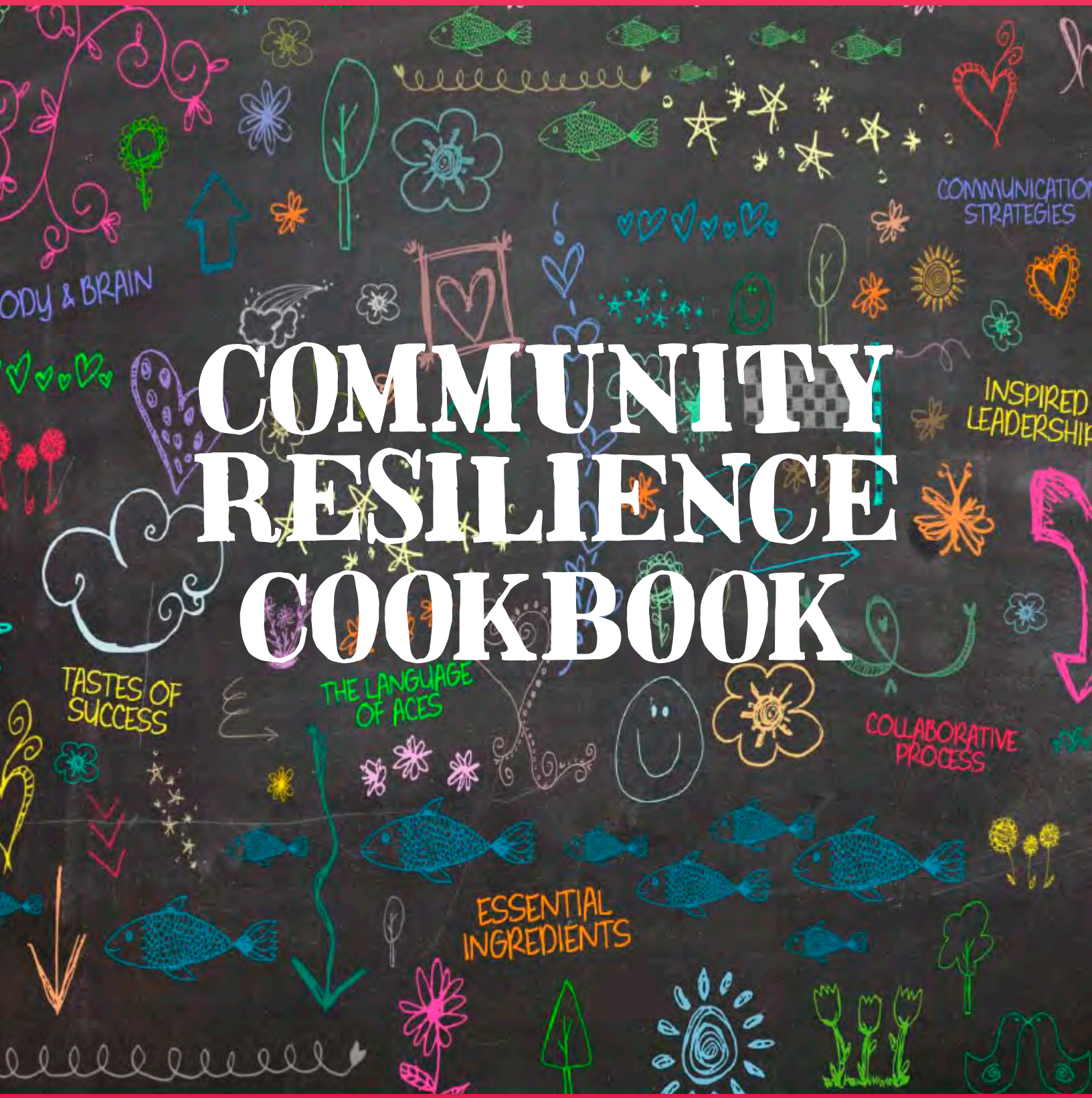

COMMUNITY RESILIENCE COOKBOOK

Printable Version V1.0

The HEALTH FEDERATION of Philadelphia

CONTENTS

WHAT'S COOKING HERE AND WHY

In a rural county in northern Maine, there is a school bus driver who will not start the engine until he has greeted and made eye contact with every child on the bus.

