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### Translating the Adverse Childhood Experiences (ACE) Study into Public Policy: Progress and Possibility in Washington State

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# **Translating the Adverse Childhood Experiences (ACE) Study Into Public Policy: Progress and Possibility in Washington State**

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*On June 15, 2011, Washington became the first state in the United States to enact legislation aimed at preventing adverse childhood experiences (ACE), reducing their prevalence, and mitigating their effects. House Bill 1965 (HB 1965) was established on the understanding among legislators and Washington communities of the need for policies aimed at preventing child abuse, promoting healthy development of children, and building community capacity to improve public health. Empirical examples of integrating ACE-related research with public policy and programmatic design are chronicled. The legislators who developed HB 1965 lay out questions that, if answered, would further improve policymakers' ability to craft public policy and programs that prevent ACE, reduce their effects, and promote a healthier, safer future.*

*KEYWORDS* *adverse childhood experiences (ACE), legislation, policy, ACE response, public health*

The Adverse Childhood Experiences (ACE) Study found powerful relationships between life stressors during the first 18 years and physical, emotional, and behavioral health across the life span. ACE-related health outcomes with substantial public costs include: depression, chronic illness, substance abuse, and teen pregnancy (Anda et al., 2006). The potential for savings and

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improvements in the public's health led Washington State legislators to pass ACE reduction legislation, leverage and expand existing efforts to prevent ACE and mitigate their effects, and consider the role of ACE when assessing the effectiveness of services for vulnerable people. The current article addresses how Washington State legislators translated ACE and related data into relevant policy, describes the State's investments based on this data, and seeks to engage researchers to answer questions that will inform next steps in ACE reduction.

## ACE REDUCTION LAW IN WASHINGTON STATE

With the signing of House Bill 1965 (HB 1965) on June 15, 2011, Washington became the first state to establish public policy specifically aimed at reducing ACE. The law recognizes that co-occurring child abuse and neglect, parental substance abuse, parental mental illness (MI), divorce or separation, incarceration of a family member, and/or witnessing intimate partner violence constitute "a powerful common determinant of a child's ability to be successful at school and, as an adult, to be successful at work, to avoid behavioral and chronic physical health conditions, and to build healthy relationships," and creates a private-public partnership to prevent ACE, reduce their prevalence, and mitigate their effects (C32, L11, E2, Sec. 1, 2011). This legislation requires a diverse group, including community organizations, philanthropy and state agencies to "coordinate and assemble the strongest components" (C32, L11, E2, Sec. 1, 2011) of Washington's ACE reduction efforts to date.

Washington legislators began to understand the impact of ACE on healthy development from researchers, the Institute on Learning and Brain Science, and the National Center on the Developing Child. Robert Anda, MD and Vincent Felitti, MD, co-principal investigators of the ACE Study (Anda et al., 2006), and a cadre of neurodevelopment researchers, including Martin Teicher, MD, PhD (Andersen & Teicher, 2008), provided extensive education across the state as part of a broader strategy to engage the public. As a result, although HB 1965 was introduced late in the 2011 legislative session, it passed with extensive bipartisan support.

For Washington legislators, HB 1965 represents advancement in two areas: primary prevention of child maltreatment and community engagement to improve public health. The Council for Children and Families (CCF), established in 1982, successfully created a network of evidence based home visiting programs, which will be consolidated with the Department of Early Learning (DEL) under HB 1965. The Family Policy Council (FPC), established in 1992 to reduce rates of multiple forms of violence and substance abuse (and the state's major provider of ACE-related education from 2002-2011), is eliminated while authorization of FPC's local affiliates, Community Public Health and Safety Networks, continues under HB 1965.

