the original members to consider restarting the group. The group is currently developing a strategic plan to align agency priorities and reinvest community resources in common projects that support the network's goals. The Investors Group members have asked the network coordinator to start a Collective Impact process to help shift local resources toward trauma-informed projects.

In fall 2013, the network presented a proposal to the Walla Walla City Council to proclaim October as ***Children's Resilience Month*** and to endorse the city as a trauma-informed community. Although the council was unable to endorse the city as being "trauma-informed" until national standards were created, the city mayor, with approval of the city council, signed a proclamation in both 2013 and 2014, designating October as Children's Resilience Month and urging residents to become informed about childhood trauma and how to create community-level resilience. In 2014, Children's Resilience Month activities included rotary luncheons, a downtown community resilience treasure hunt, media coverage, two community trainings by the Head Start-Trauma Smart program, and other events.

▲**Walla Walla Children's Resilience Month Banner**

This page has been left blank for double-sided copying.

VI. CONCLUSIONS AND NEXT STEPS

A recent review of place-based initiatives summarized the state of the community capacity development field, noting, "We have learned to embrace complexity, accelerate comprehensive solutions, and build collaborative capacity for impact" (Hopkins and Ferris 2014, p 74). In many ways, the findings in this report corroborate that statement. Over the past 10 years, the sites have focused on the complex problem of childhood trauma and have developed strong, collaborative partner networks that have initiated community change at multiple levels across multiple sectors. In this last section, we summarize our answers to the evaluation's first three questions regarding: (1) the influence of local contextual factors on the initiatives, (2) the community capacity developed by the sites, and (3) the community changes happening at the sites.

A. Community Context

The APPI sites are located outside Seattle in rural counties with small core cities, bounded by significant geographic features. These features influenced the design and operation of the APPI sites. Their relative isolation contributed to a sense of agency and self-reliance among the sites, creating a favorable climate for collaboration. The large geographic area and low population density of their counties led two sites to concentrate their activities in the core towns of their regions, while the other three sites targeted their efforts in select areas, such as at-risk neighborhoods or one or two schools, throughout their counties. Local economic realities and political dynamics affected the sites' access to local funding and local policy advocacy efforts. The state's economic downturn affected all of the sites, creating a sense of urgency to help affected families while also cutting funding for some prevention services.

The APPI initiatives have been trying to shift community conditions in dynamic environments, which also have been changing in ways unrelated to the efforts of the initiatives. To understand these dynamics, the evaluation analyzed state and county trends in 30 indicators of ACEs-related risk and protective factors over a 10-year period (2002 to 2012). For many indicators, county trends were not statistically different from statewide trends, but there were some exceptions (this is not an exhaustive list):

- Chelan and Douglas Counties (NCW) and Walla Walla County had lower prevalence of ACEs among adults (ages 18-54) than the Washington State comparison group.
- Walla Walla County showed greater decrease in the population rate of alleged victims of child abuse and neglect in accepted referrals than did the rest of the state.
- NCW, Okanogan, Skagit, and Whatcom Counties experienced a slower increase in the rate of hospitalizations due to injury among women (an indicator of domestic violence) than the rest of the state.
- Okanogan County's trends in rates of (a) school suspensions and expulsions and (b) youth arrests for violent crimes also showed greater reductions than did the state trends.

Although interesting, these differences in trends are not proof of the countywide impacts of the initiatives' efforts for several reasons. This question will be explored further in the APPI evaluation's final report.

B. Community Capacity

Although the APPI sites vary in the details of their operations, their strategies for building community capacity have been similar in numerous ways.

ACEs framed as complex problems. The FPC charged its networks with the task of addressing a range of complex problems, including child abuse and neglect, domestic violence, youth violence, youth substance abuse, dropping out of school, teen pregnancy, and youth suicide. Such problems typically require comprehensive solutions that involve the alignment and coordination of multiple programs, policies, and practices; iterative and dynamic planning; and a focus on learning. Aware of the complexity of the task, the FPC encouraged the networks to educate their communities about ACEs and develop their own community-based solutions.

Community-based theory of change. The APPI sites adopted several evidence-based community mobilization and public health prevention frameworks to organize their collective efforts: the CTC model, the SPF, and the CCD model. CTC is a well-researched community change process designed to help communities plan, implement, and evaluate proven prevention strategies to promote healthy youth development and reduce problem behaviors. The SPF has five steps: assess needs, build capacity, plan, implement, and evaluate. The CCD model emphasizes the need for networked leadership to help communities create their own solutions.

Enduring but fragile infrastructures. With some local variations, the APPI sites share a structure inherited from their days as FPC networks. The APPI sites typically have a board of approximately 25 members, divided among fiduciary members (public sector organizations, nonprofit agencies, and local foundations) and non-fiduciary members (community residents). The sites have used these structures to fulfill a key role as neutral conveners of diverse stakeholders and as facilitators of complex community problem-solving processes. But, in some ways, their independent status has created a potential liability for the sites, especially after the loss of FPC funding in 2012. These APPI sites are survivors that have continued operating, in various forms, for 10 to 20 years by leveraging the organizational assets, time, support, and resources of their community partners. However, their staffs are small, many of the site budgets are tiny, and their funding is temporary, putting their long-term sustainability at risk.

Extensive partnerships. The power of the APPI sites to leverage communitywide changes has depended, in part, on their collaborative capacity to take action with other organizations, develop new partnerships, and facilitate cross-sector training and service integration. During their tenure as community networks, the sites have developed extensive membership lists, touching almost every sector, including social services, education, early learning, public health, law enforcement, juvenile justice, business, municipal and tribal governments, and private foundations. Notably, the networks have relatively few individual community members. They typically engaged community residents through other means, including community trainings and presentations, public events, focus groups, and facilitated community conversations. However, one sector that has generally been underrepresented in the five APPI sites is health care, including behavioral health.

Widespread community engagement. The APPI sites view community engagement as an essential strategy in the prevention and mitigation of ACEs. The sites have brought in outside experts and trained network members to give different kinds of trainings and presentations in a variety of venues, including parenting programs, provider trainings, professional development workshops, school events, state and national conferences, on radio programs, and other settings. One site (Walla Walla) has given over 700 presentations, created a website, and developed a set of training materials and games. As a result, the sites report that ACEs concepts and terminology have become more visible in certain sectors of their communities, especially among service providers. For example, a recent community survey conducted in Walla Walla found that 40 percent of respondents (people attending public events) were familiar with ACEs concepts.

Data used for planning and evaluation: The APPI sites have learned how to leverage the data expertise of local health departments and universities. They use faculty and students to collect, analyze, and report on population survey and administration program data to monitor their communities' status and investigate community problems. They then use the results to advocate for change. Through these efforts, the sites have identified and worked to fill ACEs- and resilience-related data gaps by arranging for local oversamples of the state's BRFSS module of ACEs questions and working with schools to conduct student surveys on ACEs and other topics. However, the sites have less experience and capacity evaluating the quality and effectiveness of their collective efforts. Historically, the FPC did not require its networks to collect implementation and outcome data in a standardized format that could facilitate cross-site analysis. Three of the sites use a standardized coalition assessment tool required by DBHR, all of the sites have developed logic models with identified outcomes, and some sites have commissioned special research studies and evaluation reports, but none have the resources or staff to maintain ongoing performance monitoring and evaluation systems.

C. Community Change

The capacity of the APPI sites can be judged by their ability to trigger change in their communities in ways that ultimately reduce ACEs, increase resilience, and enhance community well-being. These community changes can occur at several levels: changing an individual's mindset to see through an ACEs lens, helping community organizations adopt trauma-informed service delivery models, empowering families to improve their neighborhoods, adding more evidence-based programs to a community's continuum of ACEs prevention services, working in cross-sector coalitions to protect youth, and increasing their community's collective impact on ACEs by aligning local policies and funding priorities. Such changes can impact ACEs and resilience by creating more nurturing and protective environments in several settings—at home, at school, among peers, and in the community. These interventions are designed to reduce toxic stress, limit opportunities for problem behaviors, reinforce prosocial behavior, and develop other protective factors for children, youth, and families.

Child abuse prevention and family support. The APPI sites have initiated and sustained efforts at multiple levels to address the child maltreatment prevention and treatment needs of their communities. Their accomplishments include expanding the availability of evidence-based parenting programs, creating alliances with local child welfare systems to implement population-level child protection projects, increasing the use of trauma-informed practices by social service agencies through training and technical assistance, and helping families directly through

parenting classes and training programs. For example, the Skagit, NCW, and Okanogan sites brought several evidence-based child abuse prevention programs to their communities, including the Triple P, the SFP, the Kaleidoscope Play and Learn program, and the NFP program. The Whatcom and Walla Walla networks have worked with local CPS to create Family to Family alliances and provide families involved with CPS with peer support through a new Community Navigators pilot program. The challenge has been to manage the time-limited grants and staff turnover in these programs.

Trauma-informed health care. Several of the APPI sites also worked with local health care providers to incorporate ACEs and resilience principles in their practices by providing trauma-informed medical care, providing mental health services, and referring patients to appropriate behavioral health programs. The APPI sites made some progress but encountered structural barriers that limited changes in provider practices, such as medical billing procedures that limit clinician time spent on ACEs and resilience-related activities, as well as state reimbursement policies that do not recognize or fund new trauma-informed service delivery models. Some sites have started to challenge these barriers. For example, the Health Center in Walla Walla is working to be recognized by the state as a school-based health clinic. The Okanogan Coalition succeeded in obtaining Medicaid reimbursement billing codes for Triple P services, a time-consuming process that required extensive coordination with the state health care authority.

School climate and student success. The APPI sites targeted school discipline policy and practice as a way to create more nurturing and compassionate school environments. In particular, the Whatcom Network, Walla Walla Network, and Okanogan Coalition have been working with teachers, principals, and staff in targeted elementary, middle, and high schools to shift school policies from punitive approaches to more trauma-informed practices. Their efforts included using evidence-based positive behavior management techniques; training school administrators, teachers, and other staff on ACEs, resilience, and trauma-informed practices; collecting school-level ACEs information through student surveys; changing school suspension and expulsion policies; and adding ACEs and resilience topics to courses. Promising changes have occurred reducing school suspensions and expulsions, improving student behavior, increasing student retention, and even increasing graduation rates at one high school. The APPI sites' strategy of using successful pilot projects to leverage districtwide policy change has faced more of a challenge. However, with support from school superintendents and school boards, some sites have begun to spread school-specific "wins" to more locations.

Risk behavior reduction and healthy youth development. The APPI sites have been particularly active in the area of risk behavior reduction and healthy youth development. One site (Skagit) have secured grants to hire more prevention and intervention staff in schools and community programs. Two other sites (Whatcom and Okanogan) have facilitated successful cross-sector coalitions involving schools, media, parents, law enforcement, and juvenile justice agencies in prevention efforts to limit opportunities for a range of problem behaviors, including underage drinking, gang violence, and suicide. All of the sites have helped start and operate afterschool activities, youth-led prevention clubs, and community-based programs to provide opportunities for healthy youth development. The sites have also been involved in providing youth with more intensive services, such as mental health treatment services, community truancy boards, and the use of trauma-informed practices in juvenile justice settings.

Community development. Two of the five APPI sites (Whatcom and Walla Walla) have also focused their time and resources on building formal and informal social supports for vulnerable families in targeted neighborhoods. The underlying logic is that by bringing neighbors together to work on community improvement projects, attend public events, and participate in other neighborhood-oriented activities, residents can develop a greater sense of community, become less socially isolated, and be more willing to ask others for help and reciprocate when needed as they move from being consumers of services to active producers of community engagement. The Whatcom Network also helped to bring new services and supports to an isolated community on the eastern side of the county. These development efforts have played a part in reducing neighborhood violence, improving community safety, creating more attractive park space and other amenities, and improving housing conditions for some families. Such efforts are designed to help meet basic needs, reduce toxic stress, and increase social capital among at-risk families.

Policy advocacy. Until the state FPC office was defunded in 2011, the FPC networks—including the Walla Walla and Whatcom networks—were typically involved in policy advocacy at the state level as FPC partners, working with FPC staff, state House and Senate representatives, the Governor's Office, the Office of Superintendent of Public Instruction, and other state agencies. The networks submitted formal reports and policy recommendations, participated in rule making processes, and advocated for changes in state programs and budgets. In addition, the NCW Coalition, the Okanogan Coalition, and the Skagit Consortium have had their own histories of state-level political engagement and policy advocacy as independent community coalitions. After 2011, the Walla Walla and Whatcom networks have become more active independently on state policy issues by, for example, supporting a state budget proviso that allowed more flexible use of juvenile court funds for ACEs-informed continuous improvement efforts. However, the APPI sites have had mixed success on some issues for a range of reasons, including the fact that they did not use hired lobbyists or have legislative allies to champion their causes. Indeed, the loss of previous FPC legislative champions has left a gap at the state level. Recently, two APPI sites (Walla Walla and Whatcom) have become involved in Collective Impact processes to align local policy priorities and resources. Such efforts could influence the networks' future state policy work.

D. Evaluation implications and next steps

This report presents substantial qualitative evidence of the capacity and efficacy of the APPI initiatives and describes the dynamic contexts of the sites using quantitative county-level data. However, more quantitative data are needed at the subcounty level to track the initiatives' processes, products, and impacts at individual, organizational, and cross-sector levels.

In the final 2015 phase of the APPI evaluation, the evaluation team will work with the sites to gather more quantitative information examining subcounty impacts of specific activities in all four domains—(1) child abuse prevention and family support, (2) school climate and student success, (3) risk behavior reduction and healthy youth development, and (4) community development. The APPI sites have already provided some documentation of subcounty outcomes that are reported in local program evaluations and other site-specific analyses (not included in this report). These reports will be reviewed systematically and incorporated into the findings of

the evaluation's final report. In addition, we will conduct the APPI evaluation's cost savings study.

As part of the implementation study, the evaluation will also collect new information regarding the sites' capacity for collaboration using a community network survey that will assess the alignment of goals among coalition members, the intensity and sustainability of collaboration among members, and other indicators of network capacity. In addition, we will conduct the APPI evaluation's cost-savings study. The findings from these activities will be included in the evaluation's final report, due at the end of 2015.

REFERENCES

ACEs Public-Private Initiative (APPI). "Evaluation Design for APPI: Technical Appendices: Appendix A – APPI Glossary of Terms." Seattle, WA: APPI, June 2013a.

APPI. "ACEs Public-Private Initiative (APPI) Request for Proposals Regarding a Study of Community-based Family Support Networks in Washington State." Seattle, WA: APPI, June 2013b.

Anda, R. F., A. Butchart, V. J. Felitti, and D. W. Brown, "Building a Framework for Global Surveillance of the Public Health Implications of Adverse Childhood Experiences" *American Journal of Preventive Medicine*, vol. 39, no. 1, 2010, pp. 93–98.

Bellingham Schools. "District Celebrates 2014 Promise Award Recipients." Bellingham, WA: Whatcom Middle School, 2014. Available at: [http://whatcom.bellinghamschools.org/printpdf/news/2014-05/district-celebrates-2014-promise-award-recipients]. Accessed January 18, 2015.

Biglan, A., B. R. Flay, D. D. Embry, and I. Sandler. "Nurturing environments and the next generation of prevention research and practice." *American Psychologist*, vol. 67, 2012, pp. 257–271.

Blodgett, C. "Review of Community Efforts to Mitigate and Prevent Adverse Childhood Experiences and Trauma." Spokane, WA: Washington State University Area Health Education Center, 2013.

Brownlee, K., J. Rawana, J. Franks, J. Harper, J. Bajwa, E. O'Brien, & A. Clarkson. "A systematic review of strengths and resilience outcome literature relevant to children and adolescents." *Child & Adolescent Social Work Journal*, 30(5), 2013, pp. 435-459.

Cabaj, M. "Evaluating Collective Impact: Five Simple Rules." *Philanthropist*, vol. 26, no. 1, 2014, pp. 109-124.

Centers for Disease Control and Prevention (CDC). "Adverse Childhood Experiences Reported by Adults—Five States, 2009." *Morbidity and Mortality Weekly Report*, vol. 59, no. 49, December 2010. Available at [http://www.cdc.gov/mmwr/pdf/wk/mm5949.pdf]. Accessed January 18, 2015.

Centers for Disease Control and Prevention (CDC). "Prevalence of Individual Adverse Childhood Experiences." Atlanta, GA: CDC, May 2014a. Available at [http://www.cdc.gov/violenceprevention/acestudy/prevalence.html]. Accessed January 18, 2015.

Centers for Disease Control and Prevention (CDC). "The Public Health System and the 10 Essential Public Health Services." Atlanta, GA: CDC, March 2014b. Available at [http://www.cdc.gov/nphpsp/essentialservices.html]. Accessed January 18, 2015.

Chaskin, R. "Defining Community Capacity: A Framework and Implications from a Comprehensive Community Initiative." Chicago: Chapin Hall Center for Children, University of Chicago, 1999.

Chelan Douglas Trends. "Chelan Douglas Trends Network." Available [http://www.chelandouglastrends.org]. Accessed January 18, 2015.

Child Welfare Information Gateway. *Protective factors Approaches in Child Welfare.* Washington, DC: U.S. Department of Health and Human Services, 2014. Available at [https://www.childwelfare.gov/pubPDFs/protective_factors.pdf]. Accessed January 18, 2015.

Cohen, L., V. Chavez, and S. Chehimi (eds.). *Prevention is Primary: Strategies for Community Well-Being*. San Francisco, CA: Jossey Bass and the Prevention Institute, 2010.

Communities That Care. "Communities That Care Prevention Model: How it Works." Available at [http://www.communitiesthatcare.net/how-ctc-works/]. Accessed January 18, 2015.

Felitti, V. J., R. F. Anda, D. Nordenberg, D. F. Williamson, A. M. Spitz, V. Edwards, M. P. Koss, and J. S. Marks. "Relationships of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults." *American Journal of Preventive Medicine*, vol. 14, no. 4, May 1998, pp. 245–258.

Flaspohler, P., J. Duffy, A. Wandersman, L. Stillman, and M. Maras. "Unpacking Prevention Capacity: An Intersection of Research-to-Practice Models and Community-Centered Models." *American Journal of Community Psychology*, vol. 41, 2008, pp. 182–196.

Grantmakers for Effective Organizations (GEO). "Evaluating Community Change: A Framework for Grantmakers." Washington, DC: GE, June 24, 2014. Available at [http://www.geofunders.org/resource-library/all/record/a066000000FgMTiAAN]. Accessed January 18, 2015.

Hall J., L. Porter, D. Longhi, J. Becker-Green, and S. Dreyfus. "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*, vol. 40, no. 4, 2012, pp. 325–334. Available at [http://www.tandfonline.com/doi/pdf/10.1080/10852352.2012.707463]. Accessed January 18, 2015

Hargreaves, M. "Evaluating System Change: A Planning Guide." Cambridge, MA: Mathematica Policy Research, April 2010.

Hargreaves, M. "Rapid Evaluation Approaches for Complex Initiatives." Report prepared for the Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services. Cambridge, MA: Mathematica Policy Research, March 2014.

Hargreaves, M., P. Foster-Fishman, E. Watson, and M. Morzuch. "Building Healthy Communities: Health in All Policies Project Case Study." Report submitted to the California Endowment. Cambridge, MA: Mathematica Policy Research, September 20, 2014.

Hargreaves, M., T. Honeycutt, C. Orfield, M. Vine, C. Cabili, M. Morzuch, S. Fisher, and R. Briefel. "The Healthy Weight Collaborative: Using Learning Collaboratives to Enhance Community-Based Initiatives Addressing Childhood Obesity." Journal of Health Care for the Poor and Underserved, vol. 24, no. 2, suppl., May 2013, pp. 103-115.

Hopkins, E. M. and J. M. Ferris (eds.). "Place-based Initiatives in the Context of Public Policy and Markets: Moving to Higher Ground." Los Angeles, CA: University of Southern California Sol Price Center of Public Policy, November 2014.

Institute of Medicine. "The Future of Public Health in the 21st Century." Washington, DC: National Academy Press, 2002.

Kabel, J., P. P. Howards, E. Kohlenberg, R. Flewelling, and M. Shaklee. "Profile on Risk and Protection for Substance Abuse Prevention Planning in Washington State." Olympia, WA: Washington State Department of Social and Health Services Division of Alcohol and Substance Abuse, May 1997.

Kaleidoscope. Kaleidoscope Play and Learn Program website. Available at [https://www.childcare.org/family-services/find-care-kaleidoscope.aspx]. Accessed January 18, 2015.

Kania, J. and M. Kramer. "Collective Impact." *Stanford Social Innovation Review*. Winter 2011, pp. 36-41. Available at [http://www.ssireview.org/images/articles/2011_WI_Feature_Kania.pdf]. Accessed January 18, 2015.

Love and Logic. Love and Logic Parenting Program home page. Available at [http://www.loveandlogic.com/]. Accessed January 18, 2015.

Luthar, S. S. and D. Cicchetti (2000). "The construct of resilience: Implications for interventions and social policies." Development and Psychpathology. Vo. 12, pp. 857-885.

National Child Traumatic Stress Network. "Child Trauma Therapies." Available at [http://www.nctsn.org/content/treatments-children-and-families]. Accessed January 18, 2015.

Institute of Medicine and National Research Council. *Preventing Mental, Emotional, and Behavioral Disorders Among Young People: Progress and Possibilities*. Washington, DC: The National Academies Press, 2009. Available at [http://www.nap.edu/catalog.php?record_id=12480]. Accessed January 18, 2015.

Patton, M. Q. *Developmental Evaluation: Applying Complexity Concepts to Enhance Innovation and Use*. New York: Guildford Press, 2011.

Patton, M. Q. "Fools' gold: the widely touted methodological 'gold standard' is neither golden nor a standard." Better Evaluation (blog), December 4, 2014. Available at [http://betterevaluation.org/blog/fools_gold_widely_touted_methodological_gold_standard]. Accessed January 18, 2015.

PAX. PAX Good Behavior Game home page. Available at [http://goodbehaviorgame.org/]. Accessed January 18, 2015.

Ponti, K. "Center provides safety, structure for youth." *Union Bulletin*. December 17, 2013. Available at [http://union-bulletin.com/news/2013/dec/17/center-provides-safety-structure-youth/]. Accessed January 18, 2015.

Porter, L. "NEAR Science and Washington State Resilience Findings." Presented at Healthy Generations Conference, Seattle, WA, September 2014. Available at [http://www.healthygen.org/resource-type/presentation]. Accessed September 30, 2014.

Quinby, R. K., A. A. Fagan, K. Hanson, and B. L. Brooke-Weiss. "Installing the Communities That Care Prevention System: Implementation Progress and Fidelity in a Randomized Controlled Trial." *Journal of Community Psychology*, vol. 36, no. 3, pp. 313–332.

Shapiro, V. B., S. Oesterle, R. D. Abbott, M. W. Arthur, and J. D. Hawkins. "Measuring Dimensions of Coalition Functioning for Effective and Participatory Community Practice." *Social Work Research*, vol. 37, 2014, pp. 349–359.

Stambaugh, L. F., H. Ringeisen, C. C. Casanueva, S. Tueller, K. E. Smith, and M. Dolan. "Adverse Childhood Experiences in NSCAW." OPRE Report #2013-26. Washtington, DC: Office of Planning, Research, and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services, 2013. Available at [http://www.acf.hhs.gov/programs/opre/resource/national-survey-of-child-and-adolescent-well-being-nscaw-no-20-adverse-child]. Accessed January 18, 2015.

Strengthening Families. "Program Descriptions." Available at [http://www.strengtheningfamiliesprogram.org/about.html]. Accessed January 18, 2015.

Substance Abuse and Mental Health Services Administration (SAMHSA) "About the Strategic Prevention Framework," 2014. Available at [http://captus.samhsa.gov/access-resources/about-strategic-prevention-framework-spf]. Accessed January 18, 2015

Taylor, M., P. Plastrik, J. Coffman, and A. Whatley. Evaluating Networks for Social Change: A Casebook. Washington, DC: Network Impact and the Center for Evaluation Innovation, July 2014. Available at [http://www.networkimpact.org/wp-content/uploads/2014/10/NetworkEvalGuidePt2_Casebook_Rev.pdf]. Accessed January 18, 2015.

Triple P. "Triple P – Positive Parenting Program Takes the Guesswork out of Parenting." Available at [http://www.triplep.net/]. Accessed January 18, 2015.

United Way of Skagit County. "Youth United: How Varsity in Volunteerism Helps Students Succeed." Burlington, WA: United Way of Skagit County. 2014. Available at [http://www.unitedwayskagit.org/cms-view-page.php?page=youth-united]. Accessed January 18, 2015.

Valley Intervention Program. Valley Intervention Program website. Available at [http://www.cfcsyakima.org/?id=49&p=1]. Accessed January 18, 2015.

Walla Walla County Community Network. "Children's Forum Data Book." Walla Walla, WA: Children's Resilience Initiative, 2013. Available at [http://resiliencetrumpsaces.org/docs/2013_Childrens_Forum_Data_Book.pdf]. Accessed January 18, 2015.

Washington State Institute for Public Policy. "Updated Inventory of Evidence-Based, Research-Based, and Promising Practices for Prevention and Intervention Services for Children and Juveniles in the Child Welfare, Juvenile Justice, and Mental Health Systems." Olympia, WA: Washington State Institute for Public Policy, June 2013. Available at [http://www.wsipp.wa.gov/ReportFile/1373/Wsipp_Updated-Inventory-of-Evidence-Based-Research-Based-and-Promising-Practices_Full-Report.pdf]. Accessed January 18, 2015.

This page has been left blank for double-sided copying.

APPENDIX A:
COMMUNITY CAPACITY DEVELOPMENT MODEL AND APPI COUNTIES' THEORIES OF CHANGE

This page has been left blank for double-sided copying.