In Philadelphia, a woman who suffered years of sexual abuse by her father learns to dance out her rage and shame in movement therapy workshops offered at her neighborhood health clinic.

And in Walla Walla, Washington, an alternative high school has seen suspensions plummet since staff started approaching kids with a new question in mind—not "What's wrong with you?" but "What happened to you?"

From Alberta, Canada to Tarpon Springs, Florida, a large-scale movement is changing the way we think about health and illness, human suffering and strength. Publication of the landmark study on what we call Adverse Childhood Experiences (ACEs) showed that common types of early adversity—such as neglect, physical, verbal or sexual abuse, or having a parent with a mental illness—raised the risk for a host of physical, emotional and social problems later in life.

Since then, advances in neuroscience have begun to explain how this happens. Trauma leaves tracks in the developing brain. Stress literally gets under the skin, affecting the immune system, heart health, even the expression of our genes. And when early adversity results—sometimes years later—in poor school performance, substance abuse, violence or mental illness, all of us pay the price: Out-of-control health care costs. Lost days of work. Squandered human potential.

But ACEs are not destiny, and early trauma does not have to dictate a life story. Research shows that protective factors—chiefly, the presence of a nurturing adult—can cushion the impact of adversity in a child's life.

That's why this cookbook focuses on resilience. Resilience has been shown to buffer the impact of suffering or stress. Resilience isn't just a gift of nature or an exercise of will; resilience grows through positive experiences, supportive environments and the caring intervention of others.

Individuals are resilient when they reflect on and grow from their own mistakes. Families show resilience when they rally after a death or a loss. Communities shine with resilience when they use their strengths—the stories and skills of their elders, the exuberance of their children, their sense of connectedness, their openness to new learning and research—to manage the challenges of economic, environmental or cultural change and to support the individuals within the community.

Resilience is the capacity to thrive in both good times and difficult ones. And it can be built and nourished at any age, in every human being.

When people learn about the ACE Study, they have a range of reactions, from sorrow to outrage to relief at having a framework—finally—that explains their own or others' behavior. Then they ask, "What can I do?"

This cookbook aims to answer that question. Whether you are the director of a YMCA, the head of a county health department, a sheriff, a school principal, a pediatrician or a parent, it will offer you context, definitions and questions to help you think about building resilience where you live. It will describe how communities in the United States and Canada are putting the theories of ACEs and resilience into practice.

There is no single recipe for resilience. But thanks to the work of scientists, physicians, social workers, psychologists, educators and many others who are passionately engaged in this work, we are we are starting to learn how to prevent and ameliorate ACEs at both the individual and community level. We hope you will share these examples and concepts with

others—members of your faith community, parents in your neighborhood, educators at your local school, your colleagues in the fields of health and human behavior, public safety experts, academics and elected officials—and make connections within and across all those groups.

Information about ACEs—their prevalence, their effects, and the potential for healing—needs to become common knowledge that will bolster a grass-roots movement for change. By thinking, talking and working together, from living rooms to clinic offices to legislative chambers, we can foster healthier, more vibrant lives for every child, teenager and adult.

LETTER FROM DR. ROBERT ANDA

I always knew there was suffering in the world.

As a physician with a career in preventive medicine and epidemiology. I saw that we could treat lung cancer or heart disease or diabetes, but that it was difficult to persuade people to change their behavior. I had the sense that I was looking at the wrong end of the horse. I decided to investigate the emotional origins of health-related behaviors and disease.

With the first publication from the Adverse Childhood Experiences (ACE) study, published in 1998, we looked broadly at 10 categories of childhood adversity, including abuse, neglect and family dysfunction. We asked about emotional, physical and sexual abuse, growing up in a home where there was substance abuse, having a family member who was in prison or who had a mental illness, and having parents who were separated or divorced.