## PRIMARY PREVENTION OF CHILD MALTREATMENT

Learning about healthy child development has pushed ACE prevention to the top of Washington's legislative agenda, and helped to guide investments. For example, the legislature developed a dedicated fund for evidence-based home visiting programs and protected it from significant cuts during recent budget balancing exercises, in large part due to its cost effectiveness (Aos, Lieb, Mayfield, Miller, & Pennucci, 2004). Additionally, Washington's Children's Trust Fund has led the way to prevent and reduce maternal depression (RCW 43.121.060). Together with philanthropic organizations, the state built a private-public entity, Thrive by Five, to maximize quality childcare and learning opportunities in early developmental years. As veteran lawmakers, we know that prevention, while preferable, is not always possible. Even with good initiatives, we are unable to reach everyone in need. Further, only 35% of adults living in Washington are lifelong residents. Therefore, we must also concern ourselves with secondary prevention and mitigation of the effects of ACE that have already occurred.

## COMMUNITY ENGAGEMENT TO IMPROVE PUBLIC HEALTH

Washington's Community Public Health and Safety Networks engage residents in reviewing data and taking action to reduce population rates of child-abuse and neglect, youth violence and substance abuse, teen pregnancy, teen suicide, school dropouts, and domestic violence. The ACE framework usefully galvanized this public health approach and resulted in multiple community initiatives to change policy. "The legislature recognizes that many community public health and safety networks across the state have knowledge and expertise regarding the reduction of adverse childhood experiences and can provide leadership on this initiative in their communities" (C32, L11, E2, Sec. 1, 2011). In one case, Tacoma Urban Network and Pierce County Juvenile Court used existing tools to measure ACE prevalence among juvenile offenders and the effectiveness of interventions with high-ACE youth. They found that juvenile offenders have approximately three times the number of ACE documented in the ACE Study and those with the most ACE categories struggle with school failure, multiple suspensions, substance abuse, and suicidal behaviors (Grevstad, 2010). Based on these findings, the Legislature increased flexibility to juvenile courts. In Pierce County, for example, probation officers prioritize high-ACE offenders into programs such as functional family therapy. As more citizens became engaged in community education and efforts to address ACE, a critical mass formed to advocate for preserving ACE reduction efforts despite unprecedented budget constraints. Thus, both data and community voices helped move HB 1965 forward.

## ADDRESSING THE ROLE OF ACE IN PROGRAM EFFECTIVENESS: THE CASE OF PUBLIC ASSISTANCE

Between 1997 and 2008, demand for the program commonly known as “welfare,” Temporary Assistance to Needy Families (TANF), fell by 47% (Senate Ways and Means, 2011). However, the “great recession” that began in 2007 has nearly reversed those gains. Facing a caseload of over 70,000 families and a \$5 billion budget shortfall, the 2011 Legislature had no choice but to reform public assistance without shifting costs to other systems, such as emergency medical care or child welfare. As lawmakers began analyzing data on TANF recipients and their service use, we noticed ACE indicators within these vulnerable families (Table 1). “Children’s Administration involvement” means the provision of state services due to one or more reports of child abuse or neglect, indicating physical or sexual abuse or child neglect in the home. Parental drug/alcohol treatment and mental health services were determined from medical records indicating diagnosis and/or intervention. One-parent family status is based on household data provided to TANF to determine eligibility. Domestic violence (DV) is viewed as a barrier to work in today’s welfare-to-work system; therefore, recipients reporting or fleeing from DV receive specialized services. Completion of DV services indicates resolution of the barrier. Arrest data are based on available records for one or both parents. The distribution of these indicators varies by length of time on public assistance. Leavers, who exit within 12 months and do not return to the caseload within three years, are less likely than others to receive services for child abuse or neglect, substance abuse, mental health and domestic violence. Cyclers enter, exit and re-enter the

**TABLE 1** Parental Behaviors and Eligibility for Services Indicating ACE for Children in TANF Families

Indicator of ACE	Leavers		Cyclers		Stayers <i>n</i> = 3,595
	Quick <i>n</i> = 36,025	Slow <i>n</i> = 4,062	Low intensity <i>n</i> = 15,890	High intensity <i>n</i> = 14,349	
Children’s Administration involvement	16%	20%	20%	25%	25%
Alcohol/drug treatment	7%	12%	8%	10%	11%
Mental health services	12%	25%	10%	13%	21%
One-parent family	67%	80%	68%	76%	82%
Family violence intervention	4%	8%	5%	7%	10%
Arrest	12%	12%	15%	17%	12%

*Note.* Source: Washington State Department of Social and Health Services, Research and Data Analysis Division, Integrated Database.

program, but do not use services over 36 months. Stayers receive TANF continuously for 36 months or more (Mancuso et al., 2010a).