Figure A.1. Washington State Family Policy Council Community Capacity Development Model

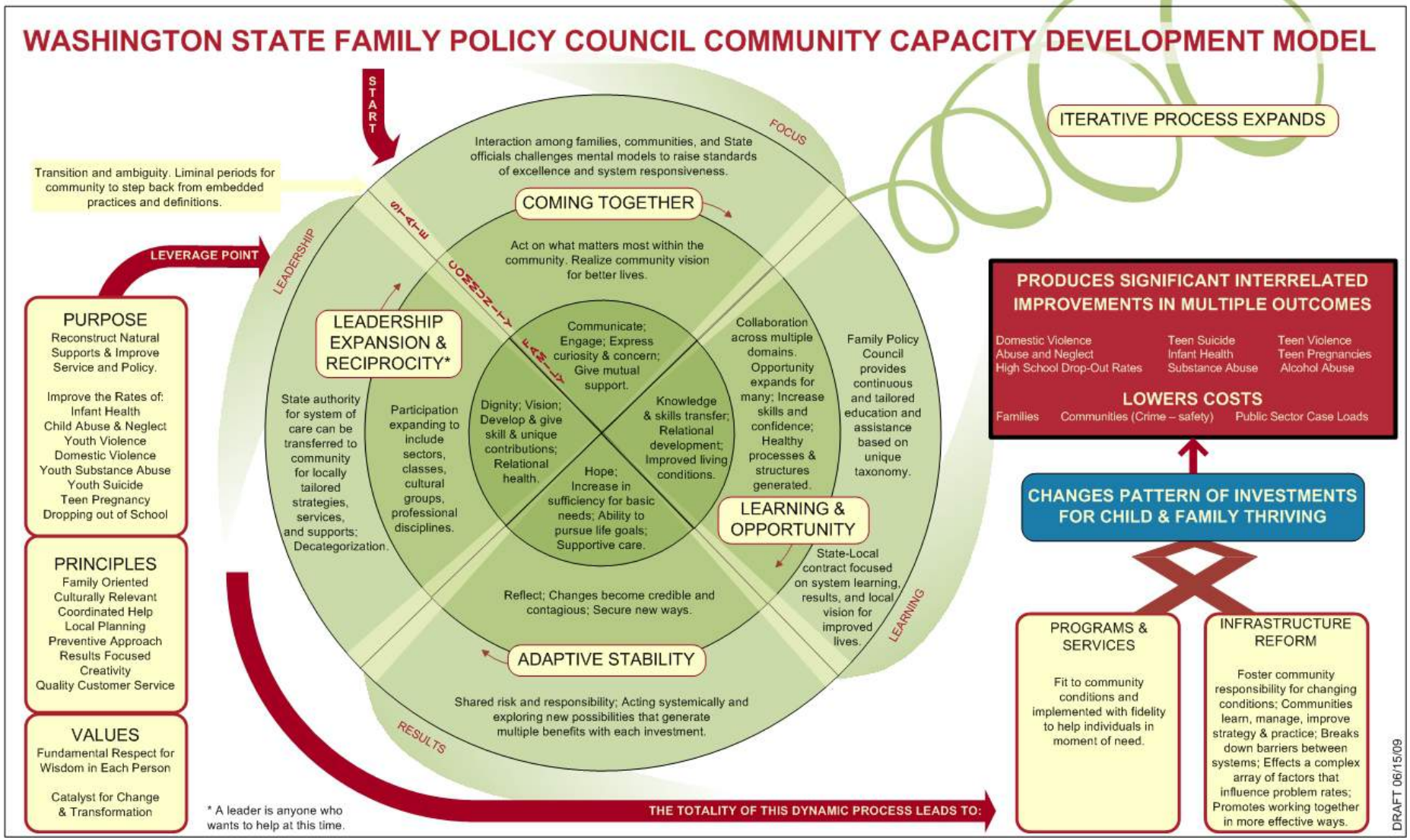
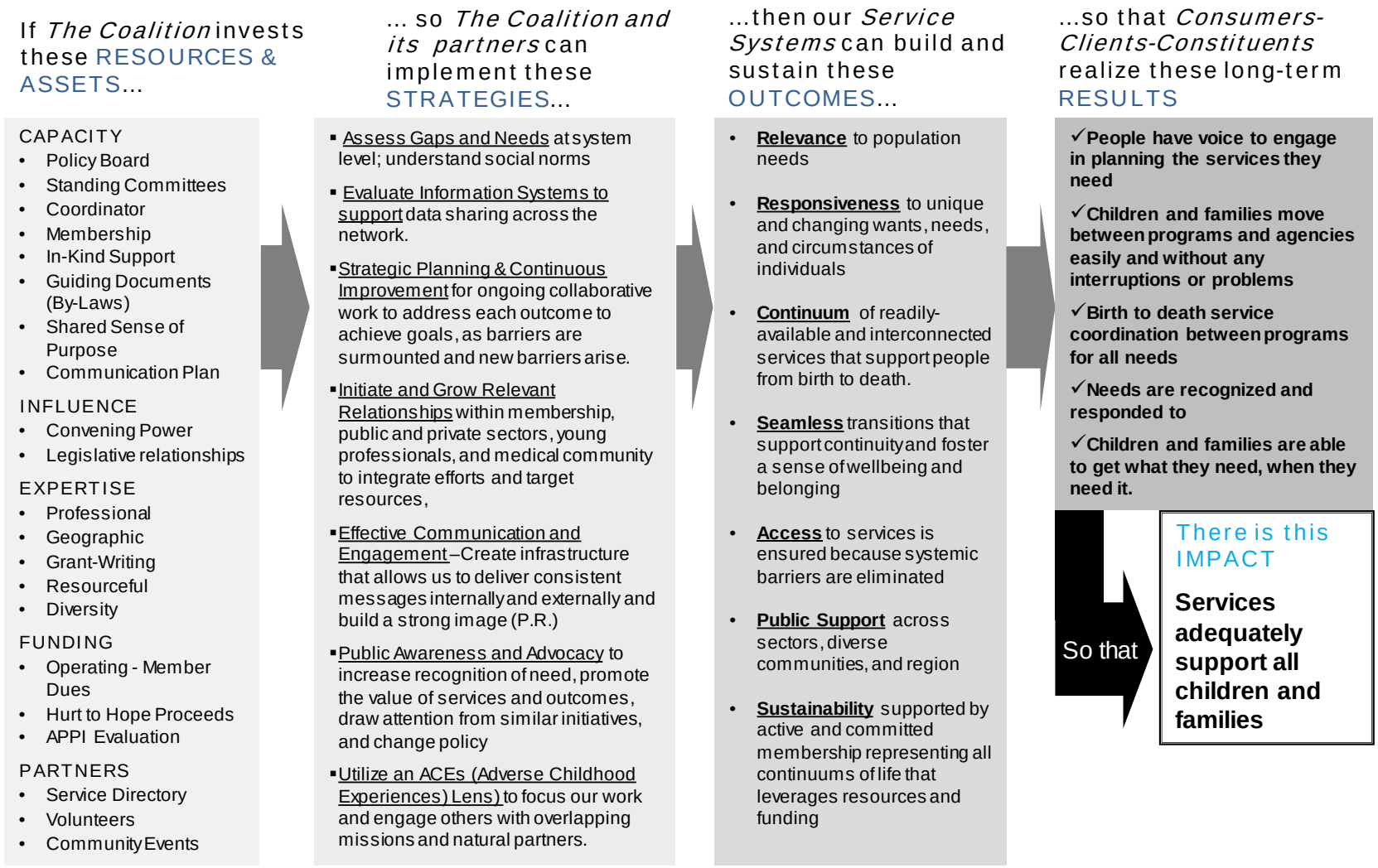


Figure A.2. Coalition for Children and Families of North Central Washington's Theory of Change



The Coalition for Children and Families of NCW – October 2013

Figure A.3. Okanogan County Community Coalition's Theory of Change

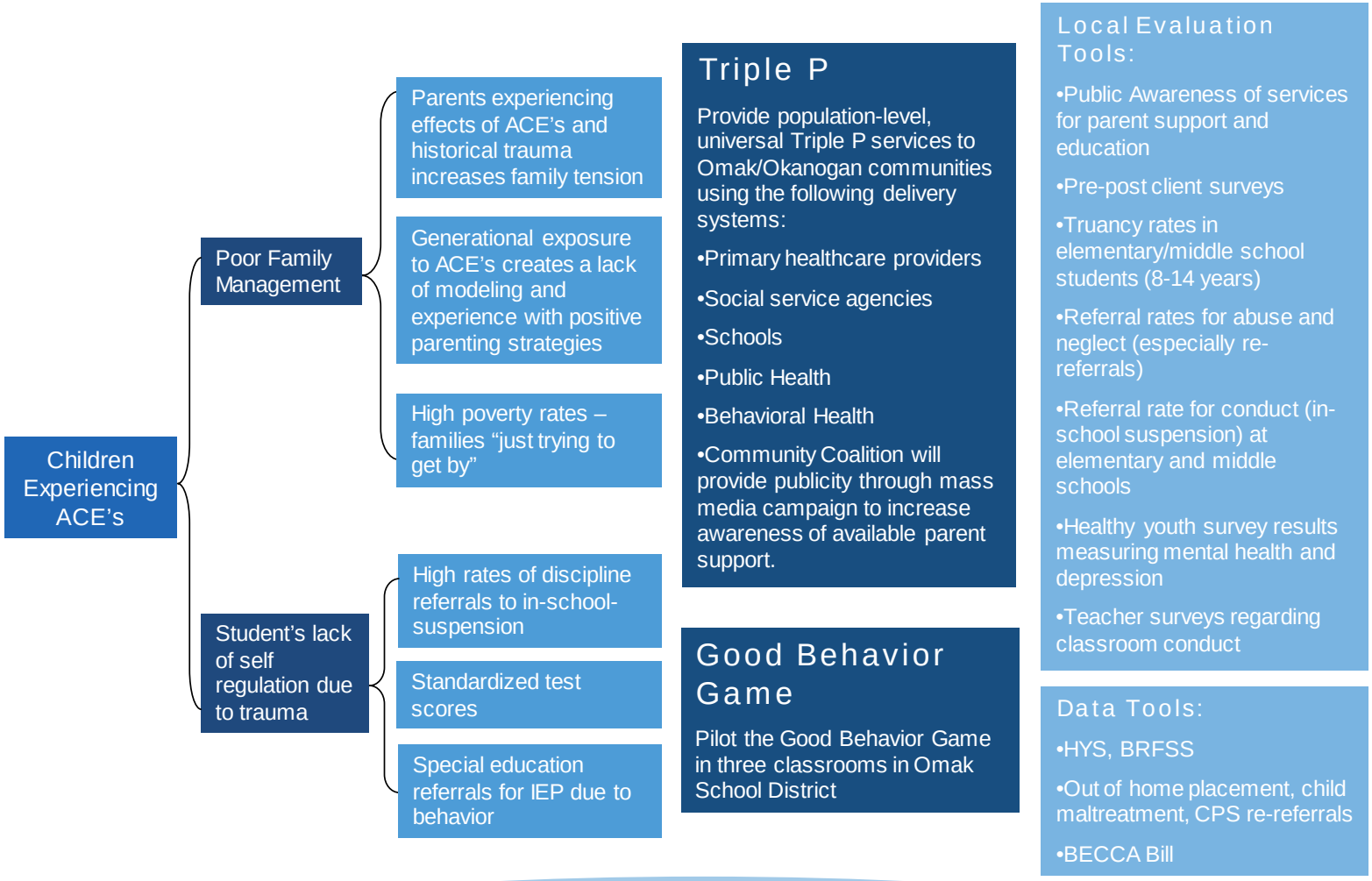


Figure A.4. Skagit County Child and Family Consortium's Theory of Change

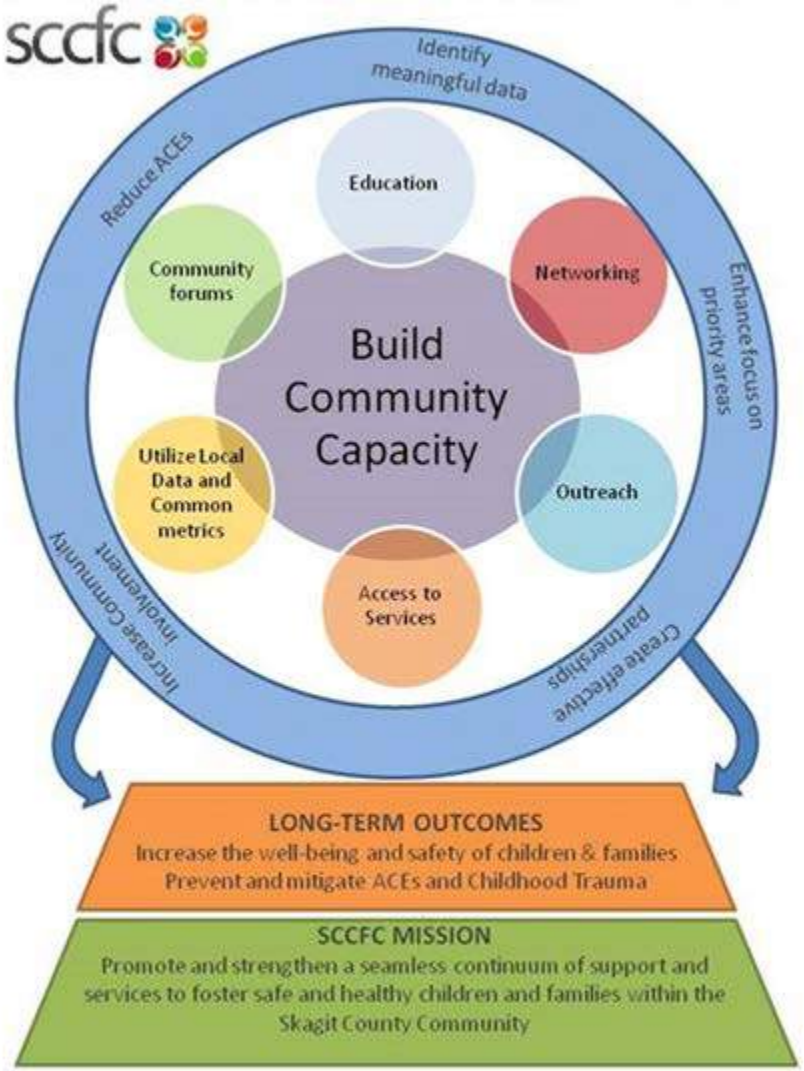


Figure A.5. Walla Walla County Community Network's Theory of Change

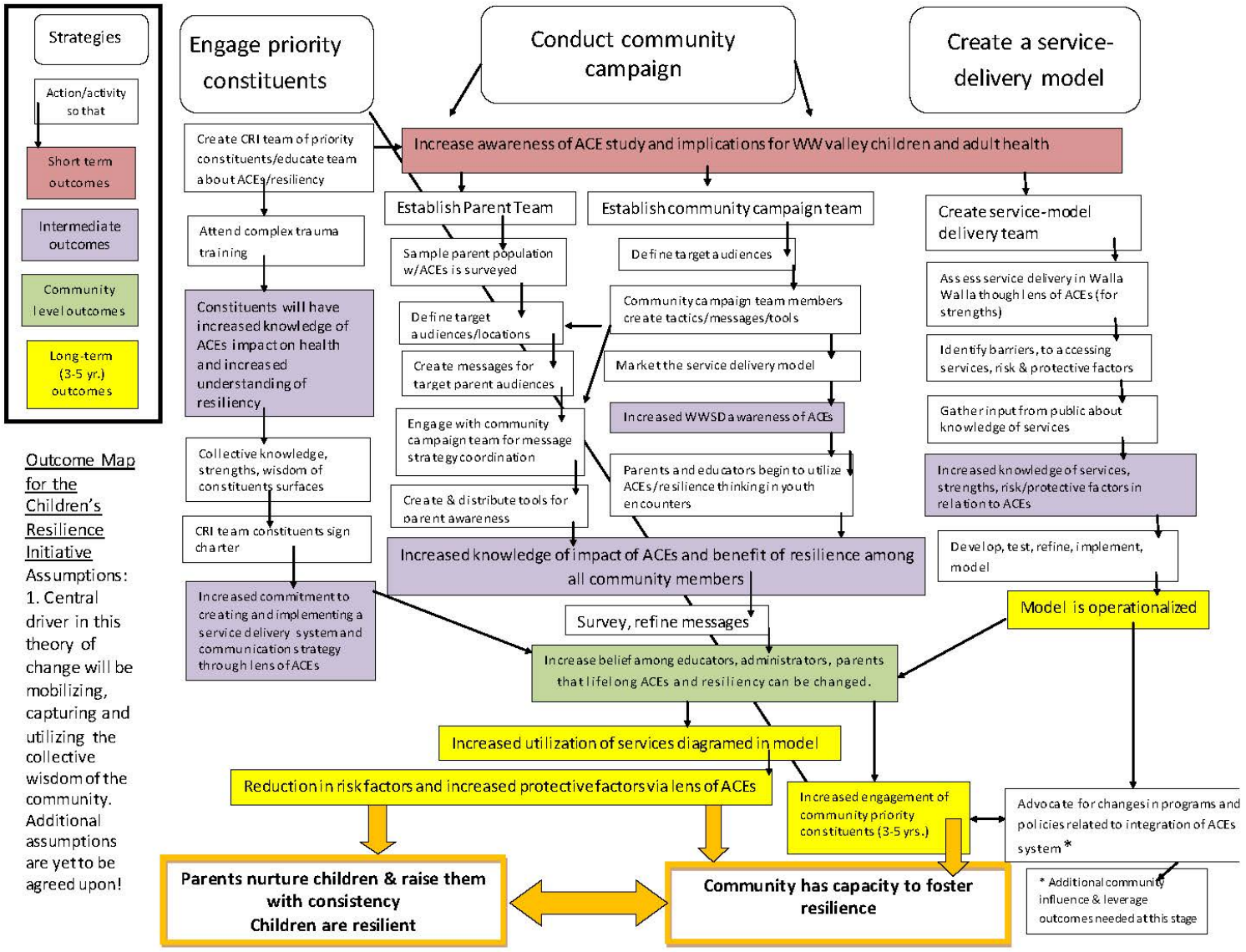
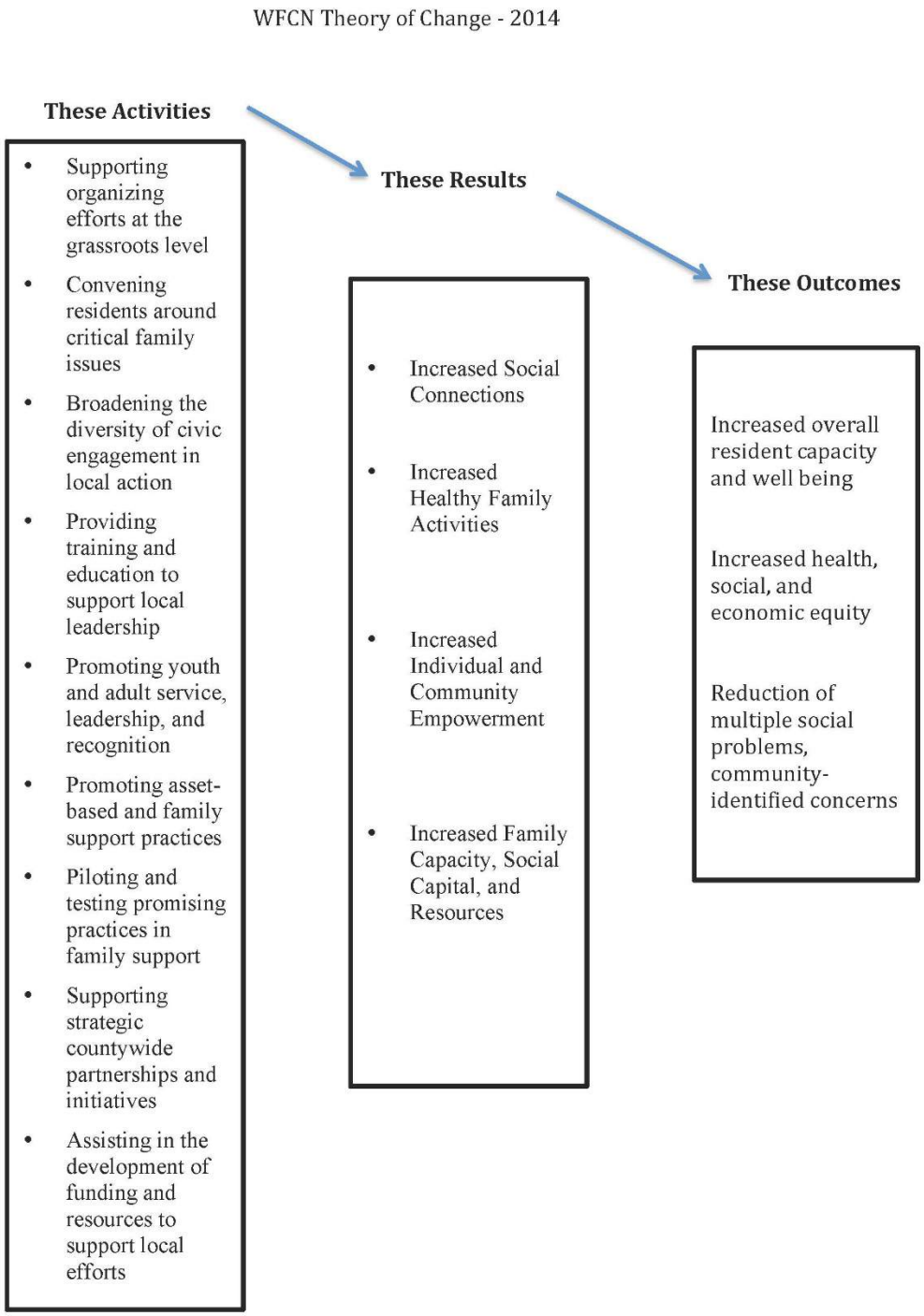


Figure A.6. Whatcom Family & Community Network's Theory of Change



APPENDIX B:
APPI SITE VISIT INTERVIEW PROTOCOL

This page has been left blank for double-sided copying.

APPI SPRING 2014 SITE VISIT
INTERVIEW MASTER PROTOCOL

ORGANIZATION: _____

RESPONDENT: _____

TITLE: _____

INTERVIEWERS: _____ **DATE:** _____

NOTE TO SITE VISITOR:

- Introductory scripts are designed to guide you as you give instructions to study respondents. You do not have to read scripts verbatim. **Use the protocol as a guide** to the type of information to cover during the interview. Please include this information either using the language provided here or in your own words. Also, **be sure to obtain informed consent from respondents** before the interview begins.
- This is a master list of questions, of which **a subset will be asked of each respondent**, depending on their project role.
- To minimize the length of the interview, **where possible, please confirm information previously provided** through reviews of project documents and other sources.
- **Some APPI grantees are networks, others are coalitions, and some are both**. Please refer to each grantee name at the beginning of the interview, and then use the appropriate organizational appellation after that.
- Sectors include: child welfare, social services, public health, health care, early childhood learning, K–12 education, juvenile justice services, courts, law enforcement, neighborhood groups, local government, tribal organizations, businesses, and advocacy groups.

INTRODUCTION TO THE INTERVIEW

Thank you for taking the time to talk to us. Before we get started, let me introduce myself and my colleague [INTERVIEWER INTRODUCTIONS]. As you know, we are part of an evaluation team that has been hired by The Adverse Childhood Experiences (ACEs) Public Private Initiative (APPI) to conduct a study of five APPI-funded Family Networks/Coalitions in Washington State, including NAME). Results from the study will inform the APPI leadership and local sites on how to improve community network/coalition efforts to prevent and mitigate ACEs and build resilience.

You have been selected to be part of this study because of your involvement in the [NAME]. The purpose of our discussion today is to learn more about your experiences in the [NAME], such as your background and involvement in and your views of the goals, objectives, strategies, and key achievements of the [NAME]. Additional topics include: the [NAME]'s origins and characteristics, capacity development activities and accomplishments, and lessons learned.

Your point of view is extremely valuable and will help us learn more about how community networks/coalitions can build resilient, nurturing communities that effectively reduce ACEs.

The interview should last about 60 minutes, during which we will take notes about our conversation. With your permission, we will audio record the interview; this would allow us to fill in later anything we missed in our written notes. There are no "right" or "wrong" answers; we are only interested in learning about your experiences and opinions. We will not identify you personally in any report or publication of this study. May we record this interview? Do you have any questions before we begin?

I. Respondent Involvement in [NAME]

1. What is your name, organization, and job title? [Note the respondent's sector.]
    a. How long have you been in this position?
    b. What are your job duties?
    c. Do you live in the [NAME]'s target area? If so, how long have you lived there?
2. In what ways are you now, or have you been, involved in the [NAME]? (Select all that apply). [NOTE. FORCE SELECTION OF RESPONSES.]
    a. As a leadership team or executive committee member of the [NAME]
    b. As a member of the [NAME]
    c. As a community partner who has participated in [NAME] activities
    d. As a community partner who has worked on [NAME]-related goals
    e. As a community resident who has attended [NAME] events, or participated in [NAME]-supported programs
    f. Other role
    g. No involvement in this [NAME]
3. When and how did you get involved in the [NAME]'s work?
    a. In what role?
    b. How much time do you currently spend on [NAME] activities per month?
4. Are you, or have you been, involved in other similar networks, coalitions or task forces, such as Early Learning Coalitions or Strengthening Families?
    a. Please describe your involvement in the group and the group's activities.
    b. Is the work of that group connected to the [NAME]?

II. [NAME] Origins and Characteristics

1. Briefly describe the [NAME]'s origins and characteristics.
2. When and why was the [NAME] started? (Confirm whether the [NAME] has been designated a Community Public Health and Safety Network.) Year begun: Why?
    a. How is work structured on the [NAME], in terms of [NAME] meetings and work groups? How often do such groups meet? Are you involved in any of these groups? If so, which ones? Who chairs the meetings? Where are they usually held?
        - Meeting frequency:
        - Your group's involvement:
        - Meeting chairs:
        - Meeting location:
3. How well resourced is the [NAME] to carry out its plans, in terms of the time and funding available, and other resources?
    a. Have the [NAME]'s resources changed over time? In what ways and when?
4. What is the current size of the [NAME]'s membership?
    a. What sectors are represented on the [NAME]?
    b. Has the [NAME]'s membership changed significantly over time? In what ways and when?
        i. Have any new people joined the [NAME]? If so, when and why did they join the [NAME]?
        ii. Have any members left the [NAME] or reduced their involvement? If so, when and why did that happen?
        iii. Are any key community leaders currently missing from the [NAME]? If so, what are the reasons?
        iv. Other membership changes?
    c. What other community partners are involved in the work of the [NAME]?
5. What did the [NAME] observe about the community's mix of resources and conditions that are necessary to accomplish and sustain change?

For the next question, I'm going to ask you for a numeric response.

6. How would you describe the level of interaction among [NAME] members? From a low of 1 to a high of 8, how closely do members work together? [SHOW INTERVIEWEE THE SCALE, AS FOLLOWS]

    a. Scores 1–2: ***Networking***, which involves providing some information without shared goals; member decisions are made independently.

    b. Scores 3–4: ***Cooperation***, which involves regular information sharing with some limited shared goals; there is limited shared decision making.

    c. Scores 5–6: ***Coalition***, which involves having common goals, regularly sharing ideas and resources; there is joint input on key decisions.

    d. Scores 7–8: ***Collaboration***, which involves having a broad mission, with significant sharing of ideas and mutually interdependent roles; there is group consensus on strategic decisions.

7. What information or education shaped the [NAME]'s larger body of work?
8. When and how did the [NAME] decide to work on ACEs and resilience?
    a. What are the [NAME]'s ACEs and resilience-related goals and strategies?
    b. How and when were these developed? Where are they documented?
    c. What outcomes did the [NAME] hope to achieve at the state-, community-, cross-sector organizational-, and individual service levels?
9. What [NAME] planning process was used to develop the [NAME]'s goals, objectives, strategies, and theory of change?
    a. Who was involved in the planning?
    b. What populations were targeted?
    c. What research was used in the planning?
    d. What dynamics did the [NAME] identify as contributing to the rates of child abuse and neglect, youth substance abuse, teen pregnancy, domestic violence, dropping out of school, youth violence, youth suicide, and child out-of-home placement in our community?
    e. What community resources, strengths, challenges, and gaps in local capacity were identified in the process?
    f. How were these challenges and gaps addressed in the plan?
    g. Is there anything else about the planning process that should be noted?
10. What kinds of change was the [NAME] expecting to achieve, for individuals, service providers or professionals, and at the community or system levels?

11. What kinds of capacity did the [NAME] hope to develop? Please describe key activities to develop:
    a. At the state level: (For example, development of state policies, rules and regulations, and program funding?)
    b. At the community level: (For example, development of community awareness, social norms supporting healthy development, ownership of the problem, and engagement in the issue?)
    c. At the cross-sector/system level: (For example, development of networks, coalitions, partnerships, service linkages, shared goals, shared measures to improve and adapt local programs?)
    d. At the individual service level: (For example, increasing the reach (scope), quality, and/or fidelity of a continuum of programs, services, policies and practices?) (Tiered responses are at different levels of intensity, depending on the service needs of the target population, such as the Triple P program.)
    e. Other kinds of capacity that was built?

IV. Capacity Development: Activities and Achievements

Next I want to ask about a set of activities and outcomes at different levels. For each level (state, community, individual service) I will ask first about the activities undertaken and then about the outcomes.

1. How has your work contributed to empowering communities to support children and families and improve flexibility and coordination of funding for services?
    a. How do these individual efforts support the larger story of change the network is implementing over time?
2. What ***activities*** did the [NAME] and its community partners use to build ***state-level capacity*** to address ACEs and build resilience? Please describe key activities to develop:
    a. State policies to shift resources from treatment to prevention services
    b. Rules and regulations, including service standards
    c. State funding, technical assistance, and other investments in [NAME] efforts
    d. Other activities?
3. What did the [NAME] and its community partners ***accomplish*** in developing and sustaining ***state-level capacity***? For example,
    a. What legislation was passed?
    e. What new policies were approved and enacted?
    f. What new funding was allocated?
    g. Other accomplishments?