Today I believe that adverse childhood experiences and the wide-ranging health and social problems they generate are our Nation's leading *public health problem*—bar none. ACEs are highly predictive of many of our Nation's worst health and social problems. The good news, however, is that what is predictive is preventable. The Community Resilience Cookbook is a wonderful compilation of the basic science and *early experience* of a variety of communities that have created their own innovative responses to this problem. The stories reflect many common themes, as well as unique examples of emerging successful approaches.

The ACE Study and related findings from surveys and studies across the country are generating a movement that, coupled with the concept of being "trauma-informed," is

spreading rapidly. However, my personal belief—based upon my experience with public health approaches to preventing and treating problems such as cardiovascular disease and cancer that I participated in at the Centers for Disease Control and Prevention (CDC)– is that any approach to a major public health problem *must necessarily include broad-based public education. In fact, an informed public is often the major driving force for change.*

You will learn that ACEs are common–in fact the number of people affected by ACEs outnumbers those who have not been affected by ACEs. Our country cannot generate enough funding for services and systems to adequately address this problem. I have seen people, however, who begin to understand how ACEs have affected their lives be empowered to take responsibility and change their lives, the lives of their children and families, and become a force for change and resilience in their communities. I believe that this is where the greatest power of healing and resilience resides. As you read the stories in the Community Resilience Cookbook you will find this common theme among them.

This movement is new and there are many communities across the country that it has not reached. The Cookbook provides examples for them that may catalyze awareness and then participation. The stories can accelerate the pace to build a trauma informed nation – a nation where the *average person works in synergy with the systems, service providers, policy makers, and legislators* to create sustainable changes that reduce the intergenerational transmission of ACEs by helping those affected by them to heal—or even to transcend their effects. However, without broad support and engagement of people affected by ACEs, the growth and sustainability of the types of changes described in the Cookbook are in jeopardy.

While there is obviously no step-by-step recipe or exact protocol to be followed to activate this movement, the intent of the cookbook theme is to generate hope and a call to action using the examples it contains.

We are rapidly learning from a wide range of communities, about how they are understanding and applying the science of ACEs, to come up with creative and collaborative ideas and responses. While we continue to learn and work, let the darkness and breadth of the adversities that our families and children face, continue to motivate us to action. We can

take hope in the creative and emerging movement of prevention and healing that the stories in the Community Resilience Cookbook represent.

Rob Anda, MD, MS
Co-Principal Investigator and Co-Founder
Adverse Childhood Experiences (ACE) Study
and Co-Founder ACE Interface

BY THE NUMBERS

The original ACE (Adverse Childhood Experiences) study, published in 1998, confirmed what physicians, nurses, psychologists, social workers, substance abuse counselors and school principals had long suspected: that abuse, neglect and trauma in early childhood have a lifelong impact on health and behavior. But the study surprised even its authors, Drs. Robert Anda and Vincent Felitti, in showing how many people—even among a mostly white, well-educated, medically insured cohort of California adults—were touched by adverse experiences.

The study, of more than 17,000 members of Kaiser Permanente, which is one of the largest not-for-profit health plans, asked participants about family dysfunction (parental separation or divorce, growing up with a household member with a mental illness or substance abuse problem, witnessing domestic violence, or incarceration of a household member), emotional, physical and sexual abuse, and emotional and physical neglect.

The conclusion: ACEs were common. ACEs were highly interrelated; where there was one ACE in the life of a child, there tended to be others. And the effects of ACEs accumulated: the more ACEs a person had during childhood, the greater his or her risk for social, mental and physical health problems throughout the lifespan.

High ACE scores were correlated with a host of medical and social ills—not just heart disease and diabetes, but substance abuse, intimate partner violence, suicide attempts and adolescent pregnancy, divorce, financial problems, and difficulty performing in the workplace. Research has shown how that happens: childhood adversity can affect the developing brain, leading to social, emotional and cognitive impairments. That, in turn, can lead to risky behaviors such as smoking, substance abuse, overeating, early and unprotected sexual activity.