Due to the nature of this data, it is not possible to calculate the numbers of ACE categories within families. However, the prevalence of ACE indicators prompted us to inquire if health outcomes documented in the ACE Study were present in the younger generation. For policymakers, this suggests a need to pay attention to ACE when working with this population and ask if ACE influence program outcomes. Based on data from available medical records, TANF children experience high levels of mental health and substance abuse need as measured by diagnosis code, prescription or provision of treatment (Table 2)

Need is more pronounced among children living with relatives (“Kinship”) and in court-ordered placements (“Legal Guardian”) compared to children living with one or both of their legal parents (“Others”) (Mancuso et al., 2010b). For public policy and budgeting reasons, these findings are striking, as about half of adults suffering from MI report symptoms by age 14 and three-quarters report symptoms by age 20 (O’Connell, Boat, & Warner, 2009). Looking through the ACE lens, legislators recognized the need to improve healthy development among TANF children. In the face of declining revenues, poor economic conditions, and a constitutional requirement for a balanced budget, there was no opportunity for program enhancements. Therefore, the adopted TANF reform measure included several low- and no-cost strategies that, based on our current understanding and experience, have the potential to mitigate ACE. In addition to more comprehensive assessment intended to identify and direct services to the most vulnerable

**TABLE 2** Health-Related Indicators of ACE Exposure Among Children Receiving TANF

	Child only cases				Others	
	Kinship		Legal guardian		All other TANF children	
	Age 6–11 <i>n</i> = 4,782	Age 12–18 <i>n</i> = 5,295	Age 6–11 <i>n</i> = 279	Age 12–18 <i>n</i> = 523	Age 6–11 <i>n</i> = 14,666	Age 12–18 <i>n</i> = 11,462
SFY 2005–2009						
Overall mental health need	44%	48%	49%	48%	29%	35%
ADHD	15%	13%	19%	10%	10%	8%
Adjustment disorder	12%	11%	17%	10%	6%	7%
Anxiety disorder	19%	19%	16%	20%	11%	14%
Bipolar/mania disorder	4%	6%	4%	5%	2%	4%
Depression	9%	23%	8%	22%	6%	16%
Alcohol or drug treatment need	1%	16%	1%	17%	1%	13%

*Note.* Source: Washington State Department of Social and Health Services, Research and Data Analysis Division, Integrated Database.

families, we authorized parent engagement in home visiting, Head Start or other parent development activities, and volunteering at a child's day care, preschool, or school to count as "work participation" (C43, L11, E1). For us, the 2011 reform of TANF provides a crystalline example of how ACE science and public policy must interact to improve health and development and reduce the prevalence of high-cost social problems. But there is much work left to do.

### POLICYMAKERS' QUESTIONS FOR RESEARCHERS

Tremendous progress is being made to inform community action and policy decisions. Yet to move forward, policymakers still need to know:

- Are our current efforts working? If so, are some more cost effective than others?
- Whom should we serve and under what conditions? How might sensitive developmental periods help prioritize public investments?
- Is there a predictable life course for high-ACE individuals that can help funders plan for, preempt, or interrupt the need for future services?
- Can we identify who is headed for ACE-related trouble so that effective assistance can be provided at the most strategic time?
- Why do some high-ACE families need government services while others do not? Is there a way to predict which individual or family will show up in which helping system?
- How can we build resilience and protective factors?

Answering these questions will help policymakers develop effective strategies to prevent and reduce the effects of ACE while promoting a healthier, safer future.

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