4. What activities did the [NAME] and its community partners use to build ***community-level capacity*** to address ACEs and build resilience? Please describe key activities to develop:
    a. Community awareness and knowledge of ACEs and resilience
    b. Informal social supports for children and families
    c. Community norms of reciprocity and social support
    d. Neighborhood revitalization projects
    e. Other activities?
5. What did the [NAME] and its community partners accomplish in developing and sustaining ***community-level capacity***? For example, did they develop or increase:
    a. Public engagement and mobilization on ACE/resilience issues?
    b. Monitoring, enforcement, and compliance with minimum age drinking laws, tobacco control and substance use laws?
    c. Clear coalition messages?
    d. Local interest and local champions working on ACEs and resilience issues?
    e. Other results?
    f. Among 10 random service providers in this community, about how many of them, do you think, are aware of ACEs? Where did they gain this awareness?
    g. Among 10 random community members, about how many of them, do you think, are aware of ACEs? Where did they gain this awareness?
6. What ***activities*** did the [NAME] and its community partners use to build ***cross-sector organizational capacity*** to address ACEs and build resilience? Please describe key activities to develop or strengthen:
    a. Local coalitions, networks, work groups, task forces, and project teams
    b. Planning and implementation of [NAME] strategies
    c. Cross-sector training of local organizations and service providers
    d. Coordinated screening, assessment, and referral practices
    e. Data system development, shared measures, and collective use of data to improve and adapt local programs and policies to local needs
    f. Other activities

7. What did the [NAME] and its community partners ***accomplish*** in developing and sustaining ***cross-sector organizational capacity***? For example, did they:
    a. Build [NAME] leadership, membership, resources, or other capacity?
    b. Develop a shared vision, conceptual framework, language, or plan?
    c. Obtain new grants and funding agreements?
    d. Train the local workforce on ACEs and resilience topics?
    e. Streamline and coordinate local service delivery?
    f. Track the impact of local efforts on:
        i. Community-level indicators of capacity,
        ii. Interim indicators of such things as:
            - reduced toxic events
            - reinforcement of pro-social behavior
            - reduced opportunities for problem behavior
            - increased psychological flexibility
            - increased incidence of protective factors, and
    g. Track the impact of long-term community outcomes such as:
            - reduced ACEs
            - increased resilience
            - improved child and family health and well-being
    h. Use program feedback to align their resources with successful strategies?
    i. Other results?
8. What ***activities*** did the [NAME] and its community partners use to build ***individual service capacity*** to address ACEs and build resilience? Please describe key activities to develop:
    a. A continuum of tiered services (such as Triple P)
    b. Services covering the life span, from early childhood learning to youth development and positive parenting classes
    c. Focused attention on achieving specific outcomes?
    d. Implementing programs with fidelity (i.e., as originally intended)
    e. Expanded reach, scope, and access to effective programs and services
    f. Other activities:

9. What did the [NAME] and its community partners ***accomplish*** in developing and sustaining ***individual service capacity***? For example:
    a. How many people participated in ACEs and resilience related services ***in the most recent year***?
    b. How many services were evaluated for effectiveness?
    c. How many services were evaluated for fidelity (adhering to the program model)?
    d. How many programs and services were created to fill identified service gaps?
    e. Did the [NAME] track residents' degree of access to needed services?
    f. Other results?
10. How does our work, in partnership with others, logically connect to the population level data we are observing over time?
    a. Are there any changes we can observe?
    b. Which are the most significant positive changes observed in your community?
    c. Share examples of activities or times when change happened.
11. When reviewing data, what did you notice?
    a. What chronic or episodic patterns are emerging?
    b. What is our current focus and its relationship to data?
    c. How does current data challenge or affirm plans, beliefs, mental models?
12. From the perspective of children, youth, and families, what has changed?

V. Lessons Learned and Next Steps

1. What are the most important changes in the last 6 years? How did you address the changes? The challenges?
2. What lessons have you learned from your involvement in this project?
    a. Which [NAME] activities worked well, which didn't, and why?
    b. What have you learned that you can use in the future?
    c. What would you share with another community interested in developing its capacity to reduce ACEs and increase resilience?
    d. Looking back, what would you change about the project?
3. Which strategies were more practical, replicable, and robust? Which were less so?

4. Did any other conditions affect the implementation and success of this initiative, including:
    a. The skills and knowledge of the stakeholders involved in the initiative?
    b. The attitudes, beliefs, and values of the people supporting the work?
    c. The relationships and connections between the community, the [NAME], and other partner organizations?
    d. Existing community practices, policies, and routines?
    e. Existing community power dynamics and decision making processes?
5. Have there been any unintended consequences or "ripple effects" of this project? Please describe.

VI. Closing

1. Is there anything else you would like to discuss before we conclude this interview?

Thank you again for your time and participation.

This page has been left blank for double-sided copying.

APPENDIX C:
QUANTITATIVE STUDY METHODOLOGY AND RESULTS OF THE FEASIBILITY ANALYSES

This page has been left blank for double-sided copying.

The five APPI sites existed in some form for more than a decade before they began communitywide ACEs-specific work in mid to late 2000s. To understand the dynamics of the environments in which the APPI sites have been operating, the evaluation analyzed county-level trends in ACEs and four domains of resiliency-related risk and protective factors: (1) child abuse prevention and family support, (2) school climate and student success, (3) risk behavior reduction and healthy youth development, and (4) community development. We then compared changes in outcome trends over time in the APPI sites to a Washington State comparison group.[35]

In addition, we conducted an assessment of the feasibility of detecting impacts of the site-specific ACEs-related efforts at the county level. For each site, we examined trends in county-level ACEs and other ACEs-related outcomes from the decade before the APPI sites focused specifically on ACEs and compared them to county-level trends after the shift to ACEs-specific work. To evaluate which changes may be related to the site's efforts (as opposed to statewide policy or other changes coinciding with the implementation of the site's activities), we then compared the changes in outcome trends pre- to post-ACEs work in the APPI community to trends in two comparison groups: (1) a matched comparison county and (2) the Washington State comparison group.

The rest of this appendix describes our methodology for (1) selecting data sources and county-level indicators for the quantitative study, (2) contextual analyses of the county-level indicators, and (3) feasibility analyses. We also summarize the results of our feasibility analyses and their limitations here.

I. Selected data sources and county-level indicators

Because exposure to ACEs and toxic stress is associated with behavioral, health, and social problems, one of the challenges of this evaluation was to select an appropriate set of key indicators for the outcome analysis. The evaluation used the following criteria to select the indicators:

- **Mutable ACEs-related indicators.** We were looking for ACEs-related indicators that could be influenced by the coalitions' efforts. For example, by educating school and district staff about ACEs and their influence on the social, emotional, neurological, and psychological development of children, the coalition could change how these adults view and react to student problem behaviors, which could, for example, decrease the number of student suspensions and expulsions.
- **Represent the range of coalition activities.** The breadth of the indicators needed to encompass ACEs and the potential effects of coalitions' activities across the four domains: (1) child abuse prevention and family support, (2) school climate and student success, (3) risk behavior reduction and healthy youth development, and (4) community development.

[35] When feasible, the Washington State comparison group excluded the five APPI sites (Chelan/Douglas, Okanogan, Skagit, Walla Walla, and Whatcom Counties) and King County, which is the most populous county in the state and contains the state's largest city, Seattle. King County was excluded because of its differences with the five APPI sites, in terms of urbanicity, demographic characteristics, and availability of resources, among others.

- **Data available for APPI and comparison communities.** To compare the trends in outcomes for APPI and comparison communities (as well as the rest of Washington State), all indicators had to be collected in a similar way across communities in Washington State and be available to the evaluation.
- **Represent short- and long-term outcomes.** Our goal was to include both short-term (for example, school attendance) and long-term (for example, school graduation) indicators to evaluate how much progress the coalition made on both of these fronts and create an initial data set that the coalition can examine and supplement as it continues its efforts.
- **Document increased resilience as well as harm reduction.** Including positive ACEs-related indicators (such as rates of family reunifications) as well as negative indicators (such as rates of alleged victims of child abuse and neglect in accepted referrals) allows us to examine how much progress was made in increasing the desirable behaviors and in decreasing the undesirable behaviors or events.
- **Encompasses the life span, from birth to adolescence and into adulthood.** ACEs are intergenerational phenomena. Poor parenting increases exposure of children to ACEs and toxic stress; adults exposed to ACEs are also more likely to expose their children to ACEs. However, parents can mitigate these effects by recognizing and successfully dealing with the aftermath of their ACEs. Our list of indicators covers the life span from birth to adulthood to capture these generational effects.
- **Capture individual-level behaviors and community-level norms and practices.** Vulnerable families need community support, as well as changes in their own behavior, to help overcome the effects of ACEs. Therefore, it is important to track changes in community-level capacity as well as individual behavior change.

Guided by these criteria, in collaboration with APPI Leadership and the APPI sites, we identified 30 indicators that we examined for this report:

- **ACEs:** We examined the prevalence of ACEs reported by adults in the community.[36] We focused on the percentage of adults reporting no ACEs, reporting a large number (three or more) of ACEs, and reporting a very large number (six or more) of ACEs.
- **Domain 1. Child abuse prevention and family support:** We examined two indicators of family well-being (average score on family rewards for prosocial involvement scale and rate of hospitalizations due to injury or accident among adult women) and three indicators of child abuse prevention (rate of hospitalizations due to injury or accident among children, rate of alleged victims of child abuse and neglect in accepted referrals, and percentage of out-of-home cases exiting to reunification within 24 months).
- **Domain 2. School climate and student success:** To measure school climate, we examined two short-term indicators of student behavior (rates of unexcused absences and incidences of suspensions and expulsions from school), an indicator of student commitment to school, and an indicator of school support (average score on a school rewards for prosocial behavior

[36] Because exposure to a high number of ACEs is associated with increased mortality risk, we restricted our analysis to the prevalence of ACEs in the community in adults ages 18 to 54 to reduce bias.

scale). We also looked at two critical end-of-school student success outcomes (rates of high school cohort dropout and high school extended graduation).

- **Domain 3. Risk behavior reduction and healthy youth development:** To access changes in risk behaviors, we focused on substance use and involvement with the justice system by youth and adults. We examined three indicators of initiation of alcohol and marijuana use among 10th grade students: percentage of students who reported (1) never having more than a sip or two of alcohol, (2) never drinking alcohol regularly, and (3) never using marijuana. We also examined three short-term indicators of substance use among 10th grade students (i.e., percentage of 10th grade students who reported never drinking alcohol, using marijuana or hashish, or using other illegal drugs in the past 30 days). Finally, we looked at arrests among youth and adults for (1) alcohol-related violations, (2) drug-related violations, and (3) violent crimes. To measure healthy youth development, we focused on four indicators: (1) youth quality of life, (2) percentage of 10th grade students reporting that they seriously considered or planned a suicide, (3) overall health as reported by adults, and (4) mental health as reported by adults.
- **Domain 4. Community development:** To examine how the coalitions' efforts affected their community's environment and social norms, we examined two indicators: (1) average score on the community rewards for prosocial involvement scale as reported by youth and (2) percentage of adults who reported having their social and emotional needs met.

The 30 indicators were drawn from five data sources:

1. **Behavioral Risk Factor Surveillance System**. BRFSS is among the largest ongoing annual health telephone surveys of adults (18 years of age and older). It tracks population health environmental factors, risk behaviors, chronic health conditions, and access and use of preventive services. BRFSS consists of a core set of questions asked by all states and an additional set of questions asked by each state. Washington State's BRFSS is sponsored by the Washington State Department of Health and CDC.
2. **Washington State's Healthy Youth Survey (HYS)** is an ongoing survey of secondary school students in Washington State. Students in 6th, 8th, 10th, and 12th grades complete the survey, which covers such topics as safety and violence, physical activity and diet, alcohol, smoking, and drugs. The survey, started in 2002, is administered every two years. HYS is a joint effort by Washington's Office of the Superintendent of Public Instruction, the Department of Health, the Department of Social and Health Service's Division of Behavioral Health and Recovery, and the Liquor Control Board.
3. **Community Outcome and Risk Evaluation Geographic Information System (CORE-GIS)** is a data set containing administrative data from 57 source systems across Washington State government. CORE-GIS tracks county-level data in multiple areas, including health, justice, education, child welfare, and poverty, from the 1990s until 2012.
4. **Washington State/Partners for Our Children Data Portal (POC Data Portal)** is a tool that displays data on children and parents who interact with the child

welfare system in Washington State. The POC Data Portal incorporates data from the state's Children's Administration as well as from the U.S. Census Bureau and Washington's Office of Financial Management. It is maintained by the Partners for Our Children research center at the University of Washington's School of Social Work.

5. **Student Behavior Data** are derived from annual reports of Washington State's Office of the Superintendent of Public Instruction. These reports present district- and county-level statistics on the number of students who were suspended or expelled in the prior year. The reports cover the 2004–2005 through 2012–2013 academic years.

(For more information on the indicators, which data sources they were derived from, and the years of available data, see Table C.1).

II. Analytic methodology for contextual analysis

To understand the dynamics of the environments in which the APPI sites have been operating, we examined county-level trends in the selected indicators in the APPI counties and compared them to the trends in the Washington State comparison group. To determine whether a trend in a given indicator was increasing, decreasing, or remained stable, we used a linear regression model, which included site-specific fixed effects and site-specific slopes. The basic form of the model was:

$$Y_{tj} = \sum_{j=1}^{6} \beta_j * I_{tj} + \sum_{j=1}^{6} \delta_j * I_{tj} * (Year_{tj} - 2010)_{tj} + \varepsilon_{tj}, \text{ where}$$

Y_{tj} was an outcome of interest at time t for site j;

β_j was a site-specific intercept;

I_{tj} was a binary indicator that took a value of one when the observation at time t came from site j and zero otherwise;[37]

δ_j was a site-specific slope;

$Year_{tj}$ indicated the year of observation at time t for site j.

The parameters of interest in this regression were site-specific slopes, δ_j. A positive site-specific slope indicated that the outcome of interest was increasing over time in site j, while a negative site-specific slope indicated that the outcome was decreasing over time in site j. The difference between site-specific slopes for a given APPI site and the Washington State comparison group indicated whether the site experience a greater or slower decline or increase over time for a specific outcome of interest. We used t-tests to determine whether the findings

[37] When data were available to allow us to combine the outcomes for Chelan and Douglas Counties, the model included six indicators: one for each of the five APPI sites and the Washington State comparison group. Otherwise, the model included separate indicators for Chelan and Douglas Counties, for a total of seven indicators.

were statistically significant at the 0.05 level. Due to the descriptive nature of these analyses, the reported p-values did not adjust for multiple comparisons.

While the three administrative data sets—CORE-GIS, POC Data Portal, and Student Behavior data—contained county-level data that could be analyzed using the regression model above, the data from the two surveys required some modifications to the model to account for the complexities in their survey designs. Analysis of outcomes from BRFSS and HYS data sets used the regression model above with individual-level responses and adjusted for unequal probability of sampling using sampling weights (BRFSS data) and for clustering of students within schools (HYS data). Due to the changes in the methodology that were implemented in 2011 BRFSS data resulting in non-comparable data, the regression analysis of BRFSS outcomes included data prior to 2011 only. Finally, since BRFSS ACEs module was administered only in two years prior to 2011 (namely, 2009 and 2010 BRFSS surveys in Washington State), the regression models for the prevalence of ACEs excluded site-specific slopes. For these outcomes, we focused on examining whether the prevalence of individuals reporting zero, three or more, or six or more ACEs differed between the APPI sites and the Washington State comparison group.

III. Analytic methodology and limitations of feasibility analyses

Due to the limited budgets, the sites strategically targeted their activities to select areas or populations within their counties. Our main impact analyses will, therefore, examine whether the sites' activities shifted their outcomes at the subcounty level; the results of these analyses will be described in the final report. In 2014, however, we examined whether it is feasible to detect any impacts of the sites' ACEs-related activities at the county levels. This section describes our methodology for identifying matched comparison counties and examining impacts, and the limitations of these analyses.

A. Analytic Methodology of Feasibility Analyses

To identify the matched comparison county, we began with "Counties Like Us" clusters identified by the Washington State Department of Social and Health Services (Kabel et al. 1997). DSHS grouped 39 counties in Washington State into five clusters based on their similarity on three key characteristics related to prevention planning—(1) population of young people (ages 10–24), (2) percentage of deaths in the county due to alcohol, and (3) percentage of deaths in the county due to drugs—as well as two geographic divisions (urban/rural and eastern/western counties). Within each "Counties Like Us" cluster, we then matched the participating communities to a comparison community based on their similarity on the prevalence of the population with three or more ACEs and poverty rates. As a result of our matching strategies, the APPI and matched comparison counties are similar on key characteristics. For example, the two differ by at most 3 percentage points on poverty rates and all but one pair of counties differ by no more than 6 percentage points on the prevalence of ACEs (Table C.2).

To examine whether localized efforts to combat ACEs, increase resilience, and improve child and adult well-being could be detected at the county level, we examined the trends in county-level ACEs and other ACEs-related outcomes from decade before a site focused specifically on ACEs (i.e, pre-intervention trend) and compared them to county-level trends after the shift to ACEs-specific work (i.e., post-intervention trend). For a given indicator, we visually examined (1) whether there are sufficient data to determine the pattern of the trend during the

pre-intervention period; (2) the direction of the pre-intervention trend, (3) the level, direction, and variability of the post-intervention trend, and (4) the overlap between the pre-intervention and post-intervention trends. We then triangulated the findings by examining whether the observed patterns in observed impacts (or lack of impacts) were consistent across related indicators.

To evaluate which changes may be attributed to the site's efforts (as opposed to statewide policy changes coinciding with the implementation of the site's activities), we then compared[38] the changes in outcome trends pre- to post-ACEs work in the APPI sites to trends in two comparison groups: (1) a matched comparison county and (2) the Washington State comparison group.[39] Table C.3 presents site-specific information for the start of the ACEs-specific work and the APPI and matched comparison counties used in these analyses.

B. Limitations

Before presenting the results, we would like to highlight some limitations of the analysis:

- **Limited data are available on the prevalence of ACEs in Washington State.** In particular, 2009–2011 BRFSS data[40] are the sole source of information on the prevalence of ACEs—the main target of the APPI efforts—in Washington State. By definition, a person can only acquire ACEs in childhood; therefore, most of the BRFSS respondents would have accumulated all their ACEs *before* the site began any ACEs-related work. Moreover, some respondents may have relocated to the focal communities *after* they accumulated all (or most) of their ACEs. This would make it impossible for the site's efforts to have significantly affected this indicator. Nonetheless, given the critical nature of this indicator, we included it in our analysis.
- **Comparability of data across time is questionable.** Long-running surveys tend to evolve as the needs of survey users change and new methodologies for data collection and statistical analysis become available. For example, CDC redesigned BRFSS methodology several times in the 1990s and 2000s, including a major redesign in 2011. Therefore, we cannot compare data before 2011 to data starting in 2011. Indicators derived from administrative data also undergo changes as the systems for recording data are upgraded and improved. Unlike major survey efforts, however, it is harder to identify when these changes occurred. When possible, we included these changes as "events" on the figures depicting indicators' trend lines. However, potential changes in the indicators due to survey or administrative system redesigns or improvements limit our ability to identify meaningful changes in the indicators across long periods of time.

[38] For this interim report, we based the results primarily on visual analysis. The results may change if statistical significance is taken into account.

[39] As with the contextual analyses, when feasible, the Washington State comparison group excluded the five APPI sites (Chelan/Douglas, Okanogan, Skagit, Walla Walla, and Whatcom Counties) and King County, which is the most populous county in the state and contains the state's largest city, Seattle. King County was excluded because of its differences with the five APPI sites, in terms of urbanicity, demographic characteristics, and availability of resources, among others.

[40] As mentioned earlier, due to the changes in the BRFSS methodology that were introduced with the 2011 survey, the data before 2011 is not comparable to the data from 2011 onward and cannot be included in the same analyses.

- **Insufficient power to detect impacts at the county level.** The county is the smallest geographic area examined for these interim analyses. Because the site's ACEs-related efforts targeted smaller geographic area, their impacts may not be detectable at the county level. Small sample sizes for some indicators or subpopulations of interest make some estimates highly variable or unreliable and further reduce our ability to detect impacts of the site's ACEs-related work.[41]
- **Preexisting differences between the APPI community and comparison groups.** This evaluation could provide suggestive evidence of the impact of the coalitions' efforts on the outcomes of interest. However, the retrospective quasi-experimental nature of this evaluation makes it impossible to rule out the possibility that differences in outcomes (or trends in outcomes) between focal and matched comparison counties (or the statewide comparison group) are not due to preexisting differences between these communities or other things happening in one of the counties during the intervention period.
- **APPI sites and matched comparison communities could be implementing similar ACEs-related activities.** As mentioned earlier, the FPC helped create over 40 networks that worked to address the issues related to ACEs, toxic stress, and resilience in their local communities. After the FPC was defunded in 2011, some of the networks disappeared, while others adjusted to the new environment and continued their work. Furthermore, new non-FPC networks could have been created to address ACEs-related issues. While we conducted interviews, site visits, and examined numerous historical documents to examine what happened in the five APPI sites, the scope of this evaluation limited what we could learn about the activities happening in the matched comparison counties. If the APPI sites and the matched comparison communities were implementing similar ACEs-related activities, this would severely limit our ability to detect any impacts.

IV. Summary of the county-level collective impact results

With a few exceptions, the examined indicators in the APPI counties were consistent with those reported for their matched comparison county or Washington State comparison groups. We summarize these exceptions here:

- **Chelan/Douglas Counties**: Both Stevens County and the Washington State comparison group had two to three times as many unexcused absences from school than in Chelan/Douglas Counties between 2004 and 2013.

- **Okanogan County**: Student behavior indicators improved in Okanogan County even though longer-term school completion outcomes deteriorated. Okanogan County also performed better than the two comparison group based on the rate of hospitalizations due to injuries and accidents among adult women—an indicator of potential domestic violence.

[41] Following guidelines from the CDC and Washington State's Department of Health, we do not report any estimates that are based on fewer than 50 respondents from the BRFSS. Similarly, we do not report any estimates based on fewer than 10 item responses, fewer than two participating school districts, or less than 40 percent student participation rate in the survey from the HYS.

- **Skagit County**: Youth in Skagit County reported higher quality of life and lower levels of suicidal thoughts or plans than those in the two comparison groups between 2002 and 2012.

- **Walla Walla County**: Between 2001 and 2010, the incidences of child abuse and neglect in accepted referrals decreased by roughly 65 percent in Walla Walla County, converging to the levels observed for both comparison groups throughout this period. Moreover, Walla Walla County performed better on both school completion indicators than did the two comparison groups.

- **Whatcom County**: Trends in the indicators in Whatcom County were consistent with those reported in one or both comparison groups.

However, we could not detect any changes at the county level that could be attributed to the site's ACEs-specific efforts for two reasons. First, most trends in the APPI sites mirrored those observed in one or both comparison groups. Second, using the available data, we were unable to observe shifts in patterns in the above-mentioned indicators coinciding with the start of the ACEs-specific efforts. Therefore, we cannot confirm that that the observed differences between site and state trends are related to the collective impact of sites' ACEs-specific efforts.

Table C.1. County-level APPI Evaluation Outcomes and Corresponding Population, Data Source, and Years of Available Data, by Domain

Outcomes	Population	Data Source	Years of Available Data
Adverse Childhood Experiences (ACEs)			
Prevalence of ACEs in the community (0, 3 or more, 6 or more)	Adults (ages 18–54)	BRFSS	2009–2011
Domain 1: Child Abuse Prevention and Family Support			
Child Abuse Prevention			
Hospitalizations due to injury or accident	Children (ages birth to 17)	CORE-GIS	1990–2012
Alleged victims of child abuse and neglect in accepted referrals [This indicator refers to children (age birth–17) identified as alleged victims in reports to Child Protective Services that were accepted for further action. Children are counted more than once if they are reported as alleged victims more than once during the year. A "referral" is a report of suspected child abuse.]	Children (birth to 17)	CORE-GIS	1998–2012
Out-of-home cases exiting to reunification within 24 months	Out-of-home cases	POC Data Portal	2000–2012
Family well-being			
Hospitalizations due to injury or accident	Adult women (ages 18 and older)	CORE-GIS	1990–2012
Family rewards for prosocial involvement scale [This scale consists of four items: 1. My parents notice when I am doing a good job and let me know about it. 2. How often do your parents tell you they're proud of you for something you've done? 3. Do you enjoy spending time with your dad? 4. Do you enjoy spending time with your mom? Possible scale scores range from 1 to 4, with higher values indicating more family rewards. The 2012 grade 6 Washington State mean is 3.36 with a standard error of 0.01.]	6th grade students	HYS	2002, 2004, 2006, 2008, 2010, 2012
Domain 2: School Climate and Student Success			
Student behavior and school climate			
Unexcused Absences	Students (grades 1–8)	CORE-GIS	2004–2013
Total number of expulsions and suspensions	Students	Student Behavior Reports	2005–2013
Low commitment to school [This scale consists of five items: 1. How often do you feel the schoolwork you are assigned is meaningful and important? 2. How interesting are most of your courses to you? 3. How important do you think the things you are learning in school are going to be for you later in life? 4. Think back over the past year in school. How often did you: A. Enjoy being in school? B. Hate being in school? C. Try to do your best work in school? 5. During the last 4 weeks, how many whole days of school have you missed because you skipped or "cut"? Possible scale scores range from 1 to 5 with higher values indicating lower level of commitment to school. The 2012 grade 10 Washington State mean is 2.40 with a standard error of 0.01.]	10th grade students	HYS	2002, 2004, 2006, 2008, 2010, 2012

Outcomes	Population	Data Source	Years of Available Data
School rewards for prosocial involvement [This scale consists of four items: 1. My teacher(s) notices when I am doing a good job and lets me know about it. 2. The school lets my parents know when I have done something well. 3. I feel safe at my school. 4. My teachers praise me when I work hard in school. Possible scale scores range from 1 to 4, with higher values indicating more rewards. The 2012 grade 10 Washington State mean is 2.50 with a standard error of 0.01.]	10th grade students	HYS	2002, 2004, 2006, 2008, 2010, 2012
End-of-school student outcomes			
High school cohort (cumulative) dropout	Students in grade 9	CORE-GIS	2006–2012
High school extended graduation [This indicator is defined as the percentage of students who graduate from high school; it includes on-time graduates as well as students who stay in school and take more than four years to complete their high school degree.]	High school students	CORE-GIS	2006–2012
Domain 3: Risk Behavior Reduction and Healthy Youth Development			
Substance use and involvement with justice system			
Never had more than a sip or two of alcohol	10th grade students	HYS	2002, 2004, 2006, 2008, 2010, 2012
Never drank alcohol regularly (at least once or twice a month)	10th grade students	HYS	2002, 2004, 2006, 2008, 2010, 2012
Never used marijuana	10th grade students	HYS	2002, 2004, 2006, 2008, 2010, 2012
Never drank alcohol in the past 30 Days	10th grade students	HYS	2002, 2004, 2006, 2008, 2010, 2012
Never used marijuana or hashish in the past 30 Days	10th grade students	HYS	2002, 2004, 2006, 2008, 2010, 2012
Never used illegal drugs (other than alcohol, tobacco, or marijuana) in the past 30 days	10th grade students	HYS	2004, 2006, 2008, 2010, 2012
Arrests for alcohol-related violations	Adolescents (ages 10–17)	CORE-GIS	1990–2012
	Adults (ages 18 and older)	CORE-GIS	1990–2012
Arrests for drug law violations	Adolescents (ages 10–17)	CORE-GIS	1990–2012
	Adults (ages 18 and older)	CORE-GIS	1990–2012
Arrests for violent crimes	Adolescents (Ages 10–17)	CORE-GIS	1990–2012
	Adults (ages 18 and older)	CORE-GIS	1990–2012

Outcomes	Population	Data Source	Years of Available Data
Healthy youth development and health outcomes			
Youth quality of life scale [This scale consists of 11 items: 1. I feel I am getting along with my parents or guardians. 2. I look forward to the future. 3. I feel good about myself. 4. I am satisfied with the way my life is now. 5. I feel alone in my life. 6. Compared with others my age, my life is ... 7. There are adults in my life who really care about me. 8. In the last month, how often have you felt that: You were unable to control the important things in your life? 9. In the last month, how often have you felt that: You dealt successfully with irritating life hassles? 10. In the last month, how often have you felt that: You were effectively coping with important changes that were occurring in your life? 11. In the last month, how often have you felt that: You were on top of things? Possible scale scores range from 0 to 100, with higher values indicating a better quality of life. The 2012 grade 10 Washington State mean is 72.83 with a standard error of 0.16.]	10th grade students	HYS	2002, 2004, 2006, 2008, 2010, 2012
Seriously consider or plan of suicide in the last 12 months	10th grade students	HYS	2002, 2004, 2006, 2008, 2010, 2012
Overall “good” mental health	Adults (ages 18 and older)	BRFSS	1995–2012
"Good" or better overall health	Adults (ages 18 and older)	BRFSS	1995–2012
Domain 4: Community Development			
Community rewards for prosocial involvement scale [This scale consists of three items: 1. My neighbors notice when I am doing a good job and let me know. 2. There are people in my neighborhood or community/neighborhood who encourage me to do my best. 3. There are people in my neighborhood who are proud of me when I do something well. Possible scale scores range from 1 to 4, with higher values indicating more rewards. The 2012 grade 6 Washington State mean is 2.19 with a standard error of 0.01.]	6th grade students	HYS	2002, 2004, 2006, 2008, 2010, 2012
Usually or always meet social and emotional support needs	Adults (ages 18 and older)	BRFSS	2005–2012

NOTE: Data source column refers to the following five data sources: (1) Washington State Department of Health, Center for Health Statistics’ Behavioral Risk Factor Surveillance System (BRFSS); (2) Washington State Department of Health’s Healthy Youth Survey (HYS); (3) Washington State’s Office of Superintendent of Public Instruction (OSPI) Student Behavior Reports; (4) public child welfare data from the Washington State/Partners for Our Children (POC) Data Portal; and (5) Washington State’s Community Outcome and Risk Evaluation Geographic Information System (CORE-GIS).