Those behaviors set the stage for dysregulation, disease, disability and early death.

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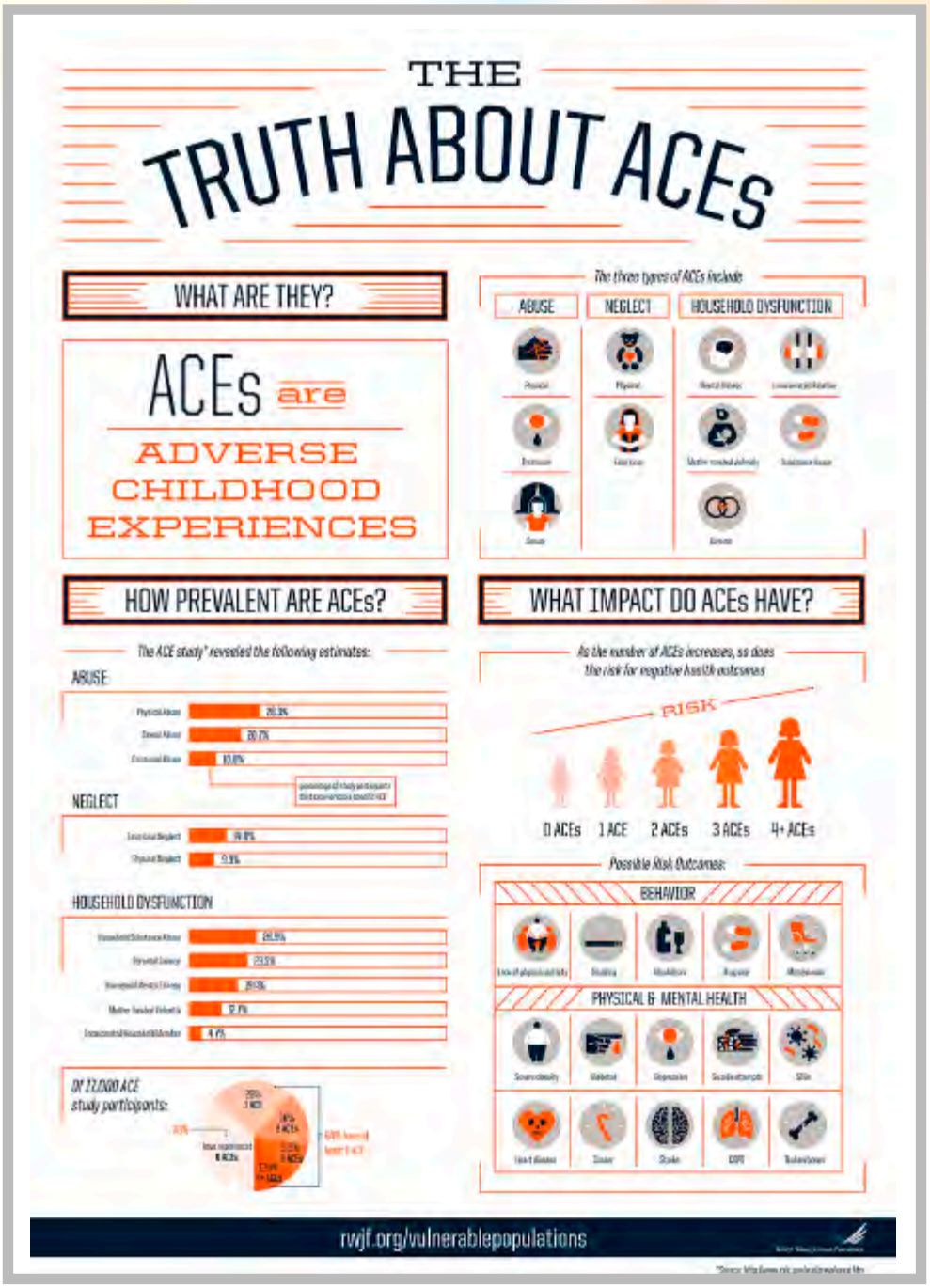


Highlights of Kaiser ACE study – Infographic provided by Robert Wood Johnson Foundation

Since the original study was published, states and localities have begun to collect their own ACE data. Those surveys drummed home the same conclusion: abuse, neglect and trauma shape the way we learn, play and grow. Stress can literally make people sick. What happens at home in the early years—and into adolescence and early adulthood—affects health across the lifespan.

Data collected as part of the Behavioral Risk Factor Surveillance System (BRFSS) in Arkansas, Louisiana, New Mexico, Tennessee and Washington showed that ACEs were just as common in those places as they were among the original Kaiser sample: nearly 60% of 26,000 adults had one or more ACE, and 8.7% had five or more.

State data also showed that ACEs hit some groups harder than others. People with the least education also were the most likely to report five or more ACEs. Those lacking a high school diploma had greater prevalence of physical abuse, an incarcerated family member, a parent with a substance abuse problem and parental separation or divorce.

But these studies were conducted with adults, who were recalling childhood experiences that happened ten, twenty or even seventy years earlier. What about the impact of ACEs on children growing up now?

The 2011-12 National Survey of Children's Health (NSCH), which includes many of the areas covered in the Kaiser study, but excludes physical, sexual, emotional abuse and neglect, answered that question: it showed that ACEs were widespread among the current generation of kids. Nearly 48% of United States children — that's 34,825,978 kids aged zero to 17 — had one or more ACE.

These surveys differed a little from the original ACE questionnaire posed to Kaiser adults; they included witnessing neighborhood violence and suffering racial/ethnic discrimination as sources of adversity.

The NSCH data showed that poor children, children of color and children with either public health insurance or no insurance were especially at risk. In a chicken-and-egg conundrum, children with chronic health conditions experienced more ACEs, and

2011/12 National Survey of Children's Health – Adverse Childhood Experiences, which excluded physical, sexual, emotional abuse and neglect, but still showed that ACEs were widespread among the current generation of kids. Nearly 48% of United States children—that's 34,825,978 kids aged zero to 17—had one or more ACE.

having more ACEs made children vulnerable to such health problems

Local data, collected by individual clinics and in some urban areas, have shown even more alarming rates of ACEs:

- At the Oklahoma University-Tulsa School of Community Medicine clinic, 30% of patients reported five or more ACEs
- At the Bayview Child Health Center in San Francisco, 67.2% of patients had one or more ACE, with 12% reporting four or more ACEs
- Practitioners at Philadelphia's 11th Street Family Health Servicesfound that 49% of their patients had four or more ACEs

Original Study vs 11th St Results

Number of Adverse Childhood Experiences (ACE Score)	Women		Men		Total	
	11th Street Patients	Original Study	11th Street Patients	Original Study	11th Street Patients	Original Study
0	6.8%	34.5%	3.9%	32.0%	6.3%	36.1%
1	12.5%	24.5%	9.9%	27.9%	12.0%	26.0%
2	18.5%	15.5%	14.5%	16.4%	17.8%	15.9%
3	14.6%	10.3%	16.4%	8.6%	14.9%	9.5%
4 or more	47.1%	15.2%	55.3%	9.2%	48.0%	12.5%

The 11th Street Family Health Services Center surveyed patients and found more than 50% had 4 or more ACEs

In Philadelphia, members of the ACE Task Force—a group that includes doctors, behavioral health specialists, social service providers and researchers—wondered if living in an urban area might bring particular stresses not covered in the original ACE study, which focused primarily on household adversities. Their Philadelphia ACE Study, conducted in 2013, asked 1,784 adult participants additional questions related to community-level adversities.

More than half of participants in the Philadelphia ACE Study experienced ACEs, with similarly high rates of household and community level adversities. These data, in parallel with NCSH findings, suggest that the actual rates of adversity experienced by children in our communities may be underestimated when based on household-level adversities alone.