Table C.2. Prevalence of Adverse Childhood Experiences (ACEs) and Poverty in APPI and Matched Comparison Counties in the 1990s

County Name	Three or More ACEs (Percentage)	Below Federal Poverty Line (Percentage)
Risk Profile: Rural Counties with High Prevalence of Alcohol and Drug-Related Deaths (Eastern Washington)		
Okanogan*	NR***	21.5
Pend Oreille**	NR***	20.2
Difference	6.0	1.3
Risk Profile: Rural Counties with Lower Prevalence of Alcohol and Drug-Related Deaths (Eastern Washington)		
Chelan/Douglas*	34.3	14.3
Stevens**	22.7	17.2
Difference	11.6	2.9
Walla Walla*	27.0	16.0
Stevens**	22.7	17.2
Difference	4.3	0.8
Risk Profile: Rural Counties with Lower Prevalence of Alcohol and Drug-Related Deaths (Western Washington)		
Skagit*	37.6	11.5
Cowlitz**	37.5	13.3
Difference	0.1	1.8
Risk Profile: Urban Counties with Small Youth Population		
Whatcom*	33.6	12.3
Thurston**	37.5	10.1
Difference	3.9	2.2

Source: Mathematica Policy Research Analysis of Washington State Department of Health, Center for Health Statistics, Behavioral Risk Factor Surveillance System (BRFSS), supported in part by Centers for Disease Control and Prevention, Cooperative Agreement U58 DP001996-1 through 2 (2009-2010); 1990 U.S. Census; Kabel et al. (1997) "Profile on Risk and Protection for Substance Abuse Prevention Planning in Washington State."

Notes: This table reports the prevalence of ACEs and poverty in APPI and matched comparison counties in the late 1990s. The prevalence of ACEs is based on the percentage of adults (ages 35–54 years old) who reported having three or more ACEs in a combined sample from the 2009–2010 BRFSS. The poverty estimates are based on the percentage of population reporting living below federal poverty line in the 1990 U.S. Census.

* APPI counties.

** Matched comparison counties.

*** Not reported due to small sample sizes, less than 50 respondents for one (or both) of the counties.

Table C.3. Date for the Start of ACEs-Specific Work, APPI and Matched Comparison Counties, by APPI Sites

APPI Site Name	Year	APPI County	Matched Comparison County
Walla Walla County Community Network	2004	Walla Walla	Stevens
Whatcom Family & Community Network	2004	Whatcom	Thurston
Skagit County Child and Family Consortium	2009	Skagit	Cowlitz
Coalition for Children and Families of North Central Washington	2010	Chelan and Douglas	Stevens
Okanogan County Community Coalition	2011	Okanogan	Pend Oreille

Table C.4. Prevalence of Adverse Childhood Experiences (ACEs) in the Five APPI Counties and Washington State Comparison Group Among Adults (Ages 18–54), 2009–2010

Number of ACEs	Chelan and Douglas (combined) (n = 182)	Okanogan County (n = 78)	Skagit County (n = 108)	Walla Walla County (n = 182)	Whatcom County (n = 233)	Washington State comparison group[a] (n = 5,993)
Adults reporting zero ACEs						
Percentage	42.82	24.42	23.79	37.77	26.52	28.27
Standard error	5.96	5.67	5.07	5.59	3.78	0.78
P^0	<0.01	<0.01	<0.01	<0.01	<0.01	<0.01
P^{state}	0.02	0.50	0.38	0.09	0.65	
Adults reporting three or more ACEs						
Percentage	31.95	33.73	38.78	22.81	35.39	35.56
Standard error	4.64	6.50	6.36	4.51	4.02	0.83
P^0	<0.01	<0.01	<0.01	<0.01	<0.01	<0.01
P^{state}	0.44	0.78	0.62	0.01	0.97	
Adults reporting six or more ACEs						
Percentage	8.00	8.90	12.70	1.69	5.22	7.70
Standard error	2.37	3.28	4.49	1.02	2.30	0.44
P^0	<0.01	0.01	<0.01	0.10	0.02	<0.01
P^{state}	0.90	0.72	0.27	<0.01	0.29	

Source: Mathematica Policy Research analysis of Washington State Department of Health, Center for Health Statistics, Behavioral Risk Factor Surveillance System (BRFSS), supported in part by Centers for Disease Control and Prevention, Cooperative Agreement U58 DP001996-1 through 2 (2009–2010).

Note: This table reports the number of respondents (n), estimates for percentage of adults who reported experiencing zero, three or more, or six or more ACEs, corresponding standard errors and two p values (p^0 denotes the p value for whether the estimate is different from zero and p^{state} denotes the p value for whether a site-specific estimate differs from the estimate for the Washington State comparison group). For example, in 2009–2010, 42.82 percent of adults between 18 and 54 years of age reported experiencing no ACEs in childhood in Chelan/Douglas counties. This estimate is significantly different from zero (p^0 < 0,01) and from the estimate for the Washington State comparison group (28.27 percent, p^{state} = 0.02). These results are based on a series of linear regression models which included site-specific fixed effects. Due to the descriptive nature of these analyses, the p values were not adjusted for multiple comparisons.

[a] The Washington State comparison group excludes the five APPI sites (Chelan/Douglas, Okanogan, Skagit, Walla Walla, and Whatcom counties) as well as King County, which is the most populous county in the state and contains the state's largest city, Seattle.

Table C.5. Average Annual Change in Child Abuse Prevention and Family Support Indicators for APPI Counties and Washington State Comparison Group

	Chelan and Douglas (combined)	Chelan County	Douglas County	Okanogan County	Skagit County	Walla Walla County	Whatcom County	Washington State comparison group[a]
Child Abuse Prevention								
Percentage of hospitalizations due to injury or accident among children [Years of data: 1990-2012]								
Estimate	-0.02			0.00	-0.01	-0.01	-0.06	-0.01
SE	0.02			0.02	0.02	0.02	0.02	0.02
p^0	0.21			0.86	0.63	0.68	<0.01	0.79
p^{state}	0.48			0.76	0.87	0.92	0.06	
Rate (per 1,000 children) of alleged victims of child abuse and neglect in accepted referrals [1998-2012]								
Estimate	-0.17			0.17	-0.08	-4.06	0.13	-0.62
SE	0.43			0.43	0.43	0.43	0.43	0.43
p^0	0.70			0.70	0.85	<0.01	0.76	0.15
p^{state}	0.46			0.20	0.38	<0.01	0.22	
Percentage of out-of-home cases exiting to reunification within 24 months [2000-2012]								
Estimate		-1.96	-1.40	-1.73	-0.45	-1.85	-0.96	-1.27
SE		0.68	0.68	0.68	0.68	0.68	0.68	0.68
p^0		<0.01	0.04	0.01	0.51	<0.01	0.16	0.07
p^{state}		0.47	0.89	0.63	0.40	0.54	0.75	
Family Well-Being								
Percentage of hospitalizations due to injury or accident among adult women [1990-2012]								
Estimate	0.20			0.09	0.29	0.44	0.26	0.39
SE	0.03			0.03	0.03	0.03	0.03	0.03
p^0	<0.01			<0.01	<0.01	<0.01	<0.01	<0.01
p^{state}	<0.01			<0.01	0.02	0.21	<0.01	
Average score on family rewards for prosocial involvement scale among 6th grade students [2002-2012]								
Estimate	-0.01			-0.01	-0.01	-0.01	-0.02	-0.02
SE	<0.01			0.01	<0.01	0.01	<0.01	<0.01
p^0	0.10			0.32	<0.01	0.18	<0.01	<0.01
p^{state}	0.10			0.19	0.15	0.28	0.27	

Source: Mathematica Policy Research Analysis of three data sources: (1) Community Outcome and Risk Evaluation Geographic Information System (CORE-GIS), (2) Washington State/Partners for Our Children Data Portal data, and (3) Washington State Department of Health's Healthy Youth Survey.

Notes: This table reports estimated annual rates of change (i.e., site-specific time slopes) for the specified indicators, corresponding standard errors, and two p values (p^0 denotes the p value for whether the estimate for the annual rate of change in an APPI site or Washington State comparison group is different from zero and p^{state} denotes the p value for whether a site-specific annual rate of change estimate differs from the WA state estimate). For example, between 1998 and 2012, the rate of alleged victims of child abuse and neglect in accepted referrals decreased, on average, by 4.06 cases (per 1,000 children) per year in Walla Walla County ($p^0 < 0.01$). Using 2011-2013 estimates from the U.S. Census Bureau's American Community Survey, this translates into roughly 52 fewer cases per year of alleged victims of child abuse and neglect in accepted referrals in Walla Walla County. Furthermore,

while Walla Walla's rate was decreasing, the rate of alleged victims of child abuse and neglect in accepted referrals remained relatively stable for the Washington State (-0.62, p^0= 0.15). These estimates are based on a series of linear regression models which included site-specific fixed effects and site-specific time slopes. Due to the descriptive nature of these analyses, the p values were not adjusted for multiple comparisons.

[a] When feasible, the Washington State comparison group excluded the five APPI sites (Chelan/Douglas, Okanogan, Skagit, Walla Walla, and Whatcom Counties) and King County, which is the most populous county in the state and contains the state's largest city, Seattle.

Table C.6. Average Annual Change in School Climate and Student Success Indicators for APPI Counties and Washington State Comparison Group

	Chelan and Douglas (combined)	Chelan County	Douglas County	Okanogan County	Skagit County	Walla Walla County	Whatcom County	Washington State comparison group[a]
Student Behavior and School Climate								
Rate (per 1,000 potential school days) of unexcused absences [Year of data: 2004-2013]								
Estimate	-0.02			-0.27	0.10	-0.59	0.00	0.02
SE	0.36			0.36	0.36	0.36	0.36	0.36
p^0	0.96			0.46	0.78	0.11	0.99	0.96
p^{state}	0.94			0.57	0.87	0.24	0.97	
Rate (per 1,000 students) of expulsions and suspensions [2005-2013]								
Estimate	1.49			-3.64	1.48	1.39	0.53	2.15
SE	0.99			0.99	0.99	0.99	0.99	0.99
p^0	0.14			<0.01	0.15	0.17	0.6	0.04
p^{state}	0.64			<0.01	0.63	0.59	0.25	
Average score on the low commitment to school scale as reported by 10th grade students [2002-2012][b]								
Estimate	0.00			-0.01	-0.01	-0.02	-0.01	-0.01
SE	<0.01			<0.01	<0.01	0.01	<0.01	<0.01
p^0	0.21			0.04	<0.01	<0.01	<0.01	<0.01
p^{state}	0.04			0.99	0.65	0.15	0.70	
Average score on the school rewards for prosocial involvement scale as reported by 10th grade students [2002-2012][b]								
Estimate	0.00			0.00	0.00	0.00	-0.01	0.00
SE	<0.01			<0.01	<0.01	0.01	<0.01	<0.01
p^0	0.77			0.52	0.05	0.59	0.08	<0.01
p^{state}	0.18			0.56	0.79	0.20	0.78	
End-of-school Student Outcomes								
High school cohort (cumulative) dropout rate [2006-2012]								
Estimate		-1.85	-0.86	0.95	-2.78	-0.61	-1.65	-1.03
SE		0.66	0.66	0.66	0.66	0.66	0.66	0.66
p^0		<0.01	0.20	0.16	<0.01	0.36	0.02	0.12
p^{state}		0.39	0.86	0.04	0.07	0.66	0.51	
High school extended graduation rate [2006-2012]								
Estimate		0.44	1.53	-1.34	2.82	1.65	2.09	1.25
SE		0.96	0.96	0.96	0.96	0.96	0.96	0.96
p^0		0.65	0.12	0.17	0.01	0.09	0.04	0.20
p^{state}		0.55	0.84	0.06	0.25	0.77	0.54	

Source: Mathematica Policy Research Analysis of three data sources: (1) Community Outcome and Risk Evaluation Geographic Information System (CORE-GIS), (2) Washington State's Office of Superintendent of Public Instruction's Student Behavior Reports, and (3) Washington State Department of Health's Healthy Youth Survey.

Notes: This table reports estimated annual rates of change (i.e., site-specific time slopes) for the specified indicators, corresponding standard errors, and two p values (p^0 denotes the p value for whether the estimate for the annual rate of change in an APPI site or Washington State comparison group is different from zero and p^{state} denotes the p value for whether a site-specific annual rate of change estimate differs from the WA state estimate). For example, between 2005 and 2013, the rate of expulsions and suspensions decreased, on average, by 3.64 cases (per 1,000 children) per year in Okanogan County ($p^0 < 0.01$). Using the average number of enrolled students in Okanogan County during this period, this translates into roughly 25 fewer suspensions and expulsions per year in Okanogan County. Furthermore, while Okanogan County's rate was decreasing, the rate of suspensions and expulsions was increasing for the Washington State comparison group (2.15, $p^0 = 0.04$). These estimates are based on a series of linear regression models which included site-specific fixed effects and site-specific time slopes. Due to the descriptive nature of these analyses, the p values were not adjusted for multiple comparisons.

[a] When feasible, the Washington State comparison group excluded the five APPI sites (Chelan/Douglas, Okanogan, Skagit, Walla Walla, and Whatcom Counties) and King County, which is the most populous county in the state and contains the state's largest city, Seattle.

[b] Due to low (less than 40 percent) response rates among 10th grade students, the regression analyses excluded 2002 and 2012 student data for Okanogan and Walla Walla counties, respectively, as these data may not be representative of these counties.

Table C.7. Average Annual Change in Risk Behavior Reduction and Healthy Youth Development Indicators for APPI Counties and Washington State Comparison Group

	Chelan and Douglas (combined)	Okanogan County	Skagit County	Walla Walla County	Whatcom County	Washington State comparison group[a]
Substance Use and Involvement with Justice System						
Percentage of 10th grade students reporting that they never had more than a sip or two of alcohol [Years of data: 2002-2012][b]						
Estimate	0.41	0.32	0.65	0.69	0.62	0.50
SE	0.10	0.30	0.13	0.35	0.23	0.05
p^0	<0.01	0.27	<0.01	0.05	0.01	<0.01
p^{state}	0.43	0.57	0.28	0.58	0.60	
Percentage of 10th grade students reporting that they never drank alcohol regularly (at least once or twice a month) [2002-2012][b]						
Estimate	0.43	0.55	0.70	0.86	0.56	0.59
SE	0.14	0.38	0.20	0.35	0.19	0.05
p^0	<0.01	0.15	<0.01	0.01	<0.01	<0.01
p^{state}	0.29	0.92	0.60	0.43	0.90	
Percentage of 10th grade students reporting that they never used marijuana [2002-2012][b]						
Estimate	-0.11	-0.08	0.10	0.53	0.06	-0.09
SE	0.13	0.24	0.15	0.48	0.18	0.05
p^0	0.39	0.74	0.51	0.27	0.73	0.09
p^{state}	0.89	0.96	0.24	0.20	0.42	
Percentage of 10th grade students reporting that they did not use alcohol in the past 30 days [2002-2012][b]						
Estimate	0.35	0.56	0.65	1.03	0.35	0.42
SE	0.15	0.23	0.14	0.32	0.16	0.05
p^0	0.02	0.01	<0.01	<0.01	0.03	<0.01
p^{state}	0.64	0.53	0.13	0.06	0.66	
Percentage of 10th grade students reporting that they did not use marijuana or hashish in the past 30 days [2002-2012][b]						
Estimate	-0.23	-0.40	-0.15	0.22	-0.10	-0.22
SE	0.10	0.19	0.09	0.23	0.10	0.03
p^0	0.03	0.03	0.09	0.34	0.34	<0.01
p^{state}	0.92	0.34	0.50	0.06	0.25	
Percentage of 10th grade students reporting that they did not use illegal drugs (other than alcohol, tobacco, or marijuana) in the past 30 days [2004-2012][b]						
Estimate	0.31	0.01	0.33	0.38	0.18	0.24
SE	0.10	0.12	0.10	0.17	0.08	0.02
p^0	<0.01	0.96	<0.01	0.03	0.03	<0.01
p^{state}	0.47	0.05	0.35	0.40	0.49	
Rate of arrests (per 1,000 adolescents) for alcohol-related violations among adolescents [1990-2012]						
Estimate	-0.75	-0.76	-0.25	-0.03	-0.89	-0.18
SE	0.12	0.12	0.12	0.12	0.12	0.12
p^0	<0.01	<0.01	0.04	0.77	<0.01	0.13
p^{state}	<0.01	<0.01	0.69	0.38	<0.01	

	Chelan and Douglas (combined)	Okanogan County	Skagit County	Walla Walla County	Whatcom County	Washington State comparison group[a]
Rate of arrests (per 1,000 adults) for alcohol-related violations among adults [1990-2012]						
Estimate	-0.93	-1.20	-0.65	-0.09	-0.70	-0.28
SE	0.06	0.06	0.06	0.06	0.06	0.06
p^0	<0.01	<0.01	<0.01	0.17	<0.01	<0.01
p^{state}	<0.01	<0.01	<0.01	0.04	<0.01	
Rate of arrests (per 1,000 adolescents) for drug law violations among adolescents [1990-2012]						
Estimate	0.10	0.13	0.21	0.15	0.04	0.08
SE	0.06	0.06	0.06	0.06	0.06	0.06
p^0	0.08	0.02	<0.01	0.01	0.43	0.16
p^{state}	0.81	0.54	0.10	0.41	0.66	
Rate of arrests (per 1,000 adults) for drug law violations among adults [1990-2012]						
Estimate	-0.01	-0.12	-0.01	0.02	0.13	-0.01
SE	0.02	0.02	0.02	0.02	0.02	0.02
p^0	0.63	<0.01	0.66	0.40	<0.01	0.78
p^{state}	0.89	<0.01	0.91	0.43	<0.01	
Rate of arrests (per 1,000 adolescents) for violent crimes among adolescents [1990-2012]						
Estimate	-0.11	-0.19	-0.02	-0.11	-0.16	-0.08
SE	0.03	0.03	0.03	0.03	0.03	0.03
p^0	<0.01	<0.01	0.49	<0.01	<0.01	<0.01
p^{state}	0.59	0.01	0.12	0.60	0.08	
Rate of arrests (per 1,000 adults) for violent crimes among adults [1990-2012]						
Estimate	-0.06	-0.14	0.01	-0.02	-0.02	-0.02
SE	0.01	0.01	0.01	0.01	0.01	0.01
p^0	<0.01	<0.01	0.51	0.04	0.07	0.06
p^{state}	<0.01	<0.01	0.07	0.87	0.96	
Healthy Youth Development and Health Outcomes						
Average score on the youth quality of life scale as reported by 10th grade students [2002-2012][b]						
Estimate	0.23	0.36	0.05	0.46	0.06	0.16
SE	0.08	0.13	0.09	0.14	0.09	0.02
p^0	<0.01	<0.01	0.57	<0.01	0.52	<0.01
p^{state}	0.37	0.11	0.27	0.03	0.31	
Percentage of 10th grade students reporting to have seriously considered or planned suicide in the last 12 months [2002-2012][b]						
Estimate	-0.11	-0.10	0.37	-0.15	0.10	0.10
SE	9.14	0.21	0.09	0.24	0.10	0.02
p^0	0.43	0.62	<0.01	0.53	0.34	<0.01
p^{state}	0.15	0.34	<0.01	0.31	0.99	
Percentage of adults reporting good mental health [1995-2010]						
Estimate	0.14	-0.21	0.00	0.66	0.50	0.17
SE	0.27	0.44	0.28	0.39	0.28	0.05

	Chelan and Douglas (combined)	Okanogan County	Skagit County	Walla Walla County	Whatcom County	Washington State comparison group[a]
p^0	0.61	0.63	0.99	0.10	0.08	<0.01
p^{state}	0.90	0.39	0.56	0.23	0.26	
Percentage of adults reporting "good" or better overall health [1995-2010]						
Estimate	-0.22	-0.63	-0.29	-0.78	0.17	-0.24
SE	0.19	0.28	0.19	0.21	0.16	0.03
p^0	0.25	0.03	0.11	<0.01	0.27	<0.01
p^{state}	0.93	0.17	0.76	0.01	0.01	

Source: Mathematica Policy Research Analysis of three data sources: (1) Community Outcome and Risk Evaluation Geographic Information System (CORE-GIS), (2) Washington State Department of Health, Center for Health Statistics, Behavioral Risk Factor Surveillance System (BRFSS), supported in part by Centers for Disease Control and Prevention, supported in part by Centers for Disease Control and Prevention, Cooperative Agreement U58/CCU002118-9 through 17 (1995–2003), U58/CCU022819-1 through 5 (2004–2008), U58 DP001996-1 through 2 (2009–2010) and U58/SO000047-1 through 2 (2011–2012), and (3) Washington State Department of Health's Healthy Youth Survey.

Notes: This table reports estimated annual rates of change (i.e., site-specific time slopes) for the specified indicators, corresponding standard errors, and two p values (p^0 denotes the p value for whether the estimate for the annual rate of change in an APPI site or Washington State comparison group is different from zero and p^{state} denotes the p value for whether a site-specific annual rate of change estimate differs from the WA state estimate). For example, between 1990 and 2012, the rate of arrests for alcohol-related violations among adolescents decreased, on average, by 0.89 (per 1,000 adolescents) per year in Whatcom County ($p^0 < 0.01$). During the same period, the rate of arrests for alcohol-related violations among adolescents remained stable for the Washington State comparison group (-0.18, $p^0 = 0.13$). These estimates are based on a series of linear regression models which included site-specific fixed effects and site-specific time slopes. Due to the descriptive nature of these analyses, the p values were not adjusted for multiple comparisons.

[a] The Washington State comparison group excluded the five APPI sites (Chelan/Douglas, Okanogan, Skagit, Walla Walla, and Whatcom Counties) and King County, which is the most populous county in the state and contains the state's largest city, Seattle.

[b] Due to low (less than 40 percent) response rates among 10th grade students, the regression analyses excluded 2002 and 2012 student data for Okanogan and Walla Walla counties, respectively, as these data may not be representative of these counties.

Table C.8. Average Annual Change in Community Development Indicators for APPI Counties and Washington State Comparison Group

	Chelan and Douglas (combined)	Okanogan County	Skagit County	Walla Walla County	Whatcom County	Washington State comparison group[a]
Average score on the community rewards for prosocial involvement scale as reported by 6th grade students [2002-2012]						
Estimate	-0.03	-0.02	-0.03	-0.02	-0.02	-0.02
SE	<0.01	0.01	<0.01	<0.01	<0.01	<0.01
p^0	<0.01	<0.01	<0.01	<0.01	<0.01	<0.01
p^{state}	0.17	0.80	0.17	0.93	0.80	
Percentage of adults reporting "usually" or "always" meeting their needs for social and emotional support [Years of Data: 2005-2010]						
Estimate	0.77	-0.13	0.45	-0.53	-0.65	0.13
SE	0.50	0.78	0.62	0.78	0.65	0.11
p^0	0.12	0.86	0.47	0.50	0.31	0.24
p^{state}	0.20	0.74	0.61	0.41	0.24	

Source: Mathematica Policy Research Analysis of two data sources: (1) Washington State Department of Health, Center for Health Statistics, Behavioral Risk Factor Surveillance System (BRFSS), supported in part by Centers for Disease Control and Prevention, supported in part by Centers for Disease Control and Prevention, Cooperative Agreement U58/CCU002118-9 through 17 (1995–2003), U58/CCU022819-1 through 5 (2004–2008), U58 DP001996-1 through 2 (2009–2010) and U58/SO000047-1 through 2 (2011–2012) and (2) Washington State Department of Health's Healthy Youth Survey.

Notes: This table reports estimated annual rates of change (i.e., site-specific time slopes) for the specified indicators, corresponding standard errors, and two p values (p^0 denotes the p value for whether the estimate for the annual rate of change in an APPI site or Washington State comparison group is different from zero and p^{state} denotes the p value for whether a site-specific annual rate of change estimate differs from the WA state estimate). For example, between 2005 and 2010, the percentage of adults reporting that they have adequate social support remained stable in the five APPI counties (the annual rate of change estimates range between -0.65 and 0.77, $p^0 > 0.10$) and were comparable to the Washington State comparison group (1.13, $p^{state} \geq 0.20$).These estimates are based on a series of linear regression models which included site-specific fixed effects and site-specific time slopes. Due to the descriptive nature of these analyses, the p values were not adjusted for multiple comparisons.

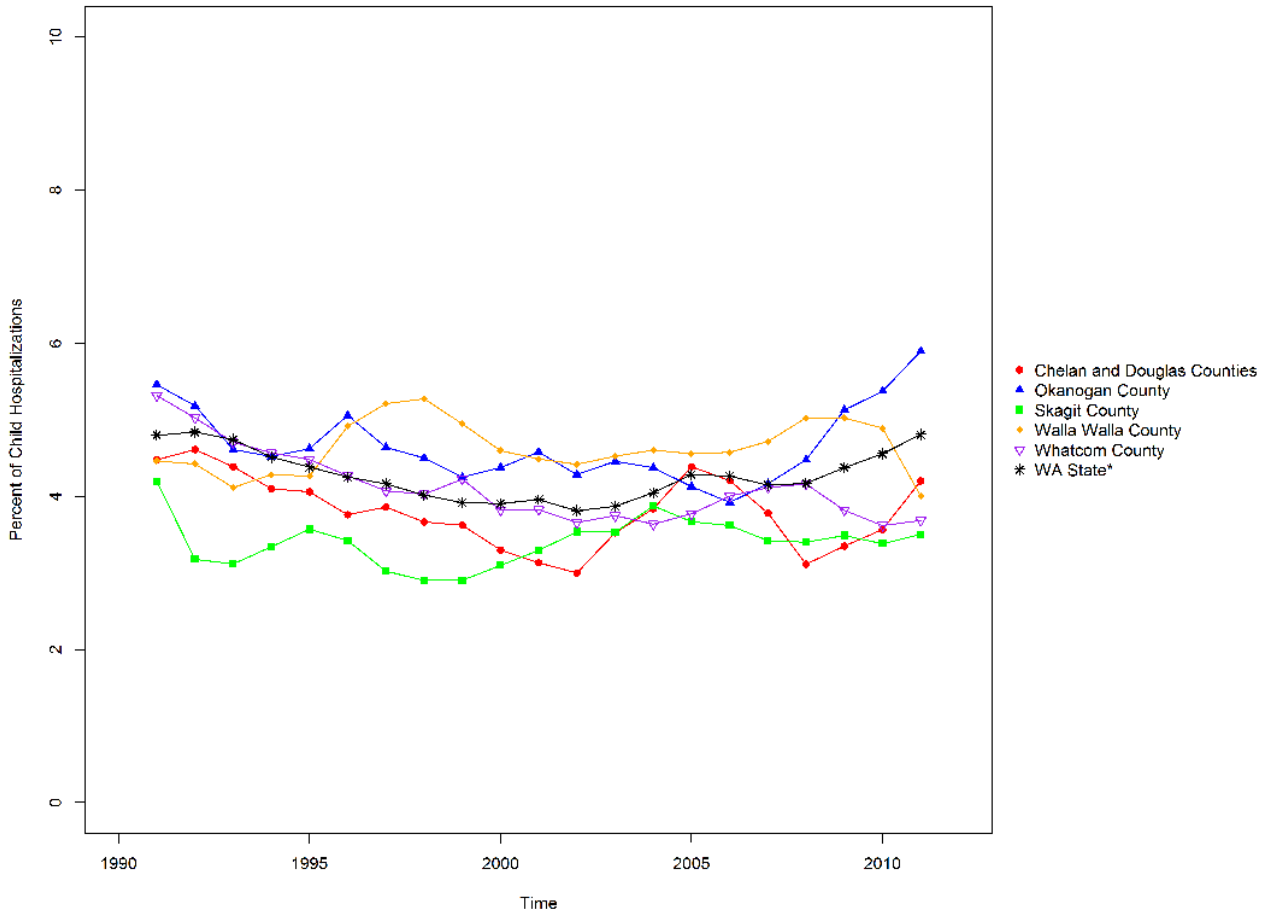
[a] The Washington State comparison group excluded the five APPI sites (Chelan/Douglas, Okanogan, Skagit, Walla Walla, and Whatcom Counties) and King County, which is the most populous county in the state and contains the state's largest city, Seattle.

APPENDIX D:
QUANTITATIVE STUDY FIGURES

This page has been left blank for double-sided copying.

DOMAIN 1: CHILD ABUSE PREVENTION AND FAMILY SUPPORT

Figure D.1. Rate of Hospitalizations due to Injury and Accidents Among Children (Ages Birth to 17 Years Old)

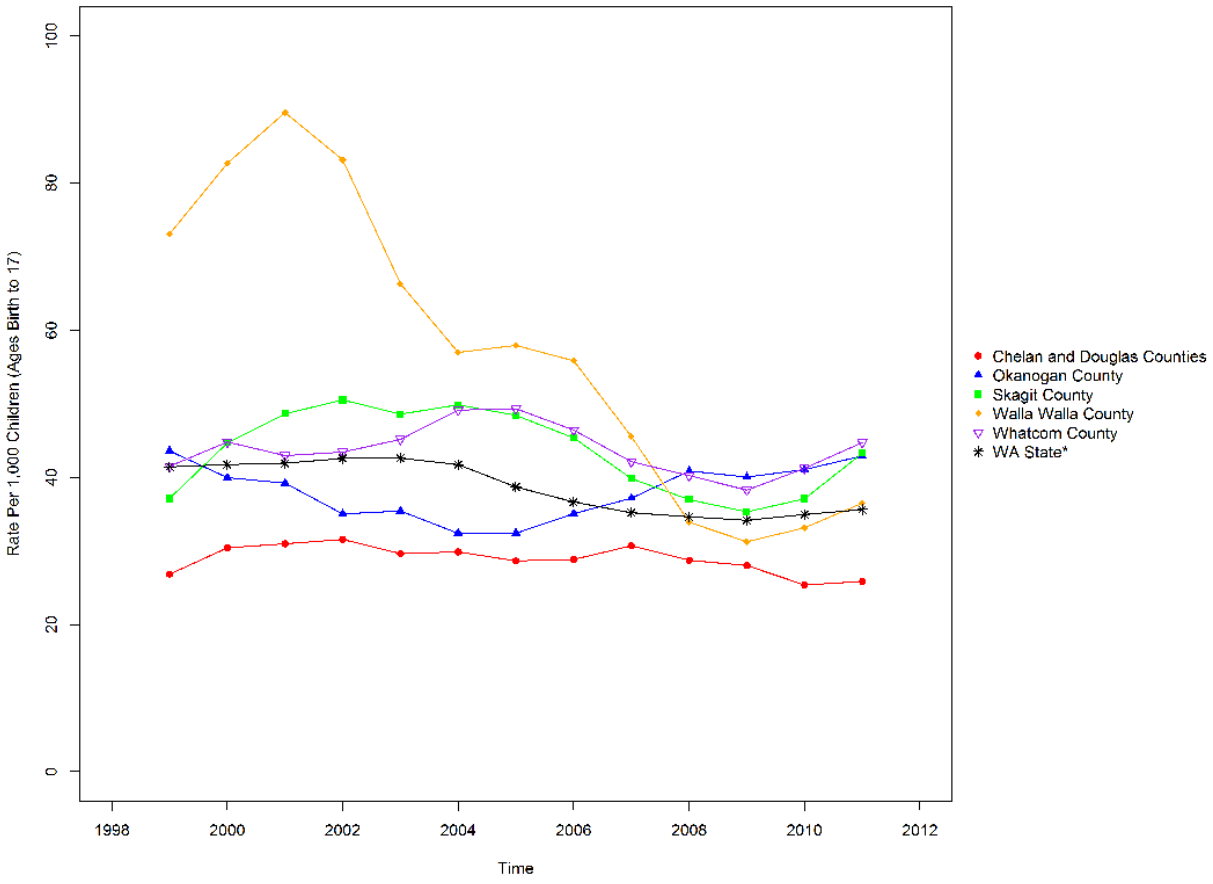


Source: Mathematica Policy Research's analyses of Community Outcome and Risk Evaluation Geographic Information System (CORE-GIS), 1990–2012.

Notes: To smooth out the year-to-year variability in this indicator, this figure displays three-year moving average estimates. For example, the values for 2010 were calculated by averaging 2009, 2010, and 2011 raw values.

* Washington State comparison group excluded the five APPI sites (Chelan/Douglas, Okanogan, Skagit, Walla Walla, and Whatcom Counties) and King County, which is the most populous county in the state and contains the state's largest city, Seattle.

Figure D.2. Rate of Alleged Victims of Child Abuse and Neglect in Accepted Referrals



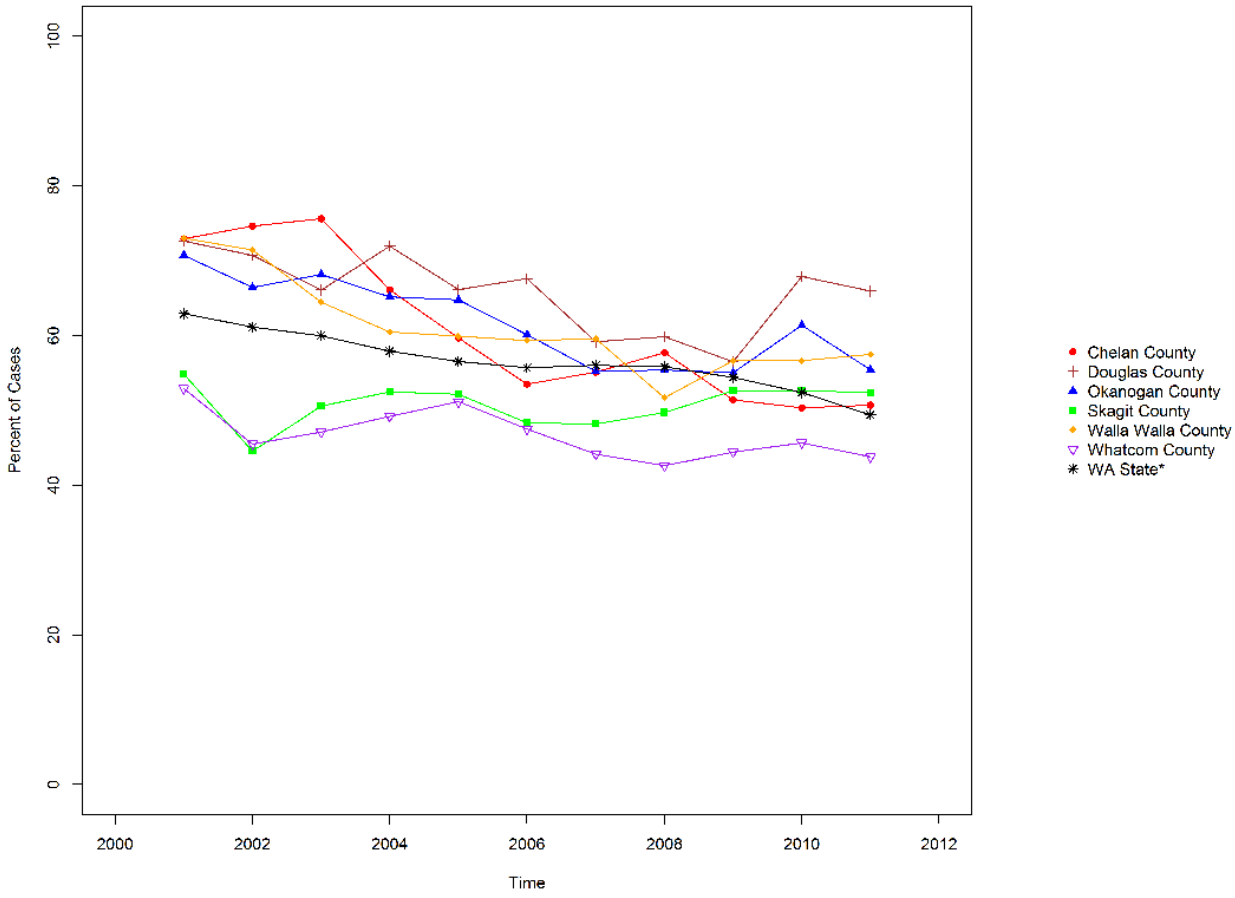
Source: Mathematica Policy Research's analyses of Community Outcome and Risk Evaluation Geographic Information System (CORE-GIS), 1998–2012.

Notes: This figure displays the rate of alleged victims of child abuse and neglect in accepted referrals which includes children (age birth–17) identified as alleged victims in reports to Child Protective Services that were accepted for further action. The rate is calculated by dividing the number of children reported as alleged victims by the population of children (age birth–17) and multiplying by 1,000. Children are counted more than once if they are reported as alleged victims more than once during the year. A "referral" is a report of suspected child abuse.

To smooth out the year-to-year variability in this indicator, this figure displays three-year moving average estimates. For example, the values for 2010 were calculated by averaging 2009, 2010, and 2011 raw values.

* Washington State comparison group excluded the five APPI sites (Chelan/Douglas, Okanogan, Skagit, Walla Walla, and Whatcom Counties) and King County, which is the most populous county in the state and contains the state's largest city, Seattle.

Figure D.3. Percentage of Out-of-Home Cases Exiting to Reunification Within 24 Months

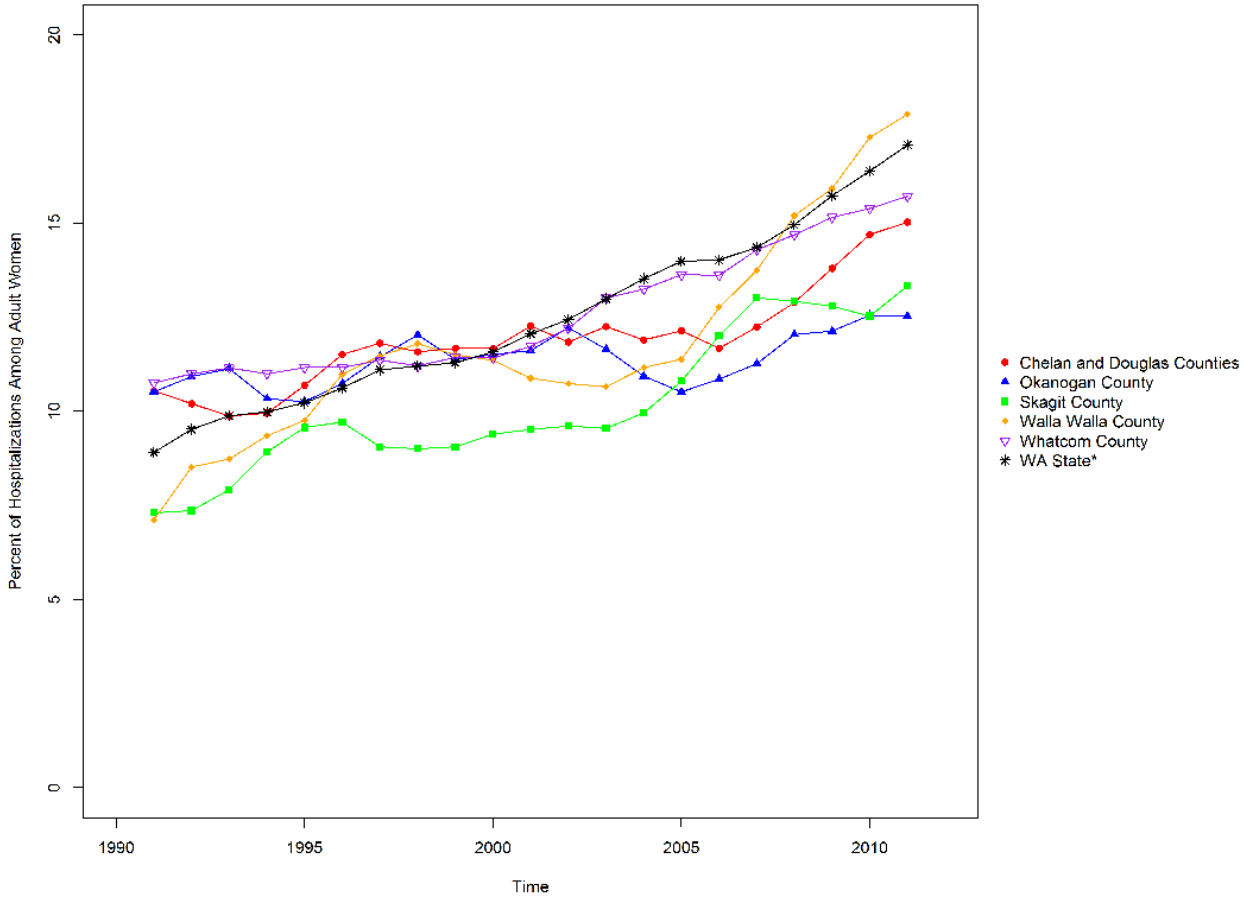


Source: Mathematica Policy Research's analyses of Washington State/Partners for Our Children Data Portal data, 2000–2012.

Notes: To smooth out the year-to-year variability in this indicator, this figure displays three-year moving average estimates. For example, the values for 2010 were calculated by averaging 2009, 2010, and 2011 raw values.

* Washington State comparison group included the entire state.

Figure D.4. Rate of Hospitalizations due to Injury and Accidents Among Adult Women (Ages 18 and Older)

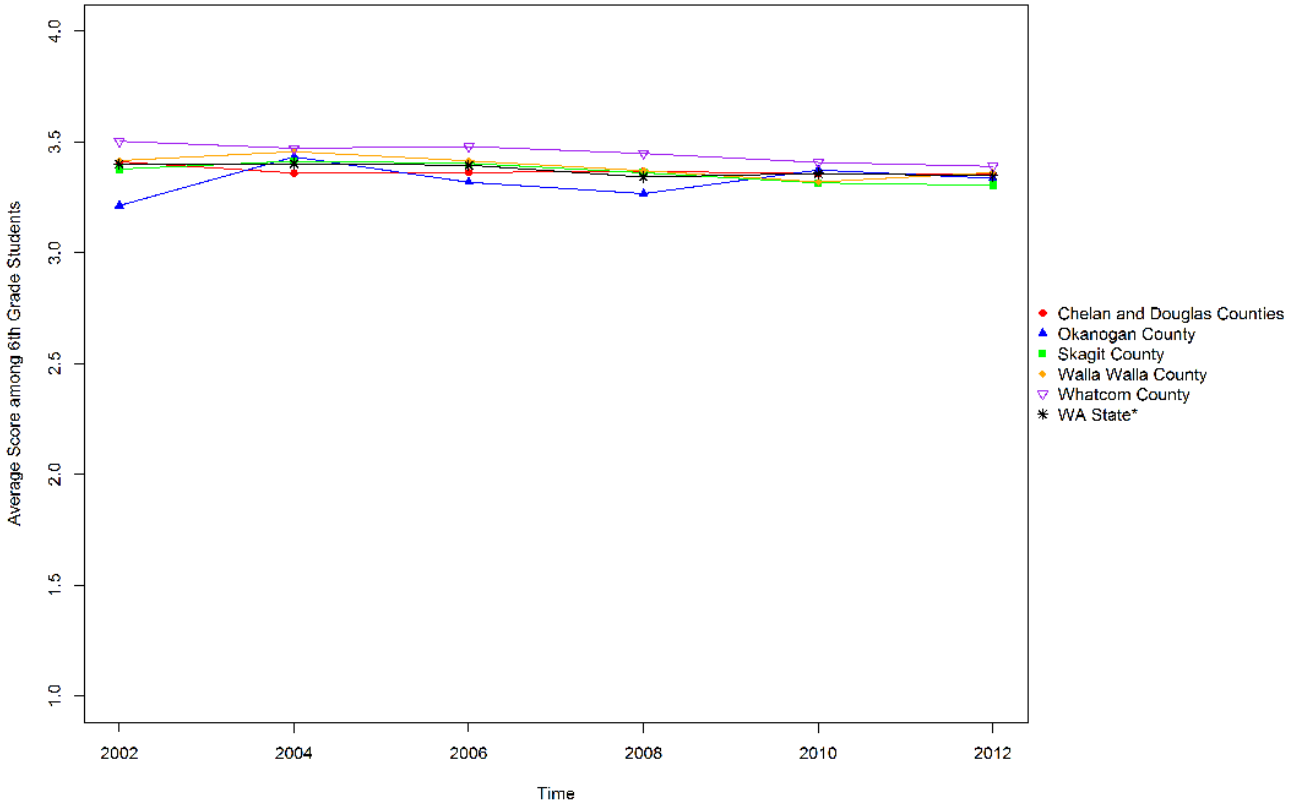


Source: Mathematica Policy Research's analyses of Community Outcome and Risk Evaluation Geographic Information System (CORE-GIS), 1990–2012.

Notes: To smooth out the year-to-year variability in this indicator, this figure displays three-year moving average estimates. For example, the values for 2010 were calculated by averaging 2009, 2010, and 2011 raw values.

* Washington State comparison group excluded the five APPI sites (Chelan/Douglas, Okanogan, Skagit, Walla Walla, and Whatcom Counties) and King County, which is the most populous county in the state and contains the state's largest city, Seattle.

Figure D.5. Family Rewards for Prosocial Involvement Reported by 6th Grade Students



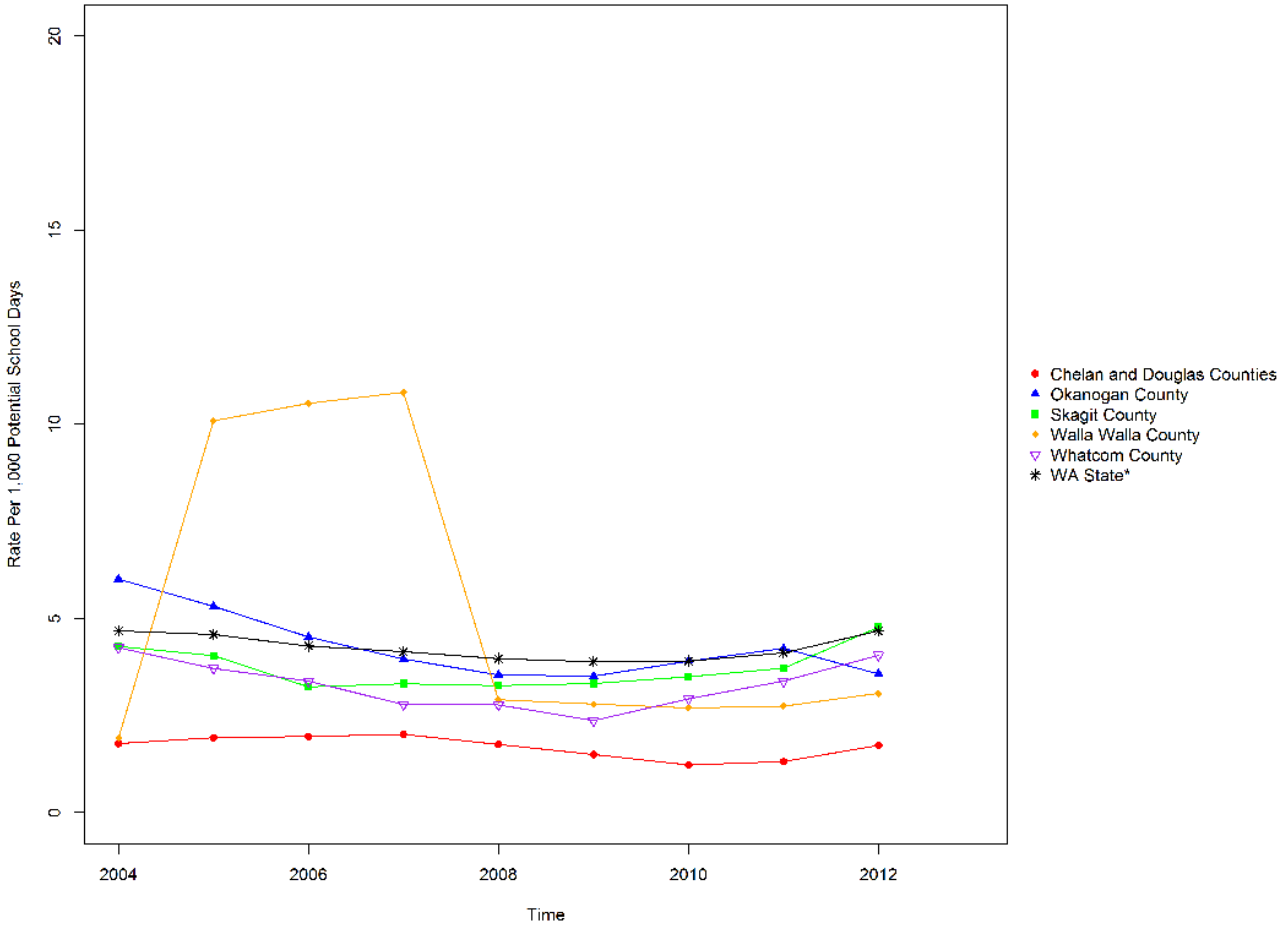
Source: Mathematica Policy Research's analysis of Washington State Department of Health's Healthy Youth Survey, 2002–2012.

Notes: This figure displays the average scores for the family rewards for prosocial involvement scale among 6th grade students. This scale consists of four items: 1. My parents notice when I am doing a good job and let me know about it. 2. How often do your parents tell you they're proud of you for something you've done? 3. Do you enjoy spending time with your dad? 4. Do you enjoy spending time with your mom? Possible scale scores range from 1 to 4, with higher values indicating more family rewards.

* Washington State comparison group excluded the five APPI sites (Chelan/Douglas, Okanogan, Skagit, Walla Walla, and Whatcom Counties) and King County, which is the most populous county in the state and contains the state's largest city, Seattle.

DOMAIN 2: SCHOOL CLIMATE AND STUDENT SUCCESS

Figure D.6. Rate of Unexcused Absences Among Elementary and Middle School Students (Grades K–8)

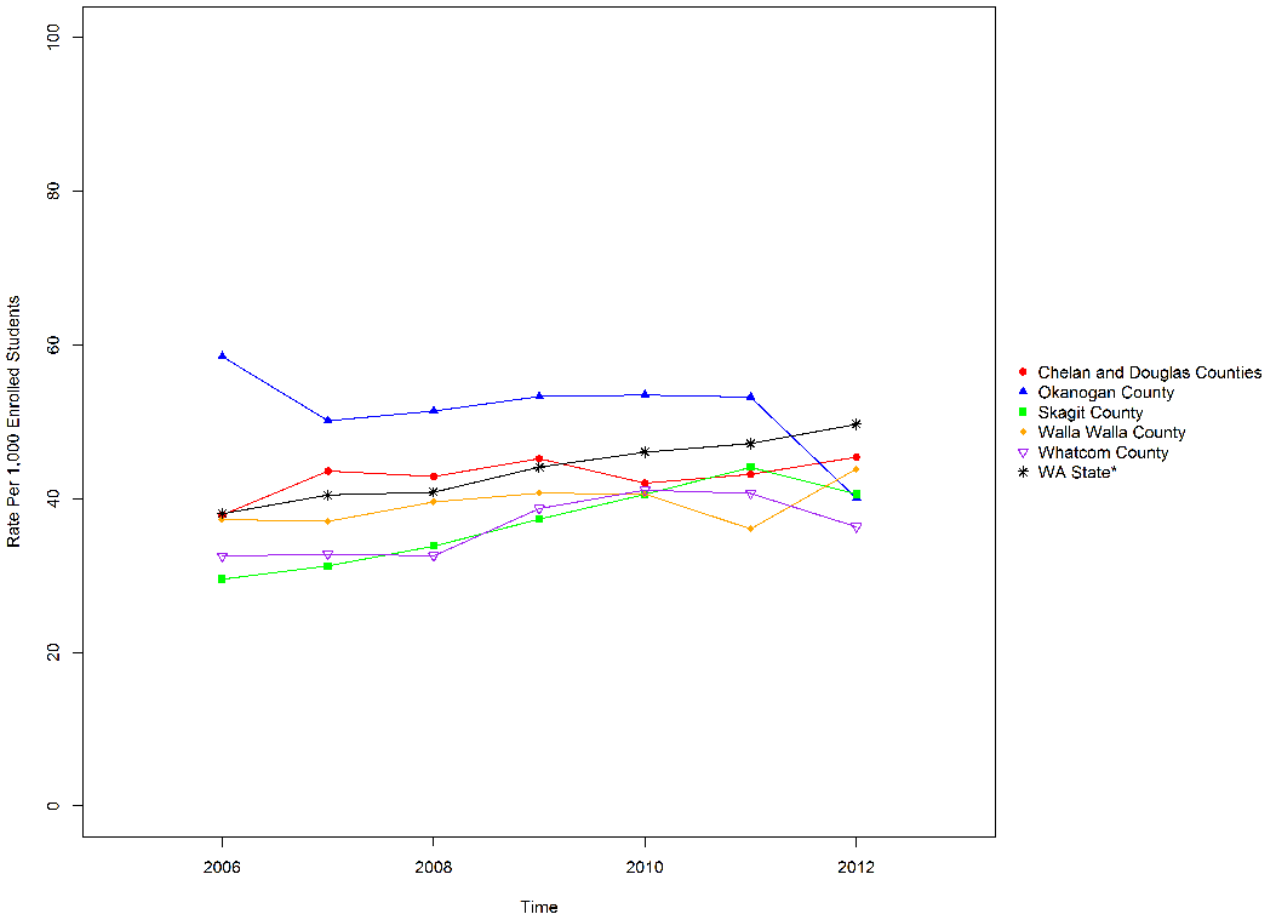


Source: Mathematica Policy Research's analyses of Community Outcome and Risk Evaluation Geographic Information System (CORE-GIS), 2004–2013.

Notes: To smooth out the year-to-year variability in this indicator, this figure displays three-year moving average estimates. For example, the values for 2010 were calculated by averaging 2009, 2010, and 2011 raw values.

* Washington State comparison group excluded the five APPI sites (Chelan/Douglas, Okanogan, Skagit, Walla Walla, and Whatcom Counties) and King County, which is the most populous county in the state and contains the state's largest city, Seattle.

Figure D.7. Rate of Suspension and Expulsions for Any Cause Among Students

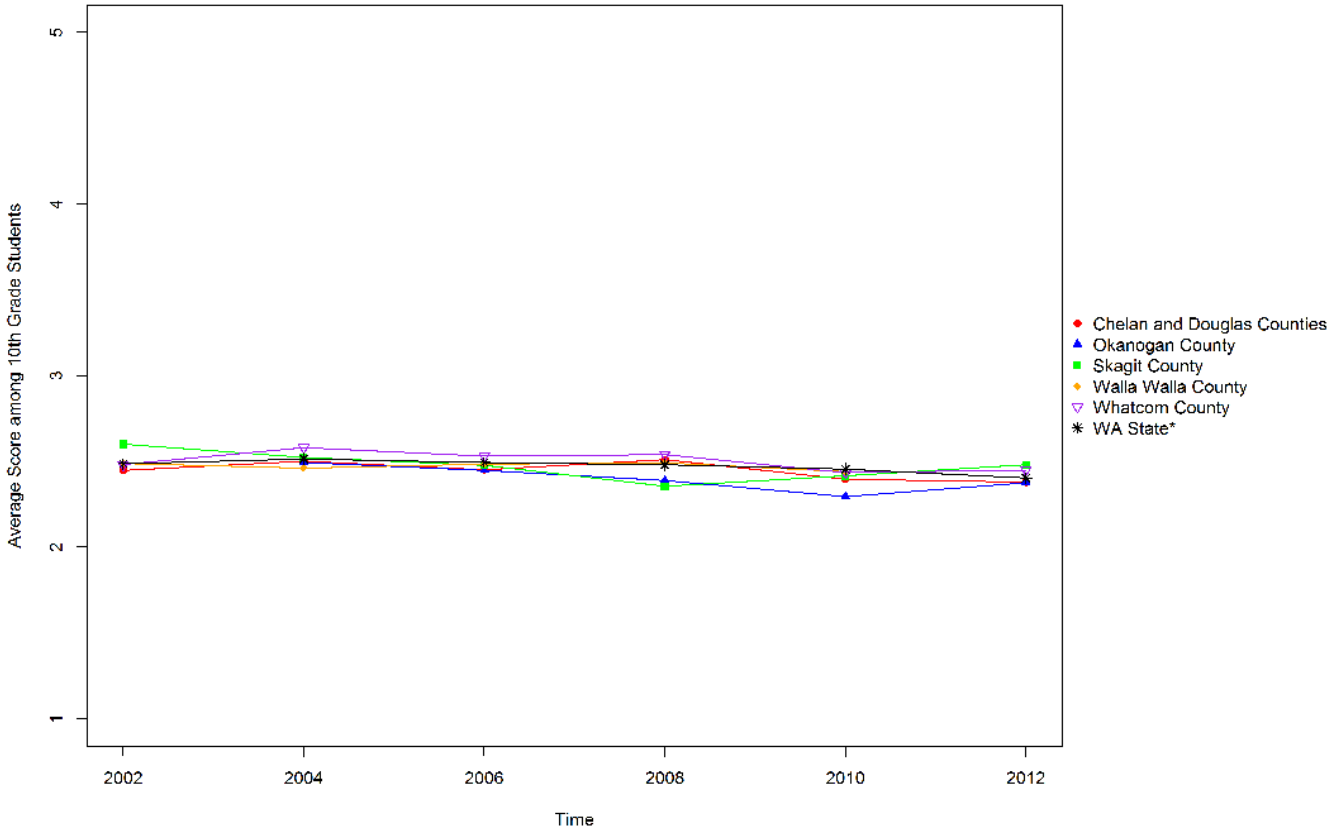


Source: Mathematica Policy Research's analyses of Washington State Office of Superintendent of Public Instruction's Student Behavior Reports, 2005–2013.