The ACE numbers tell a compelling story: ACEs are common in children and adults. They are corrosive to individuals, families and communities. They cost money in emergency room care, missed days of work, substance abuse treatment and incarceration.

But they are not a life sentence. As localities and states focus on treating and preventing ACEs, they are learning some of the good news: the behaviors, skills and interventions that

help people to recover from trauma also nurture the next generation.

We are beginning to learn what works. Data from the NSCH shows that children who receive health care within a medical home model—a team-based approach to providing comprehensive health services—are more likely to have positive health outcomes, even among children already affected by ACEs.

Other NSCH data shows that children who are resilient—able to stay calm and in control when faced with challenges—are less likely to miss days of school or to repeat a grade, even when they have two or more ACEs. And resilience is not just a gift of nature; it's a skill that kids and adults can learn to help buffer and heal the damage caused by early adversity.

Robert Anda, co-principal investigator of the original ACE Study, believes in the power of individuals to repair brokenness in themselves and in others. "Our job in doing this work is to help people find meaning in what they've experienced," he said at the National Summit on ACEs in Philadelphia in 2013, "so they can take responsibility in changing their own lives, in healing themselves, their families and people around them, in interrupting the intergenerational transmission of toxic stress."

A fascinating and inspiring presentation by Dr. Rob Anda at the National Summit on ACEs in Philadelphia: "ACES in Society – Where the Sciences Collide"

THE LANGUAGE OF ACES

What do we mean when we say adversity, toxic stress or resilience? To have a conversation that crosses disciplines—medicine, mental health, social service, juvenile justice, education—and includes everyone from health policy experts to grass-roots organizers, we need to be clear about our terms.

ADVERSE CHILDHOOD EXPERIENCES (ACES)

This term refers to traumatic or disruptive things that happen in childhood. The original study published in 1998, of more than 17,000 members of Kaiser Permanente, looked at ten different categories of ACEs. These included physical and emotional neglect; physical, verbal and sexual abuse; parental abandonment through separation or divorce; a parent with a mental illness or substance abuse problem; and a family member in jail. Later ACE studies have included experiences such as racism and living in a violent neighborhood.

ADVERSITY

Hardship, distress or suffering. In the context of ACEs, adversity refers to circumstances in a child's life including neglect, abuse and family dysfunction. It can also refer to hardships faced by individuals and communities due to natural disaster, violence, discrimination or poverty.

ALLOSTASIS, ALLOSTATIC LOAD

Allostasis refers to the way the brain and body respond to challenges or stresses: by reacting, adapting and then recovering. But if the stress is extreme, negative and unrelenting, the brain and body pay a price. That accumulated wear-and-tear, called allostatic load, can cause chemical imbalances, accelerate certain diseases, and even alter brain structures. Genetics, early brain development, the social and physical environment, diet and other behaviors can all influence a person's allostatic load.

COLLECTIVE IMPACT

While the term "collective impact" is not limited to the work of building resilient communities, this approach, in which different sectors–for example, juvenile justice, education and social services–share an agenda and goals, has been key to creating successful social change. Collective impact initiatives, unlike simple collaborations, have a "backbone organization," shared measurement systems, continuous communication and mutually reinforcing activities.

COMPLEX TRAUMA

When children are exposed to multiple traumatic events, such as ongoing physical or sexual abuse, witnessing family or community violence, or separation from family members, they may suffer complex trauma, with deep and long-lasting effects on their ability to think, learn and relate to others. Research has shown that the more ACEs a person has, the higher his or her risk for problems including addiction, chronic physical conditions, depression and anxiety, self-harming behaviors, and other psychiatric disorders.

EPIGENETICS

Even our genes respond to what happens to us, through chemical reactions that turn certain parts of the genome on or off in response to stress, diet, behavior, toxins and other factors. Epigenetics is the study of how the social and physical environment change the expression of our genes.

NEUROPLASTICITY

Where ACEs are concerned, neuroplasticity is the good news. It refers to the brain's ability to grow, adapt, reorganize and form new connections throughout life. Exercise, sleep, music, spending time in nature, meditation, support from family and friends, and a reduction in stress can all help the brain recover from the effects of adverse experiences. Neuroplasticity means that ACEs are not destiny; the brain can be hurt, but it can also heal.

POST TRAUMATIC STRESS DISORDER (PTSD)

It's human nature to react to fear or danger; this is often called the "fight, flight or freeze" response. But many people, after experiencing traumatic stress, feel frightened even when they're no longer at risk. PTSD can develop after experiencing a traumatic event such as war, sexual assault, a plane crash or an earthquake; it can also develop in response to the chronic stress of witnessing violence or being physically or sexually abused.

PROTECTIVE FACTORS

Think of these as the opposite of ACEs—the factors or circumstances in a child's life that buffer her/him from harm and promote stability and resilience. Research has shown that supportive family and social relationships, exercise, adequate sleep, proper nutrition, spending time in nature, listening to music, and meditation are key protective factors for individuals. Protective community factors may include adequate housing, access to health care, support in times of need and caring adults outside the family who serve as mentors and role models.

RESILIENCE

This is the capacity to cope with stress, overcome adversity and thrive despite (and perhaps even because of) challenges in life. People who are resilient see setbacks and disappointments as opportunities to grow. While some people may seem to be naturally more resilient, research shows that children, adults and even communities can learn skills and ways of thinking that boost resilience and help them grow.

SECONDARY TRAUMA/VICARIOUS TRAUMA

This refers to the suffering and stress that comes from witnessing, helping or trying to help a traumatized person. Nurses, teachers, hospice workers, foster parents, child welfare workers, physicians, police officers and judges may experience secondary trauma; so can emergency workers who assist following a natural disaster. Symptoms of secondary trauma can include sadness, anger, poor concentration, emotional exhaustion and shame.

SOCIAL AND EMOTIONAL LEARNING

This is the understanding that people learn best in the context of supportive relationships, and that teaching children certain skills—self-awareness, self-regulation, social awareness, responsible decision-making— in a caring and trauma-sensitive environment can not only help them thrive in school but can help prevent bullying, drug and alcohol use and other risky behavior.

SOCIAL DETERMINANTS OF HEALTH

In some ways, a person's health is due to the "luck of the draw." All the circumstances in which people are born, grow up, live and work affect how they develop physically, mentally and emotionally. These circumstances—an individual's neighborhood, family, education, race, gender, class background, diet, workplace and access to health care, for instance—are in turn shaped by a bigger set of forces: economics, social policies and politics. But the social determinants of health are not fixed: individuals and communities can work to change those circumstances so all people have equal opportunities to grow and thrive.

TOXIC STRESS

Not all stress is bad for the brain and body. The stresses that are part of everyday life—taking a test, learning to drive, preparing for a job interview—can strengthen our problem-solving abilities and boost our resilience. But continual or extreme stress, especially in the early years, can damage a child's ability to think, learn, grow and relate to others. It can have a lifelong effect on both physical and mental health. Research shows that nurturing, supportive relationships with adults can help reduce the damage caused by early toxic stress.