Notes: To smooth out the year-to-year variability in this indicator, this figure displays three-year moving average estimates. For example, the values for 2010 were calculated by averaging 2009, 2010, and 2011 raw values.

* Washington State comparison group excluded the five APPI sites (Chelan/Douglas, Okanogan, Skagit, Walla Walla, and Whatcom Counties) and King County, which is the most populous county in the state and contains the state's largest city, Seattle.

Figure D.8. School Commitment Reported by 10th Grade Students



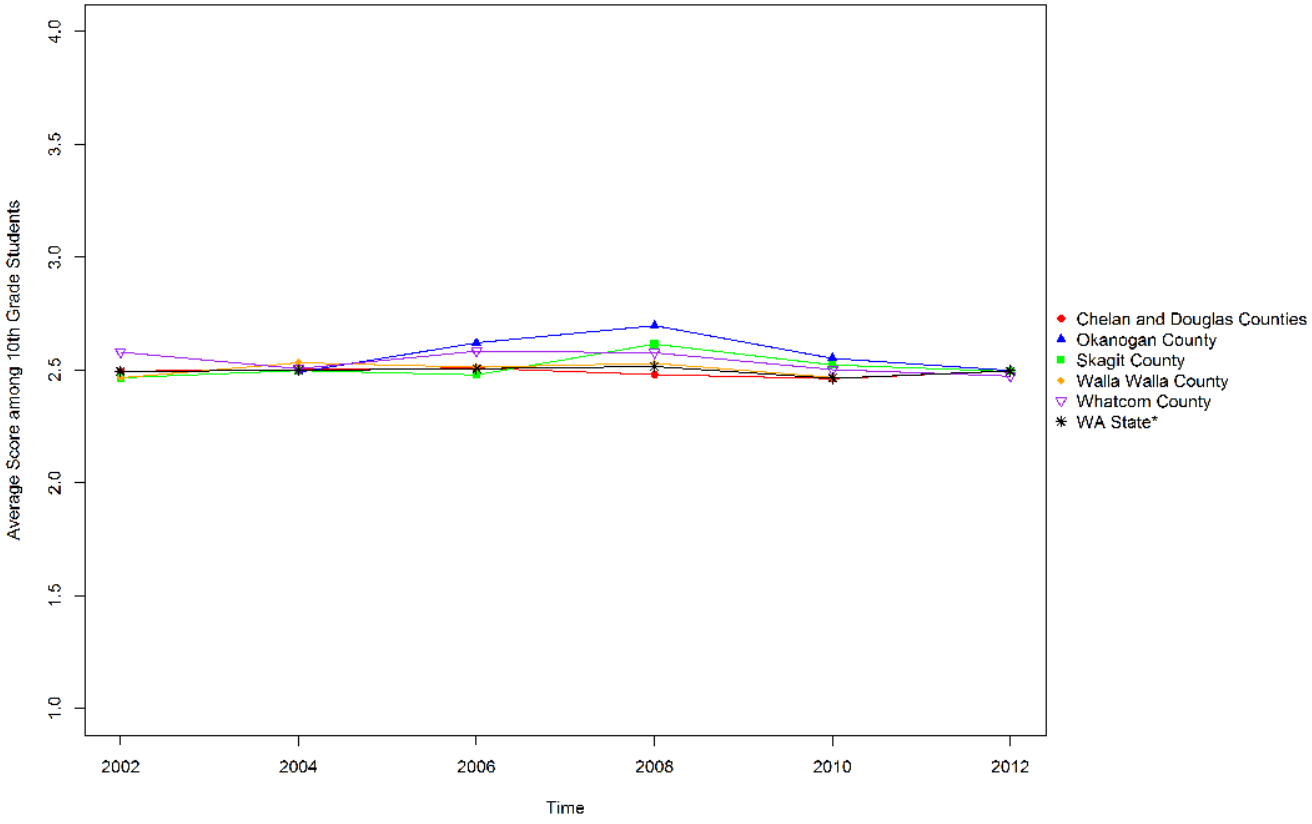
Source: Mathematica Policy Research's analysis of Washington State Department of Health's Healthy Youth Survey, 2002–2012.

Notes: This figure displays the average scores for the school commitment scale among 10th grade students. This scale consists of five items: 1. How often do you feel the schoolwork you are assigned is meaningful and important? 2. How interesting are most of your courses to you? 3. How important do you think the things you are learning in school are going to be for you later in life? 4. Think back over the past year in school. How often did you: a. Enjoy being in school? b. Hate being in school? c. Try to do your best work in school? 5. During the LAST 4 WEEKS, how many whole days of school have you missed because you skipped or "cut"? Possible scale scores range from 1 to 5, with higher values indicating lower level of commitment to school.

Due to low (less than 40 percent) response rates among 10th grade students, we do not report the statistics for Okanogan County in 2002 and Walla Walla County in 2012 as these results may not be representative of these counties.

* Washington State comparison group excluded the five APPI sites (Chelan/Douglas, Okanogan, Skagit, Walla Walla, and Whatcom Counties) and King County, which is the most populous county in the state and contains the state's largest city, Seattle.

Figure D.9. School Rewards for Prosocial Involvement Reported by 10th Grade Students



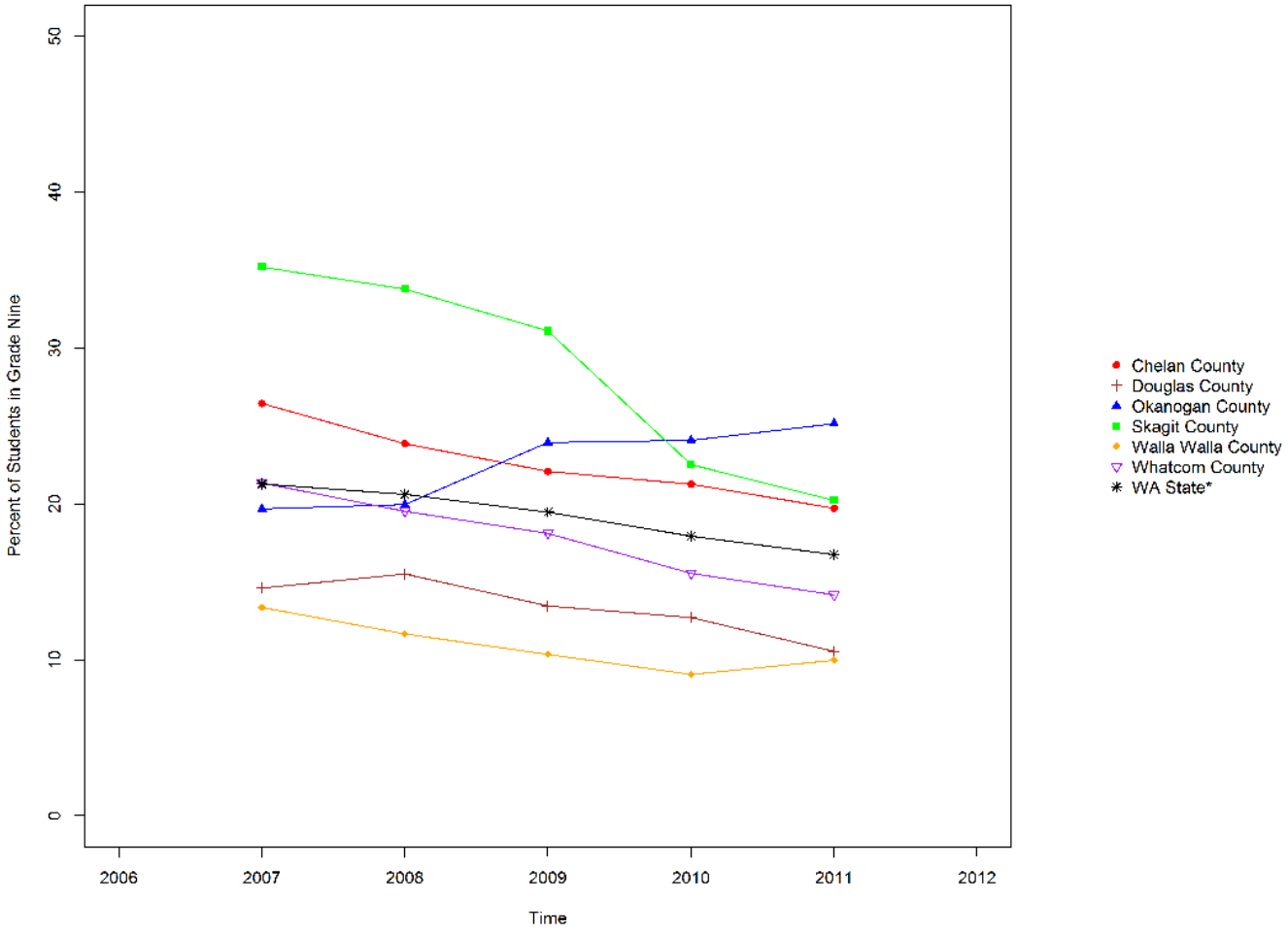
Source: Mathematica Policy Research's analysis of Washington State Department of Health's Healthy Youth Survey, 2002–2012.

Notes: This figure displays the average scores for the school rewards for prosocial involvement scale among 10th grade students. This scale consists of four items: 1. My teacher(s) notices when I am doing a good job and lets me know about it. 2. The school lets my parents know when I have done something well. 3. I feel safe at my school. 4. My teachers praise me when I work hard in school. Possible scale scores range from 1 to 4, with higher values indicating more rewards.

Due to low (less than 40 percent) response rates among 10th grade students, we do not report the statistics for Okanogan County in 2002 and Walla Walla County in 2012 as these results may not be representative of these counties.

* Washington State comparison group excluded the five APPI sites (Chelan/Douglas, Okanogan, Skagit, Walla Walla, and Whatcom Counties) and King County, which is the most populous county in the state and contains the state's largest city, Seattle.

Figure D.10. High School Cohort (Cumulative) Dropout Rate

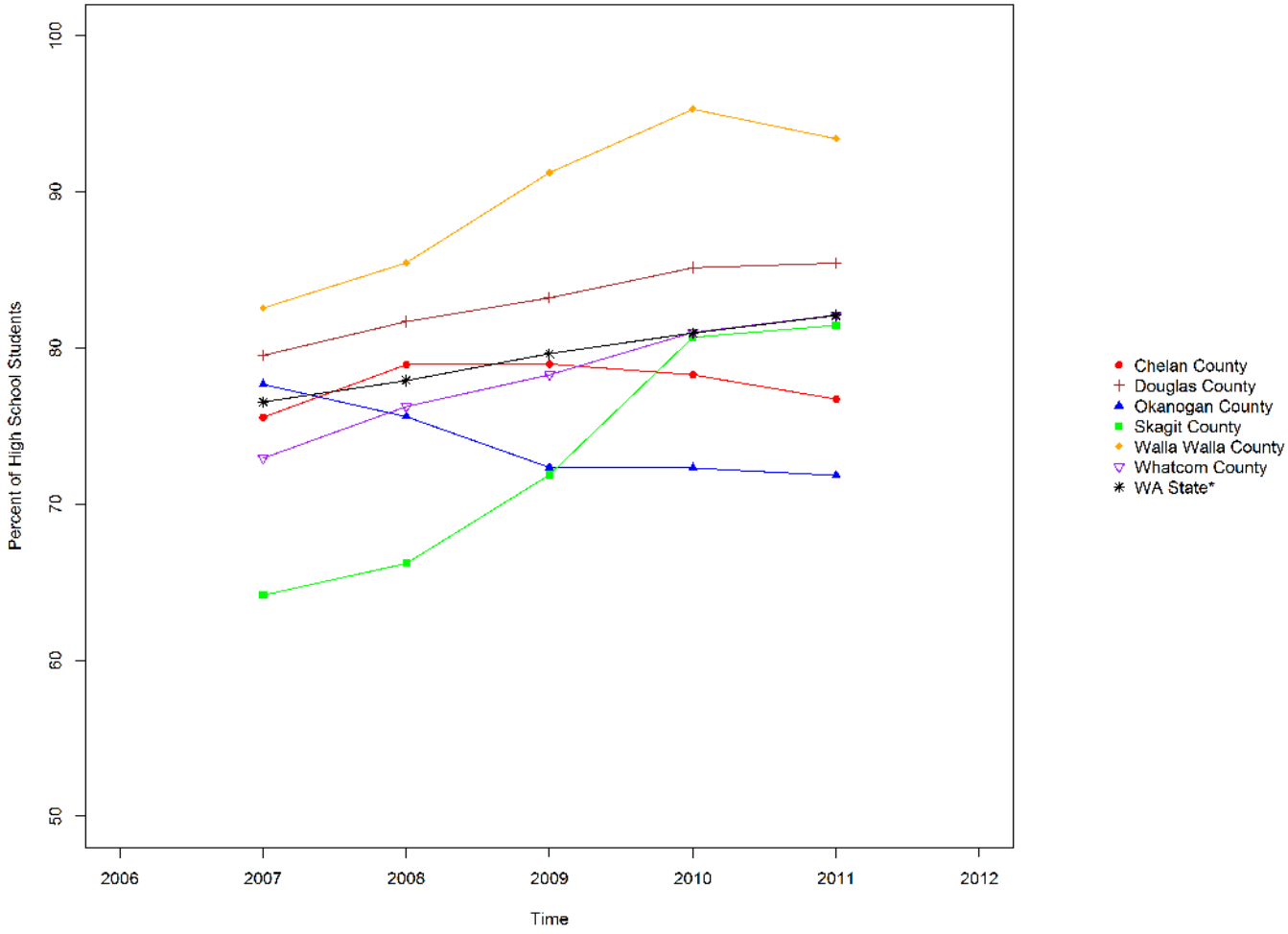


Source: Mathematica Policy Research's analyses of Community Outcome and Risk Evaluation Geographic Information System (CORE-GIS), 2006–2012.

Notes: To smooth out the year-to-year variability in this indicator, this figure displays three-year moving average estimates. For example, the values for 2010 were calculated by averaging 2009, 2010, and 2011 raw values.

* Washington State comparison group included the entire state.

Figure D.11. High School Extended Graduation Rate



Source: Mathematica Policy Research's analyses of Community Outcome and Risk Evaluation Geographic Information System (CORE-GIS), 2006–2012.

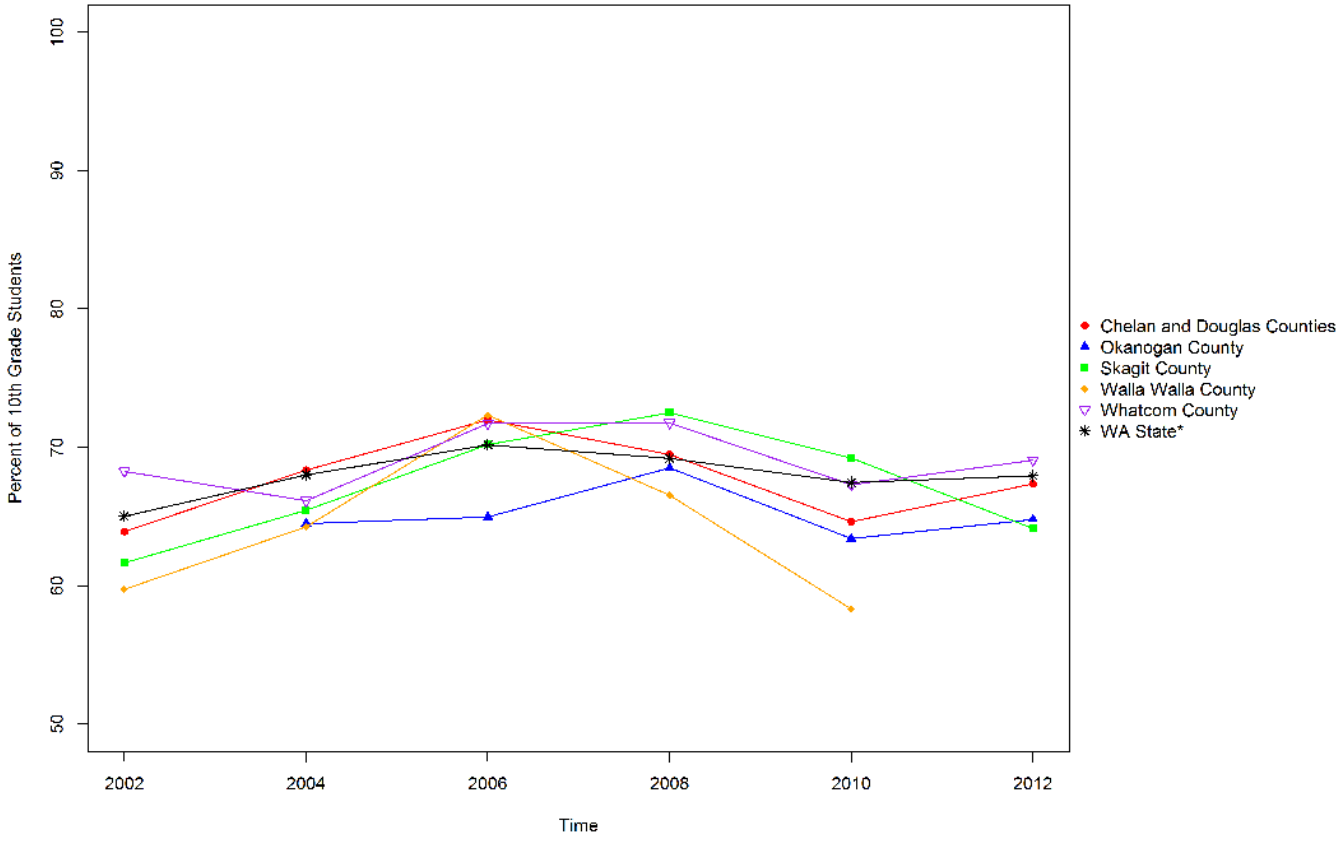
Notes: This figure displays the percentage of students who graduate from high school; it includes on-time graduates as well as students who stay in school and take more than four years to complete their high school degree.

To smooth out the year-to-year variability in this indicator, this figure displays three-year moving average estimates. For example, the values for 2010 were calculated by averaging 2009, 2010, and 2011 raw values.

* Washington State comparison group included the entire state.

DOMAIN 3: RISK BEHAVIOR REDUCTION AND HEALTHY YOUTH DEVELOPMENT

Figure D.12. Percentage of 10th Grade Students Who Reported Never Drinking More Than a Sip or Two of Alcohol



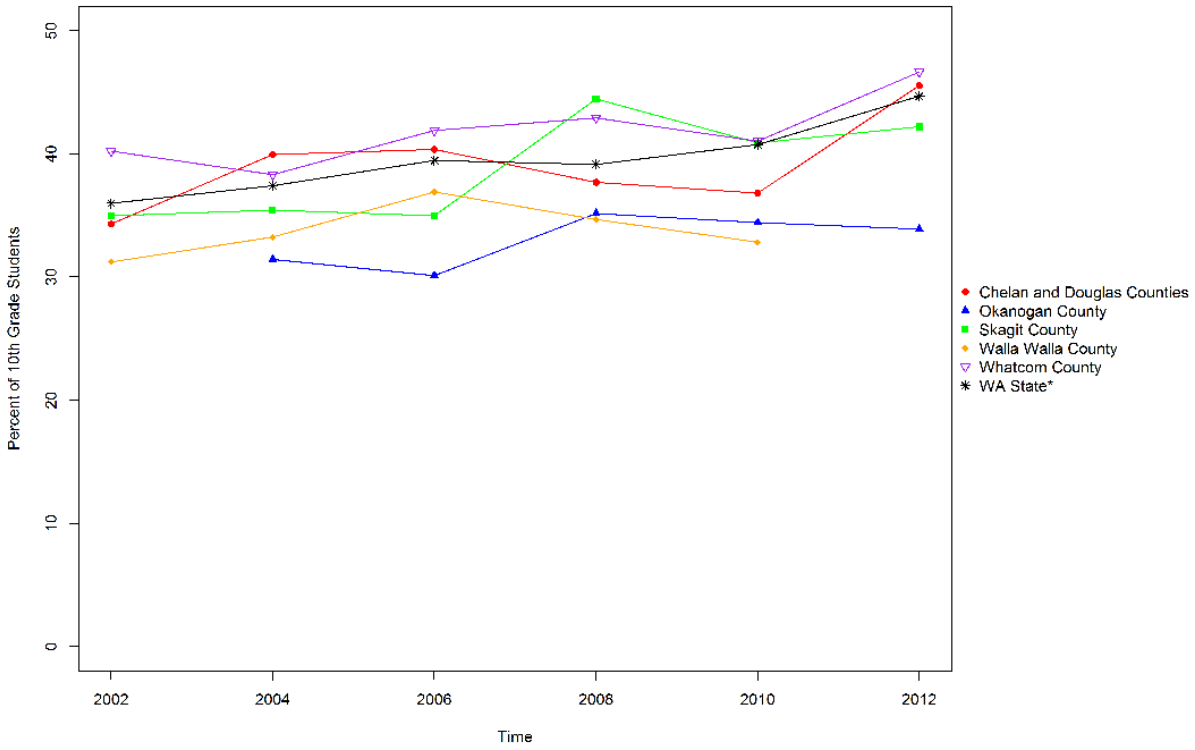
Source: Mathematica Policy Research's analysis of Washington State Department of Health's Healthy Youth Survey, 2002–2012.

Notes: This figure displays percentages based on the number of 10th grade students who answered "never have" to the survey question "How old were you the first time you had more than a sip or two of beer, wine, or hard liquor (for example vodka, whiskey, or gin)?"

Due to low (less than 40 percent) response rates among 10th grade students, we do not report the statistics for Okanogan County in 2002 and Walla Walla County in 2012 as these results may not be representative of these counties.

* Washington State comparison group excluded the five APPI sites (Chelan/Douglas, Okanogan, Skagit, Walla Walla, and Whatcom Counties) and King County, which is the most populous county in the state and contains the state's largest city, Seattle.

Figure D.13. Percentage of 10th Grade Students Who Reported Not Drinking Alcohol Regularly



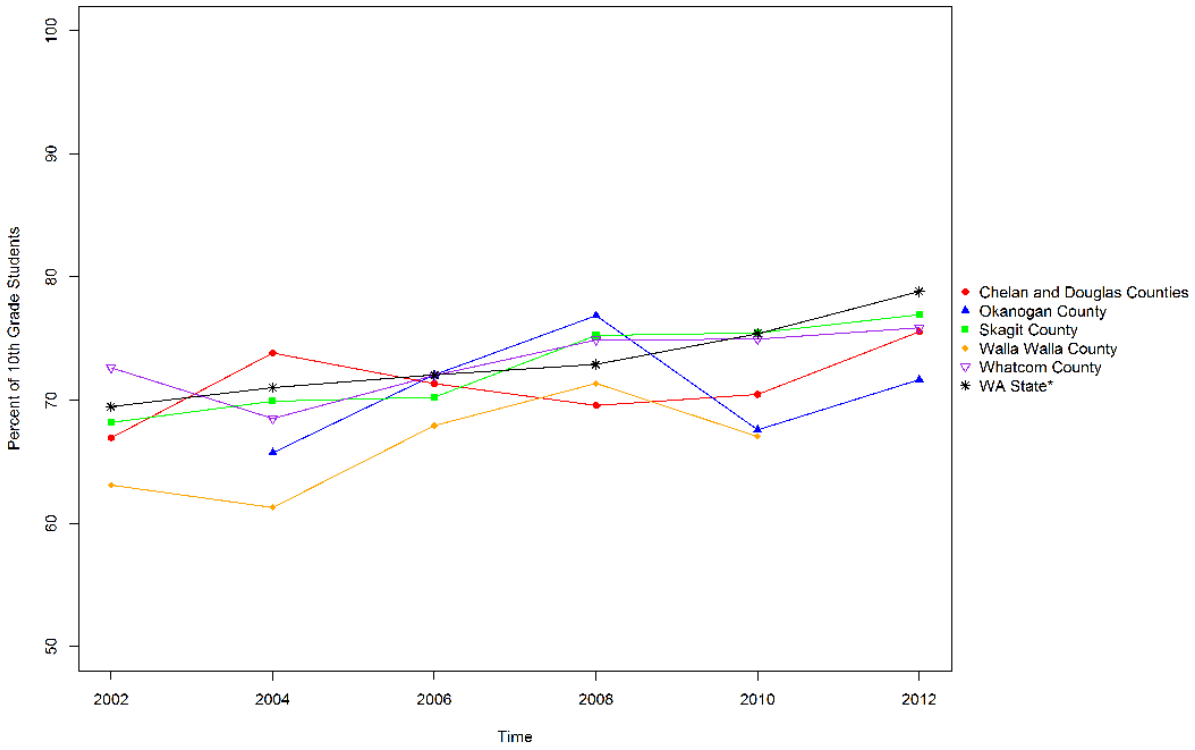
Source: Mathematica Policy Research's analysis of Washington State Department of Health's Healthy Youth Survey, 2002–2012.

Notes: This figure displays percentages based on the number of 10th grade students who answered "never have" to the survey question "How old were you the first time you began drinking alcoholic beverages regularly, that is, at least once or twice a month?"

Due to low (less than 40 percent) response rates among 10th grade students, we do not report the statistics for Okanogan County in 2002 and Walla Walla County in 2012 as these results may not be representative of these counties.

* Washington State comparison group excluded the five APPI sites (Chelan/Douglas, Okanogan, Skagit, Walla Walla, and Whatcom Counties) and King County, which is the most populous county in the state and contains the state's largest city, Seattle.

Figure D.14. Percentage of 10th Grade Students Who Reported Never Using Marijuana



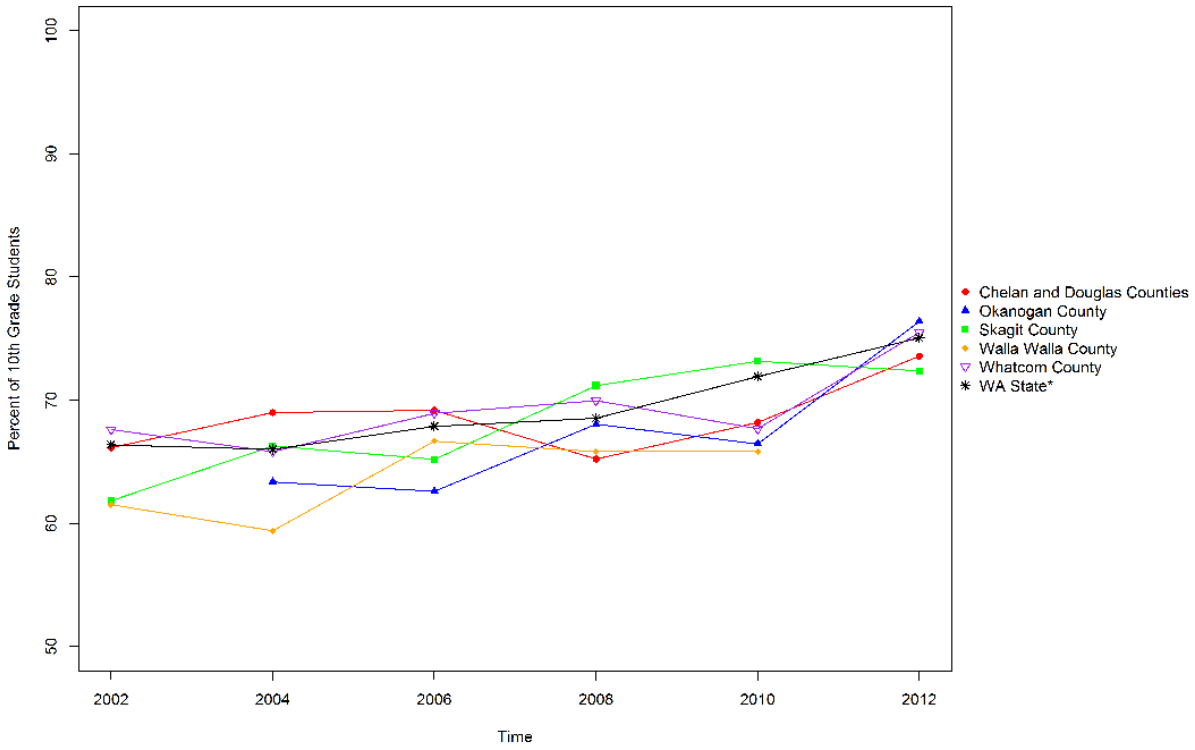
Source: Mathematica Policy Research's analysis of Washington State Department of Health's Healthy Youth Survey, 2002–2012.

Notes: This figure displays percentages based on the number of 10th grade students who answered "never have" to the survey question "How old were you the first time you smoked marijuana?"

Due to low (less than 40 percent) response rates among 10th grade students, we do not report the statistics for Okanogan County in 2002 and Walla Walla County in 2012 as these results may not be representative of these counties.

* Washington State comparison group excluded the five APPI sites (Chelan/Douglas, Okanogan, Skagit, Walla Walla, and Whatcom Counties) and King County, which is the most populous county in the state and contains the state's largest city, Seattle.

Figure D.15. Percentage of 10th Grade Students Who Reported Not Drinking Alcohol in the Past 30 Days



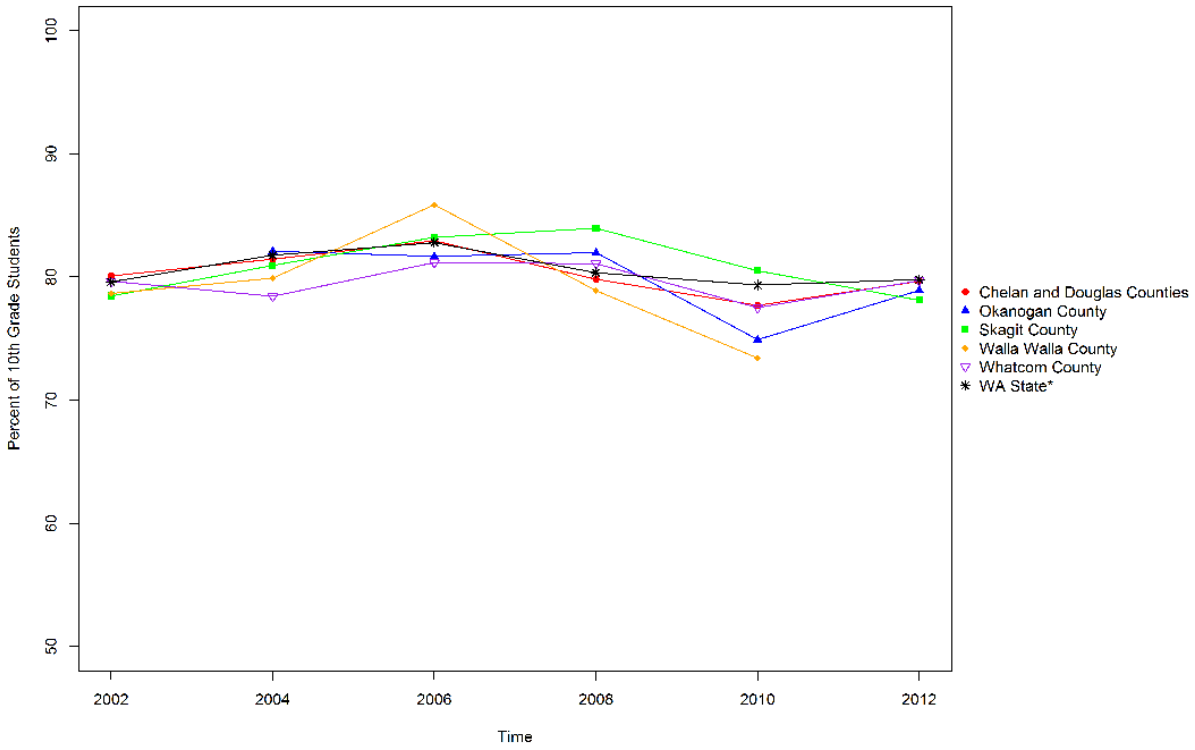
Source: Mathematica Policy Research's analysis of Washington State Department of Health's Healthy Youth Survey, 2002–2012.

Notes: This figure displays percentages based on the number of 10th grade students who answered "none" to the survey question "During the past 30 days, on how many days did you drink a glass, can, or bottle of alcohol (beer, wine, wine coolers, hard liquor)?"

Due to low (less than 40 percent) response rates among 10th grade students, we do not report the statistics for Okanogan County in 2002 and Walla Walla County in 2012 as these results may not be representative of these counties.

* Washington State comparison group excluded the five APPI sites (Chelan/Douglas, Okanogan, Skagit, Walla Walla, and Whatcom Counties) and King County, which is the most populous county in the state and contains the state's largest city, Seattle.

Figure D.16. Percentage of 10th Grade Students Who Reported Not Using Marijuana or Hashish in the Past 30 Days



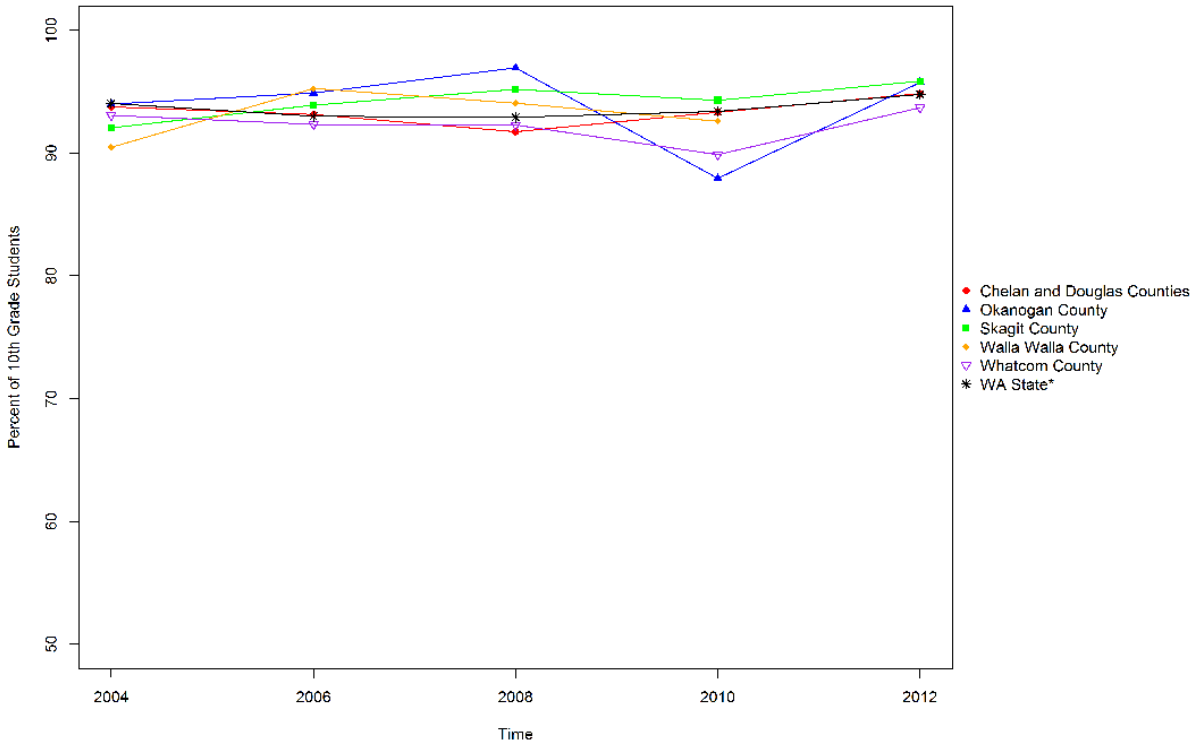
Source: Mathematica Policy Research's analysis of Washington State Department of Health's Healthy Youth Survey, 2002–2012.

Notes: This figure displays percentages based on the number of 10th grade students who answered "none" to the survey question "During the past 30 days, on how many days did you use marijuana or hashish (grass, hash, pot)?"

Due to low (less than 40 percent) response rates among 10th grade students, we do not report the statistics for Okanogan County in 2002 and Walla Walla County in 2012 as these results may not be representative of these counties.

* Washington State comparison group excluded the five APPI sites (Chelan/Douglas, Okanogan, Skagit, Walla Walla, and Whatcom Counties) and King County, which is the most populous county in the state and contains the state's largest city, Seattle.

Figure D.17. Percentage of 10th Grade Students Who Reported Not Using Illegal Drugs (Other Than Alcohol, Tobacco, or Marijuana) in the Past 30 Days



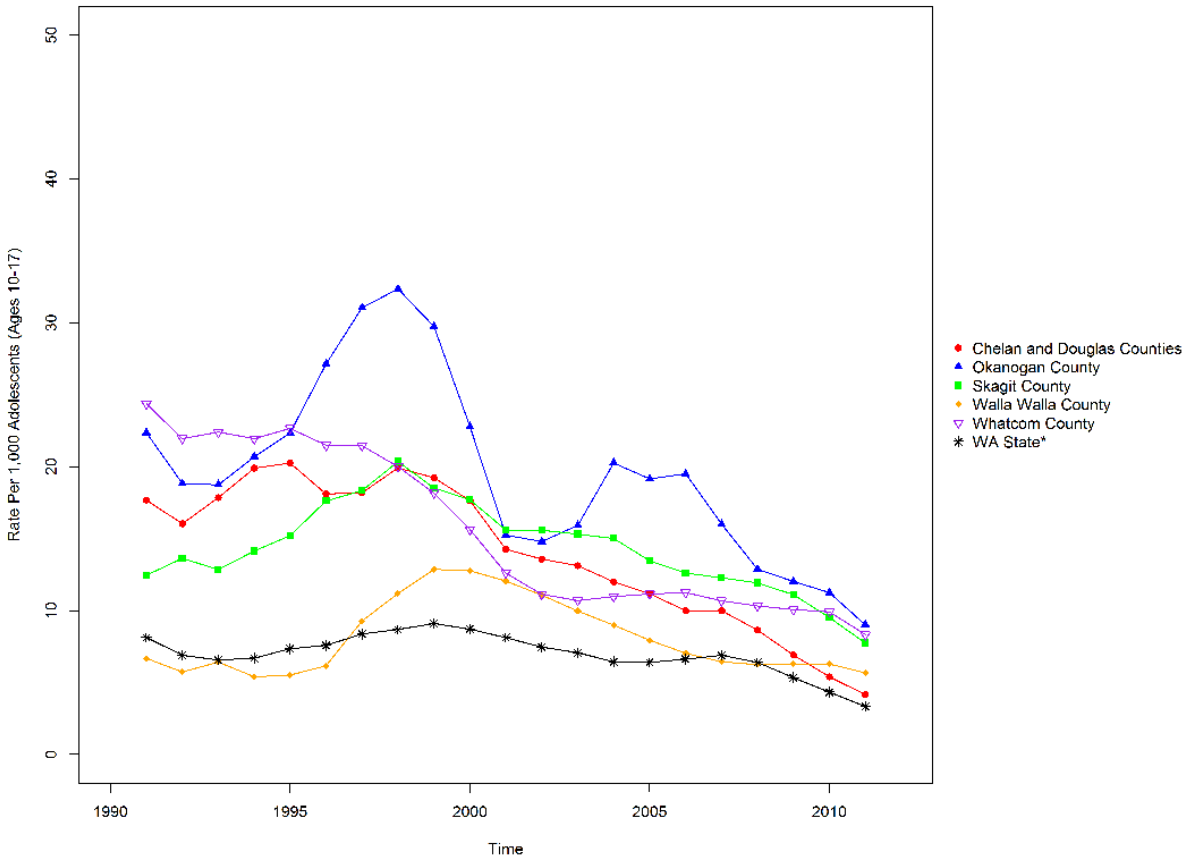
Source: Mathematica Policy Research's analysis of Washington State Department of Health's Healthy Youth Survey, 2002–2012.

Notes: This figure displays percentages based on the number of 10th grade students who answered "none" to the survey question "During the past 30 days, on how many days did you, not counting alcohol, tobacco, or marijuana, use another illegal drug?"

Due to low (less than 40 percent) response rates among 10th grade students, we do not report the statistics for Walla Walla County in 2012 as these results may not be representative of this county.

* Washington State comparison group excluded the five APPI sites (Chelan/Douglas, Okanogan, Skagit, Walla Walla, and Whatcom Counties) and King County, which is the most populous county in the state and contains the state's largest city, Seattle.

Figure D.18. Arrests for Alcohol-Related Violations Among Adolescents (Ages 10–17)

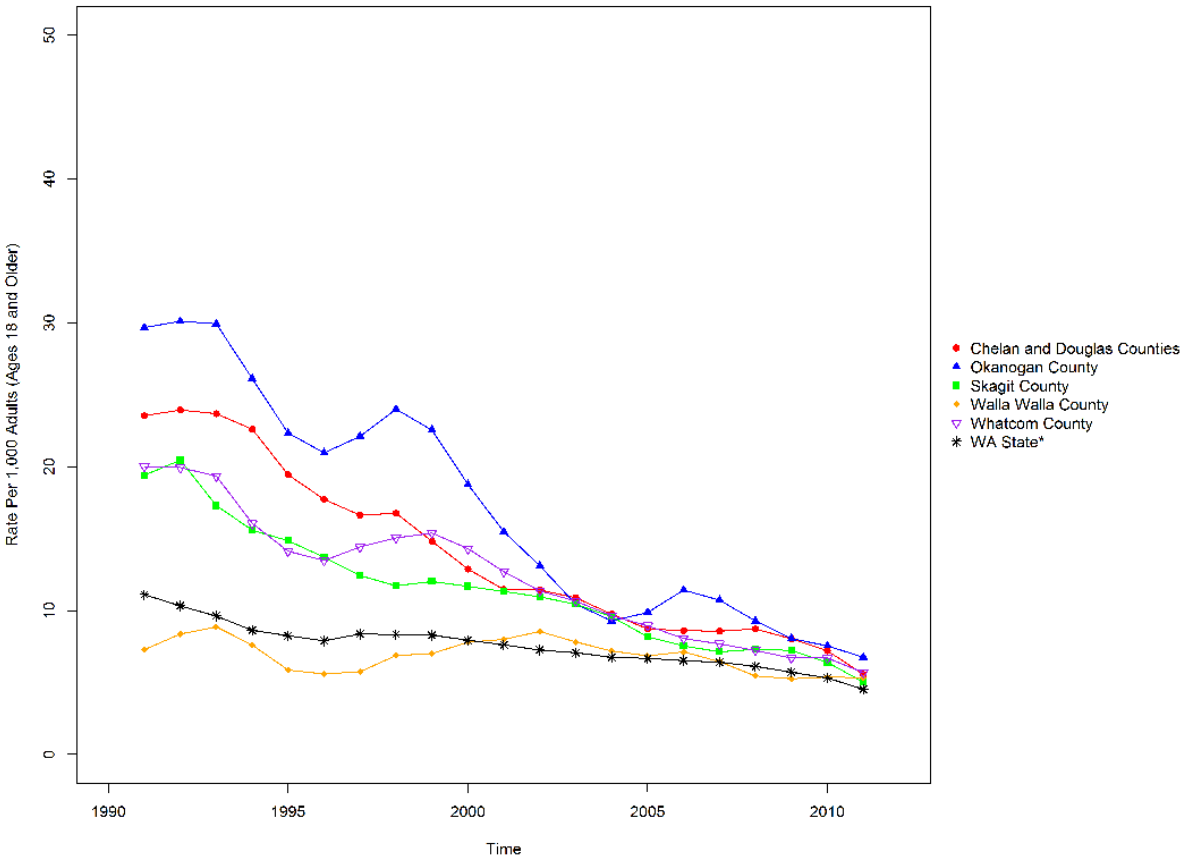


Source: Mathematica Policy Research's analyses of Community Outcome and Risk Evaluation Geographic Information System (CORE-GIS), 1990–2012.

Notes: To smooth out the year-to-year variability in this indicator, this figure displays three-year moving average estimates. For example, the values for 2010 were calculated by averaging 2009, 2010, and 2011 raw values.

* Washington State comparison group excluded the five APPI sites (Chelan/Douglas, Okanogan, Skagit, Walla Walla, and Whatcom Counties) and King County, which is the most populous county in the state and contains the state's largest city, Seattle.

Figure D.19. Arrests for Alcohol-Related Violations Among Adults (Ages 18 and Older)

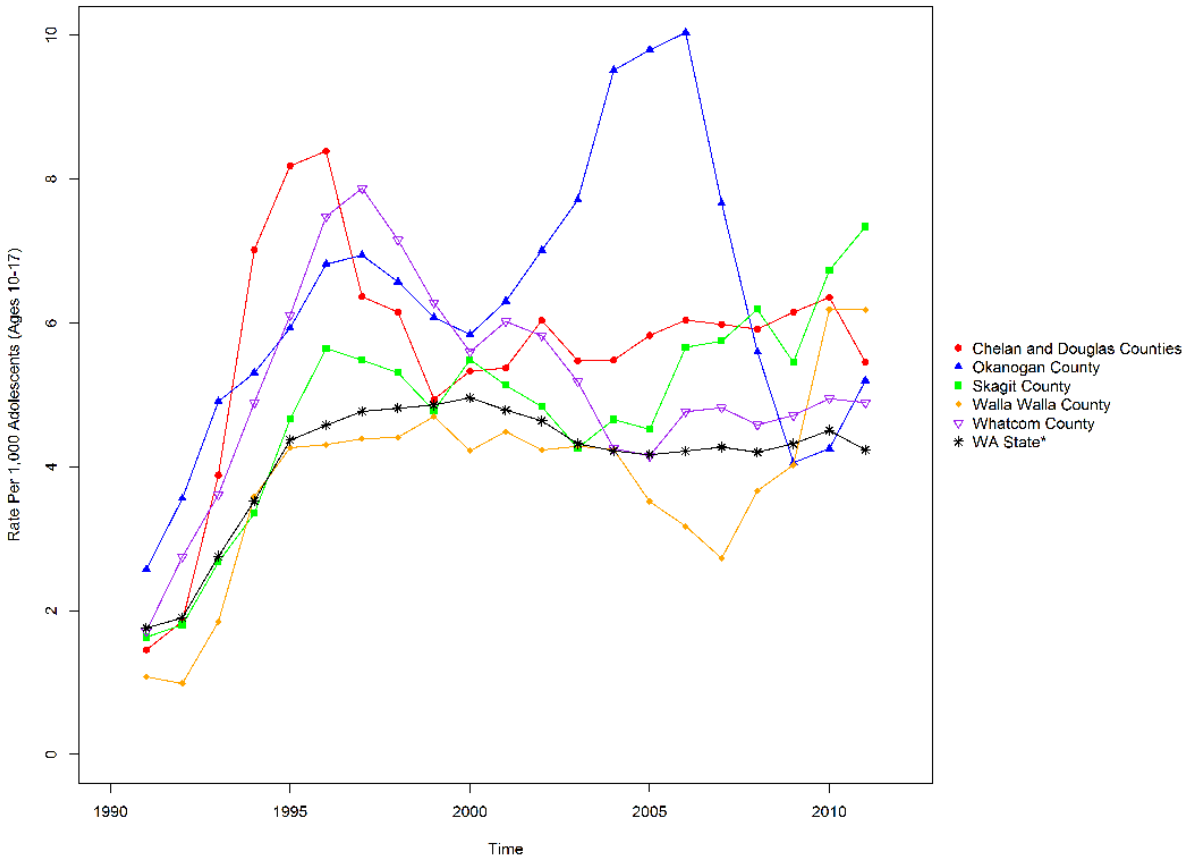


Source: Mathematica Policy Research's analyses of Community Outcome and Risk Evaluation Geographic Information System (CORE-GIS), 1990–2012.

Notes: To smooth out the year-to-year variability in this indicator, this figure displays three-year moving average estimates. For example, the values for 2010 were calculated by averaging 2009, 2010, and 2011 raw values.

* Washington State comparison group excluded the five APPI sites (Chelan/Douglas, Okanogan, Skagit, Walla Walla, and Whatcom Counties) and King County, which is the most populous county in the state and contains the state's largest city, Seattle.

Figure D.20. Arrests for Drug Law Violations Among Adolescents (Ages 10–17)

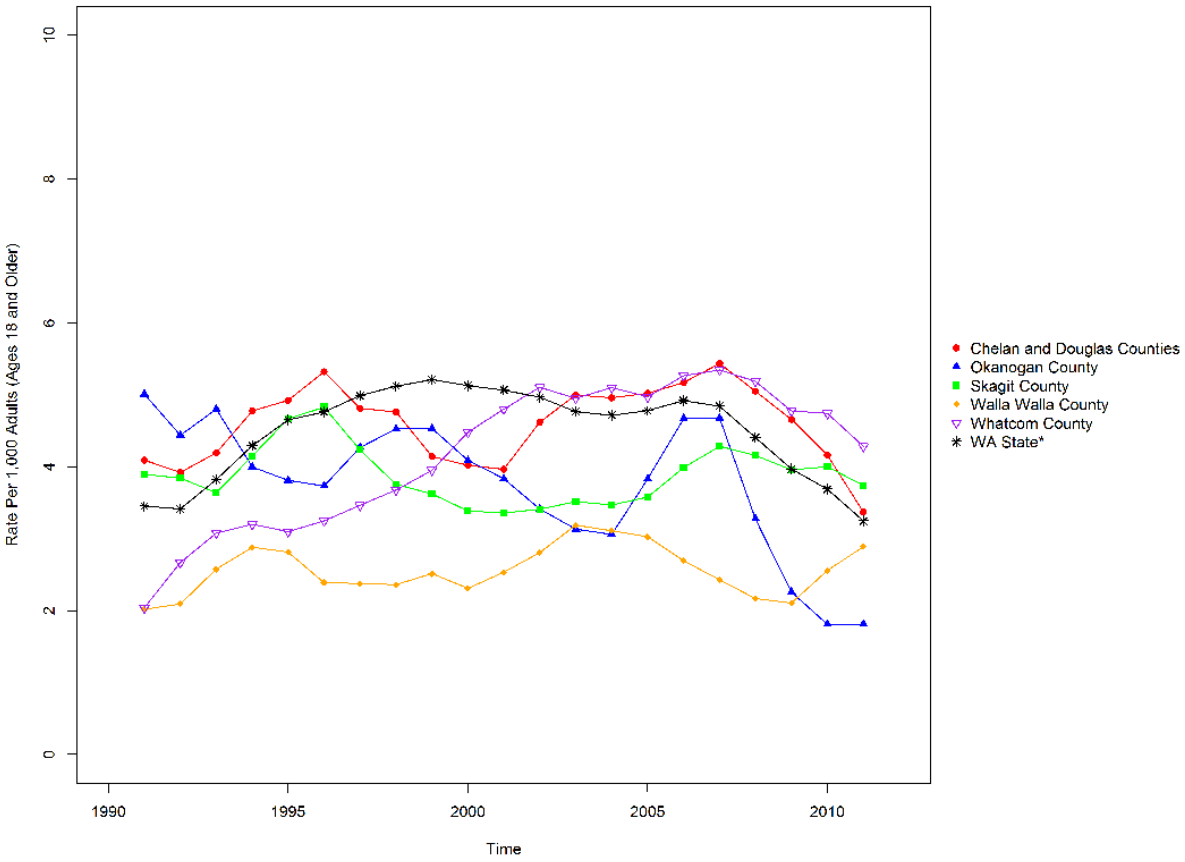


Source: Mathematica Policy Research's analyses of Community Outcome and Risk Evaluation Geographic Information System (CORE-GIS), 1990–2012.

Notes: To smooth out the year-to-year variability in this indicator, this figure displays three-year moving average estimates. For example, the values for 2010 were calculated by averaging 2009, 2010, and 2011 raw values.

* Washington State comparison group excluded the five APPI sites (Chelan/Douglas, Okanogan, Skagit, Walla Walla, and Whatcom Counties) and King County, which is the most populous county in the state and contains the state's largest city, Seattle.

Figure D.21. Arrests for Drug Law Violations Among Adults (Ages 18 and Older)

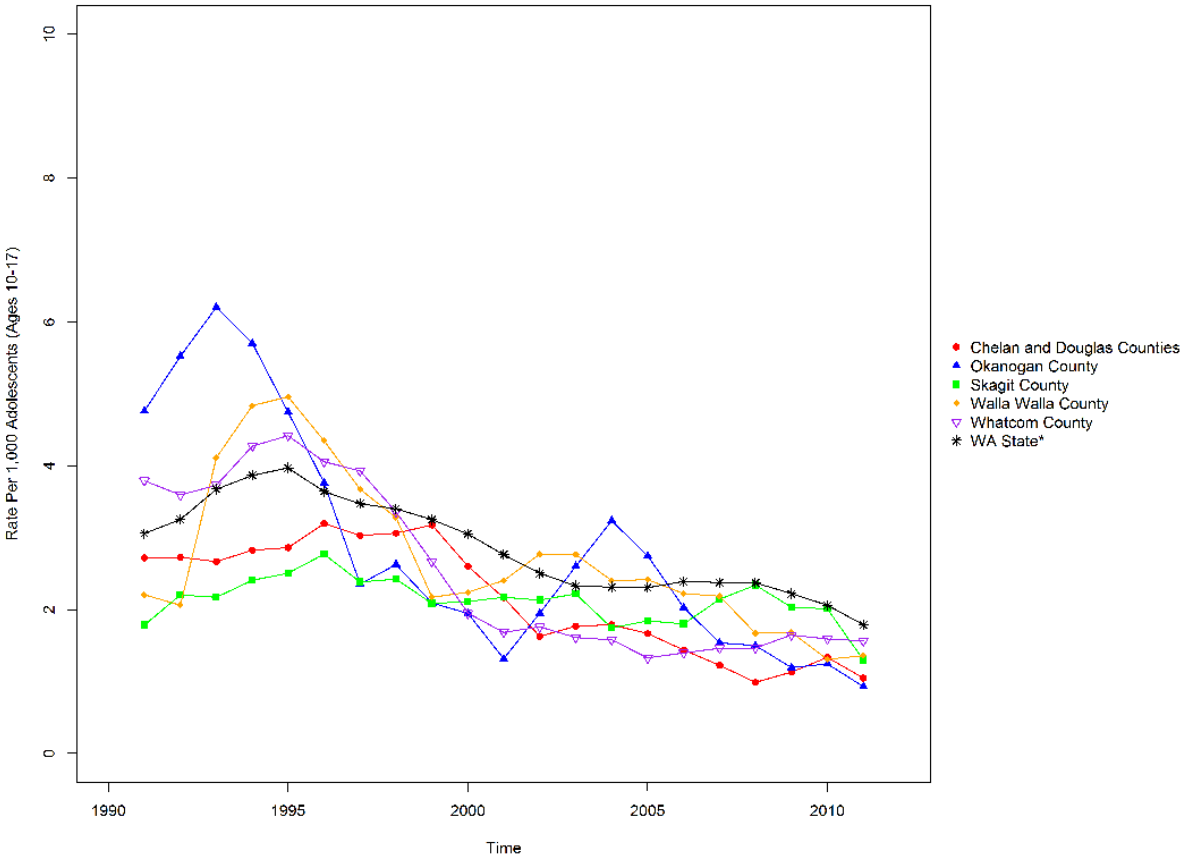


Source: Mathematica Policy Research's analyses of Community Outcome and Risk Evaluation Geographic Information System (CORE-GIS), 1990–2012.

Notes: To smooth out the year-to-year variability in this indicator, this figure displays three-year moving average estimates. For example, the values for 2010 were calculated by averaging 2009, 2010, and 2011 raw values.

* Washington State comparison group excluded the five APPI sites (Chelan/Douglas, Okanogan, Skagit, Walla Walla, and Whatcom Counties) and King County, which is the most populous county in the state and contains the state's largest city, Seattle.

Figure D.22. Arrests for Violent Crimes Among Adolescents (Ages 10–17)

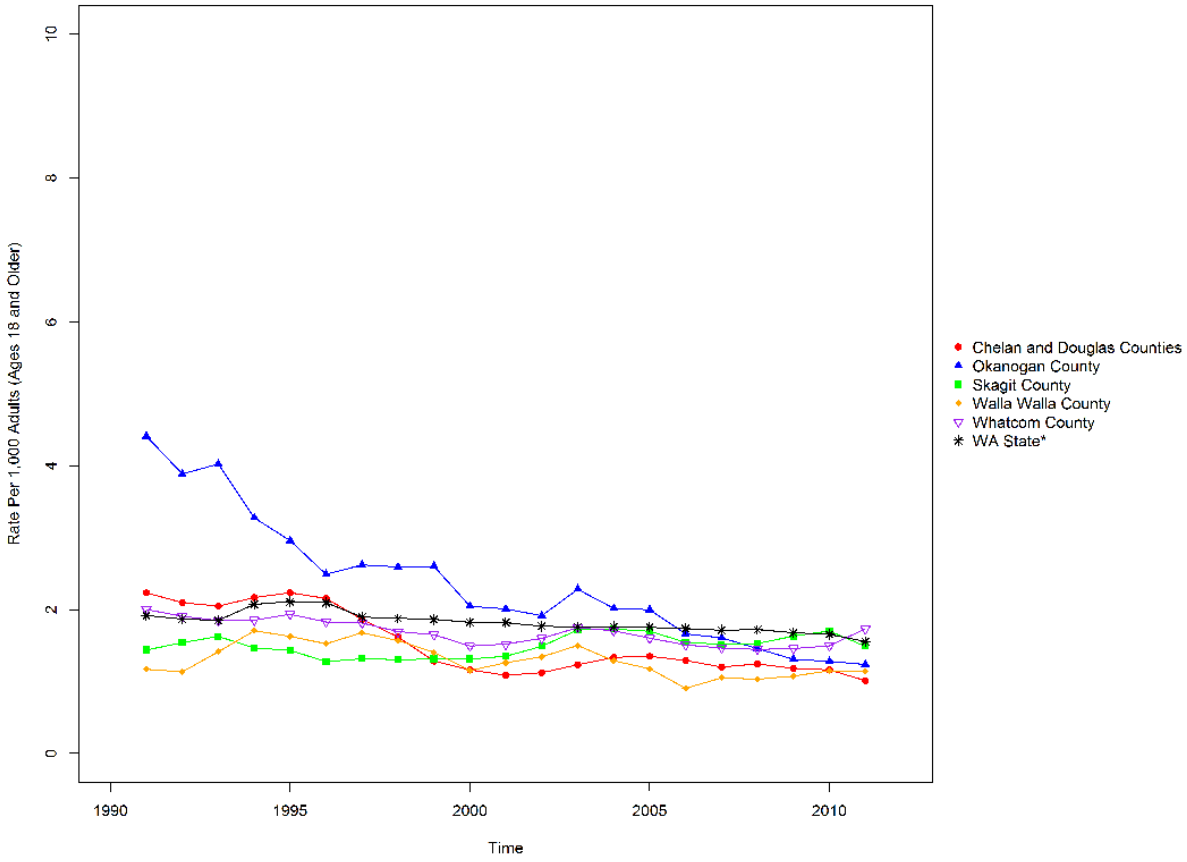


Source: Mathematica Policy Research's analyses of Community Outcome and Risk Evaluation Geographic Information System (CORE-GIS), 1990–2012.

Notes: To smooth out the year-to-year variability in this indicator, this figure displays three-year moving average estimates. For example, the values for 2010 were calculated by averaging 2009, 2010, and 2011 raw values.

* Washington State comparison group excluded the five APPI sites (Chelan/Douglas, Okanogan, Skagit, Walla Walla, and Whatcom Counties) and King County, which is the most populous county in the state and contains the state's largest city, Seattle.

Figure D.23. Arrests for Violent Crimes Among Adults (Ages 18 and Older)

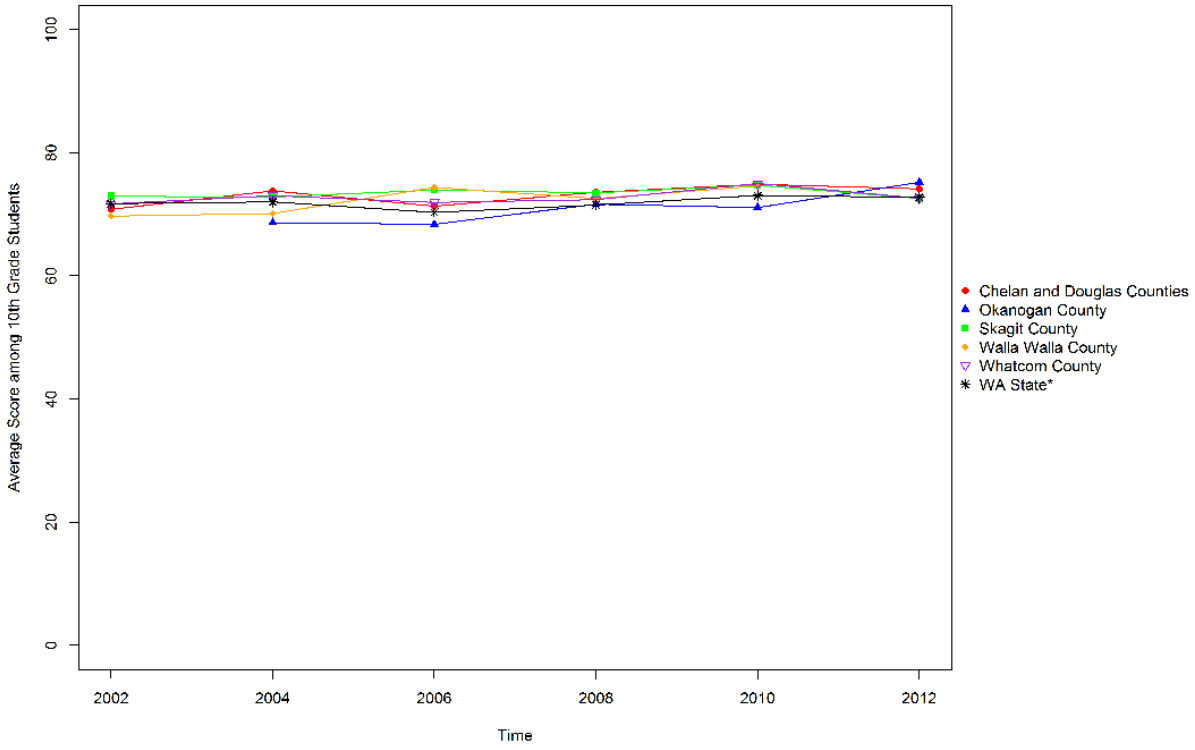


Source: Mathematica Policy Research's analyses of Community Outcome and Risk Evaluation Geographic Information System (CORE-GIS), 1990–2012.

Notes: To smooth out the year-to-year variability in this indicator, this figure displays three-year moving average estimates. For example, the values for 2010 were calculated by averaging 2009, 2010, and 2011 raw values.

* Washington State comparison group excluded the five APPI sites (Chelan/Douglas, Okanogan, Skagit, Walla Walla, and Whatcom Counties) and King County, which is the most populous county in the state and contains the state's largest city, Seattle.

Figure D.24. Youth Quality of Life Reported by 10th Grade Students



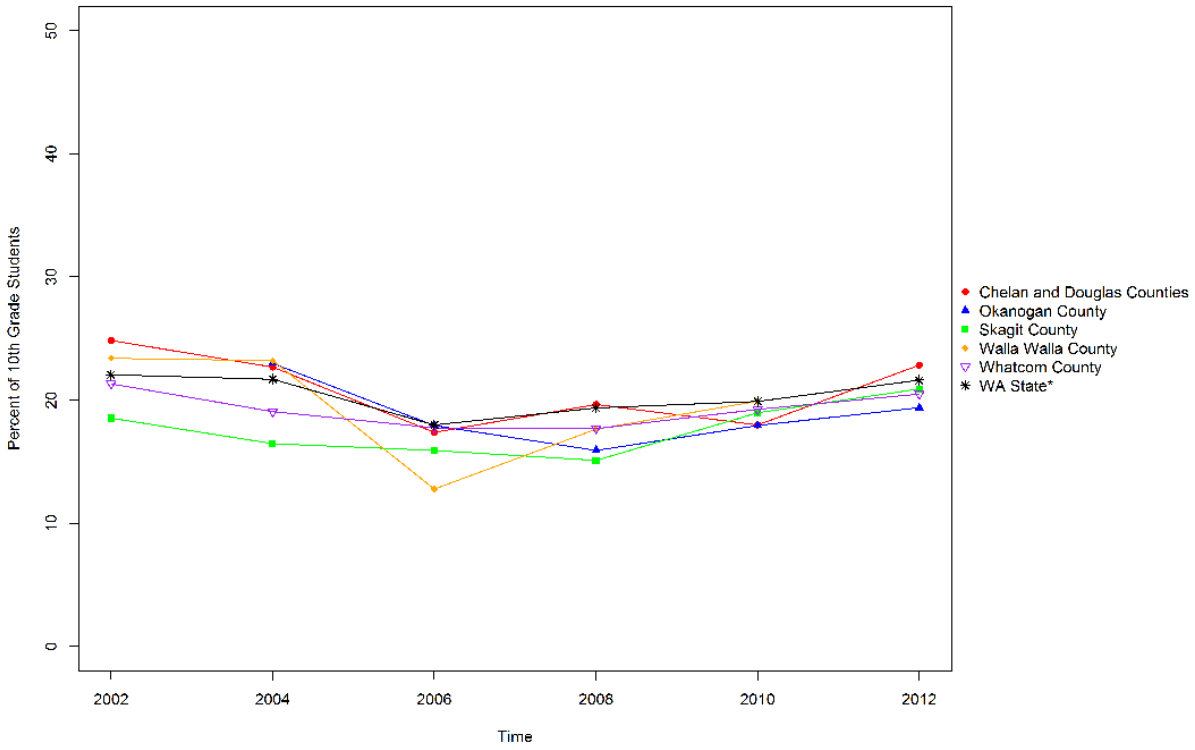
Source: Mathematica Policy Research's analysis of Washington State Department of Health's Healthy Youth Survey, 2002–2012.

Notes: This figure displays the average scores for the youth quality of life scale among 10th grade students. This scale consists of 11 items: 1. I feel I am getting along with my parents or guardians. 2. I look forward to the future. 3. I feel good about myself. 4. I am satisfied with the way my life is now. 5. I feel alone in my life. 6. Compared with others my age, my life is .... 7. There are adults in my life who really care about me. 8. In the last month, how often have you felt that: You were unable to control the important things in your life? 9. In the last month, how often have you felt that: You dealt successfully with irritating life hassles? 10. In the last month, how often have you felt that: You were effectively coping with important changes that were occurring in your life? 11. In the last month, how often have you felt that: You were on top of things? Possible scale scores range from 0 to 100, with higher values indicating a better quality of life.

Due to low (less than 40 percent) response rates among 10th grade students, we do not report the statistics for Okanogan County in 2002 and Walla Walla County in 2012 as these results may not be representative of these counties.

* Washington State comparison group excluded the five APPI sites (Chelan/Douglas, Okanogan, Skagit, Walla Walla, and Whatcom Counties) and King County, which is the most populous county in the state and contains the state's largest city, Seattle.

Figure D.25. Percentage of 10th Grade Students Who Reported Seriously Considering or Planning Suicide in the Last 12 Months



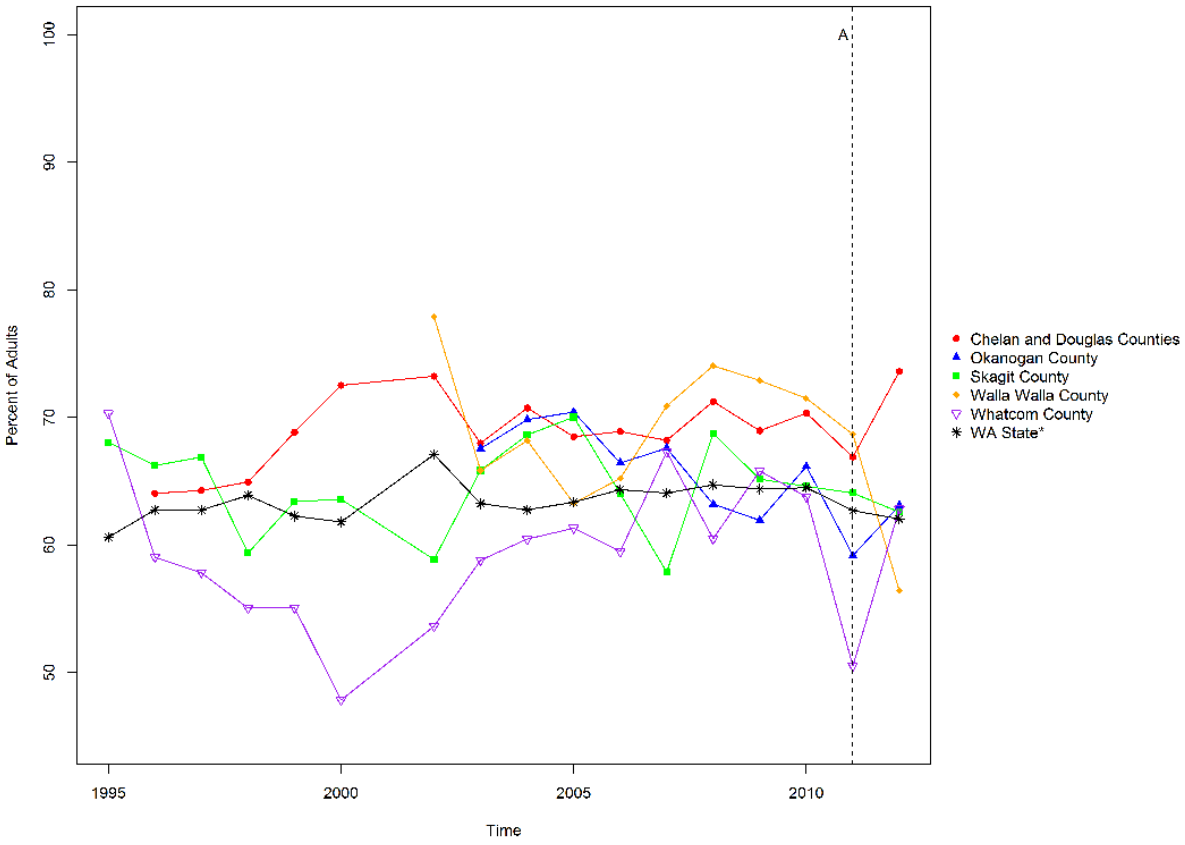
Source: Mathematica Policy Research's analysis of Washington State Department of Health's Healthy Youth Survey, 2002–2012.

Notes: This figure displays percentages based on the number of 10th grade students who answered "yes" to either of the two survey questions: (1) "During the past 12 months, did you ever seriously consider attempting suicide?" (2) "During the past 12 months, did you make a plan about how you would attempt suicide?"

Due to low (less than 40 percent) response rates among 10th grade students, we do not report the statistics for Okanogan County in 2002 and Walla Walla County in 2012 as these results may not be representative of these counties.

* Washington State comparison group excluded the five APPI sites (Chelan/Douglas, Okanogan, Skagit, Walla Walla, and Whatcom Counties) and King County, which is the most populous county in the state and contains the state's largest city, Seattle.

Figure D.26. Percentage of Adults (Ages 18 and Older) Who Reported "Good" Overall Mental Health



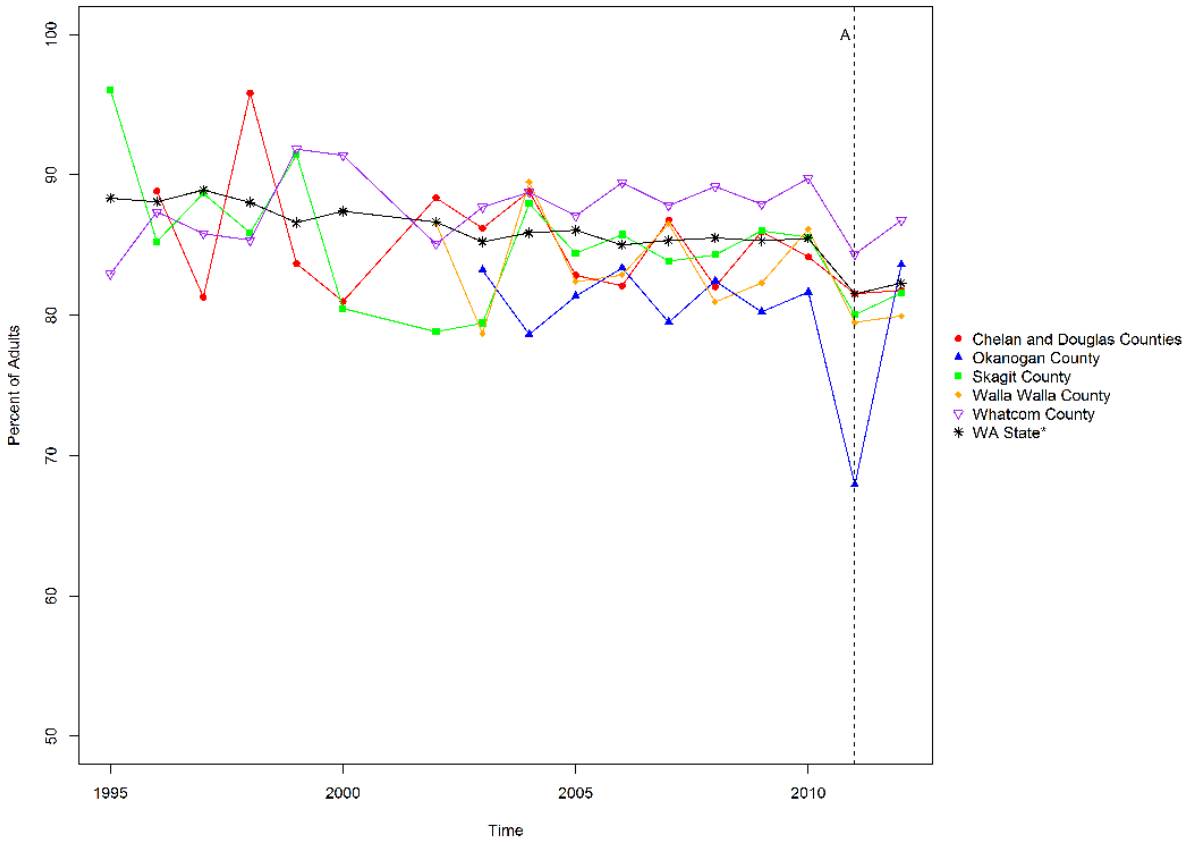
Source: Mathematica Policy Research's analyses of Washington State Department of Health, Center for Health Statistics, Behavioral Risk Factor Surveillance System (BRFSS), supported in part by Centers for Disease Control and Prevention, Cooperative Agreement U58/CCU002118-9 through 17 (1995–2003), U58/CCU022819-1 through 5 (2004–2008), U58 DP001996-1 through 2 (2009–2010) and U58/SO000047-1 through 2 (2011–2012).

Notes: This figure displays percentages based on the number of respondents who answered "0" or "none" to the survey question "Now thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good?"

A: This dashed vertical line designates the 2011 redesign of the BRFSS survey methodology, which may have affected the comparability of estimates before 2011 and from 2011 onward.

* Washington State comparison group excluded the five APPI sites (Chelan/Douglas, Okanogan, Skagit, Walla Walla, and Whatcom Counties) and King County, which is the most populous county in the state and contains the state's largest city, Seattle.

Figure D.27. Percentage of Adults (Ages 18 and Older) Who Reported "Good" or Better Overall Health



Source: Mathematica Policy Research's analyses of Washington State Department of Health, Center for Health Statistics, Behavioral Risk Factor Surveillance System (BRFSS), supported in part by Centers for Disease Control and Prevention, Cooperative Agreement U58/CCU002118-9 through 17 (1995–2003), U58/CCU022819-1 through 5 (2004–2008), U58 DP001996-1 through 2 (2009–2010) and U58/SO000047-1 through 2 (2011–2012).

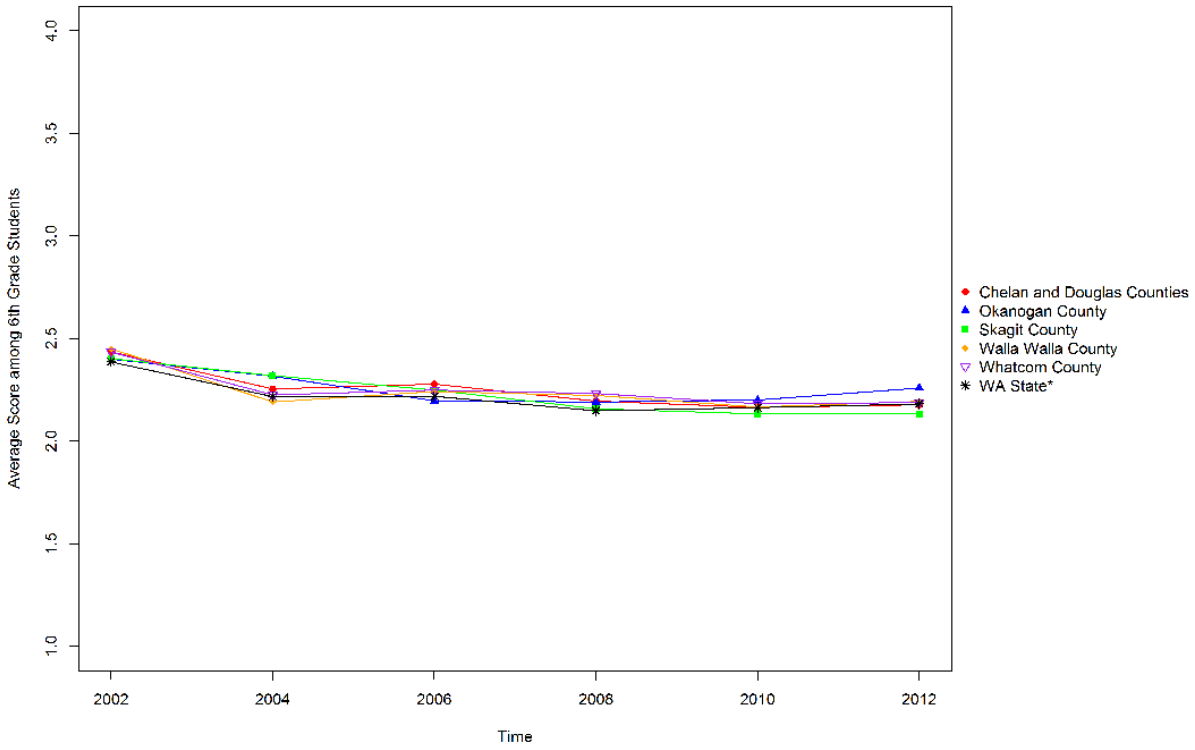
Notes: This figure displays percentages based on the number of respondents who answered "good" or better to the survey question "Would you say that in general your health is …."

A: This dashed vertical line designates the 2011 redesign of the BRFSS survey methodology, which may have affected the comparability of estimates before 2011 and from 2011 onward.

* Washington State comparison group excluded the five APPI sites (Chelan/Douglas, Okanogan, Skagit, Walla Walla, and Whatcom Counties) and King County, which is the most populous county in the state and contains the state's largest city, Seattle.

DOMAIN 4: COMMUNITY DEVELOPMENT

Figure D.28. Community Rewards for Prosocial Involvement Scale Reported by 6th Grade Students

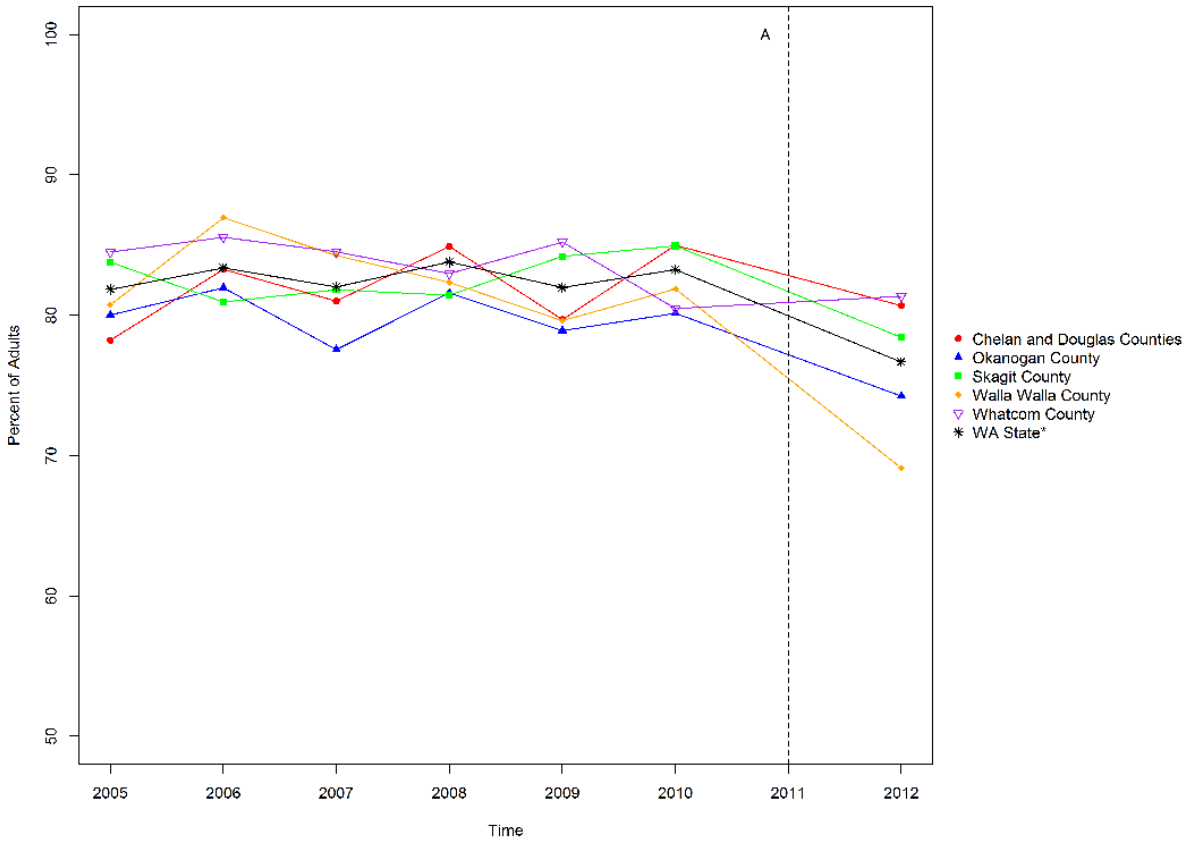


Source: Mathematica Policy Research's analysis of Washington State Department of Health's Healthy Youth Survey, 2002–2012.

Notes: This figure displays the average scores for the community rewards for prosocial involvement scale among 6th grade students. This scale consists of three items: 1. My neighbors notice when I am doing a good job and let me know. 2. There are people in my neighborhood or community/neighborhood who encourage me to do my best. 3. There are people in my neighborhood who are proud of me when I do something well. Possible scale scores range from 1 to 4, with higher values indicating more rewards.

* Washington State comparison group excluded the five APPI sites (Chelan/Douglas, Okanogan, Skagit, Walla Walla, and Whatcom Counties) and King County, which is the most populous county in the state and contains the state's largest city, Seattle.

Figure D.29. Percentage of Adults (Ages 18 and Older) Who Reported Having Their Emotional and Social Needs Met "Usually" or "Always"



Source: Mathematica Policy Research's analyses of Washington State Department of Health, Center for Health Statistics, Behavioral Risk Factor Surveillance System (BRFSS), supported in part by Centers for Disease Control and Prevention, Cooperative Agreement U58/CCU022819-2 through 5 (2005–2008), U58 DP001996-1 through 2 (2009–2010) and U58/SO000047-1 through 2 (2011–2012).

Notes: This figure displays percentages based on the number of respondents who answered "usually" or "always" to the survey question "How often do you get the social and emotional support you need?"

A: This dashed vertical line designates the 2011 redesign of the BRFSS survey methodology, which may have affected the comparability of estimates before 2011 and from 2011 onward.

* Washington State comparison group excluded the five APPI sites (Chelan/Douglas, Okanogan, Skagit, Walla Walla, and Whatcom Counties) and King County, which is the most populous county in the state and contains the state's largest city, Seattle.

This page has been left blank for double-sided copying.

This page has been left blank for double-sided copying.

www.mathematica-mpr.com

Improving public well-being by conducting high quality, objective research and data collection

PRINCETON, NJ ■ ANN ARBOR, MI ■ CAMBRIDGE, MA ■ CHICAGO, IL ■ OAKLAND, CA ■ WASHINGTON, DC

MATHEMATICA
Policy Research

Mathematica® is a registered trademark
of Mathematica Policy Research, Inc.