TRAUMA

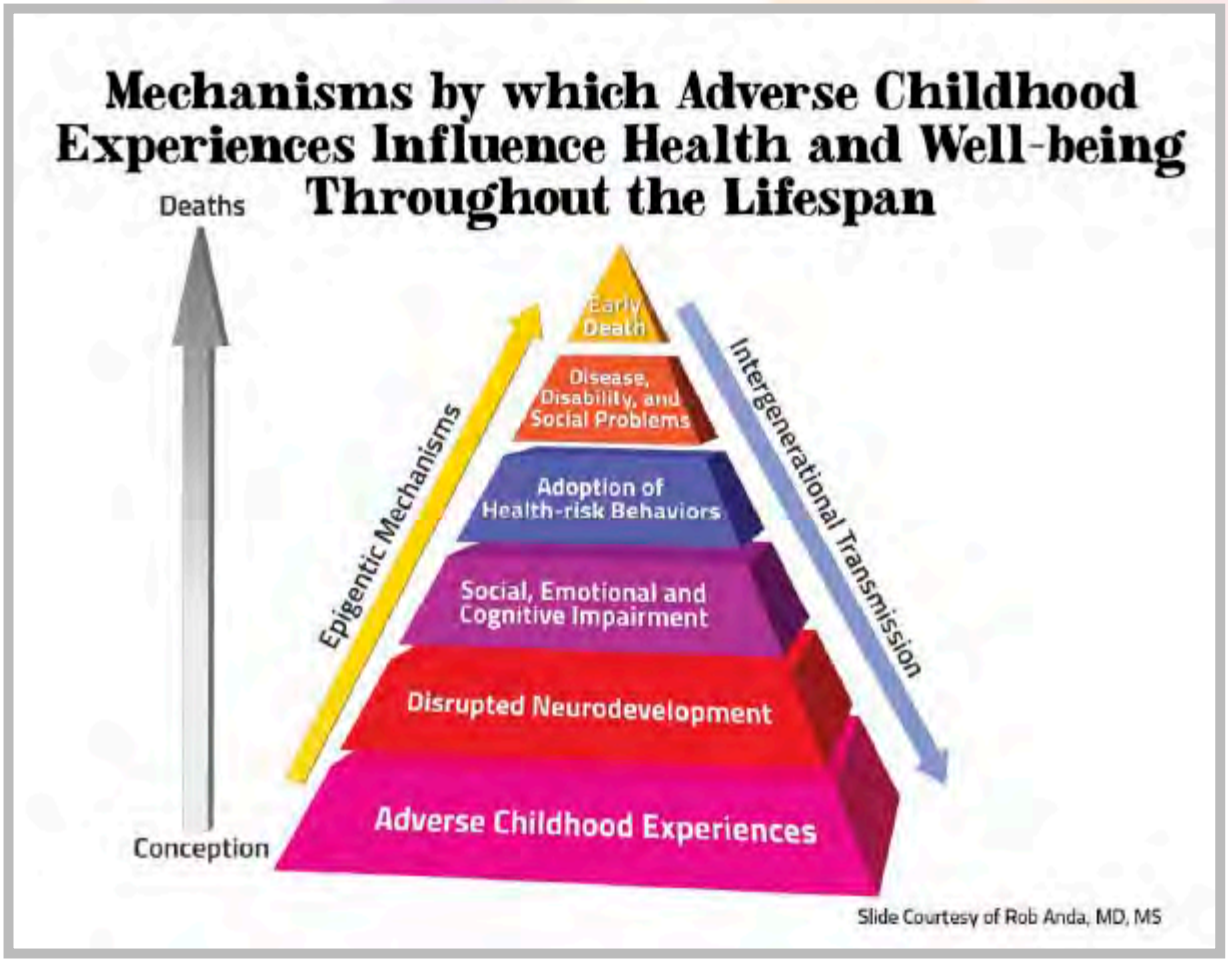
Trauma generally refers to an individual's emotional response—including shock, denial, anger and physical symptoms—to a dramatic threat or event: being the victim of sexual or physical abuse, gun violence, war or natural disaster. But trauma can occur even without

these cataclysmic events: ongoing neglect or family dysfunction can also be traumatic, triggering changes in the brain and body that lead to physical, behavioral and mental health problems in later life.

TRAUMA-INFORMED, TRAUMA-SENSITIVE

Health care systems, schools, child protection agencies and other such organizations can develop approaches that recognize the role of trauma in their clients' and staff members' lives. They can work to build trust, provide supportive relationships and work with clients as partners in healing. A trauma-informed or trauma-sensitive agency asks: "What happened to you?" rather than "What's wrong with you?"

YOUR BODY & BRAIN



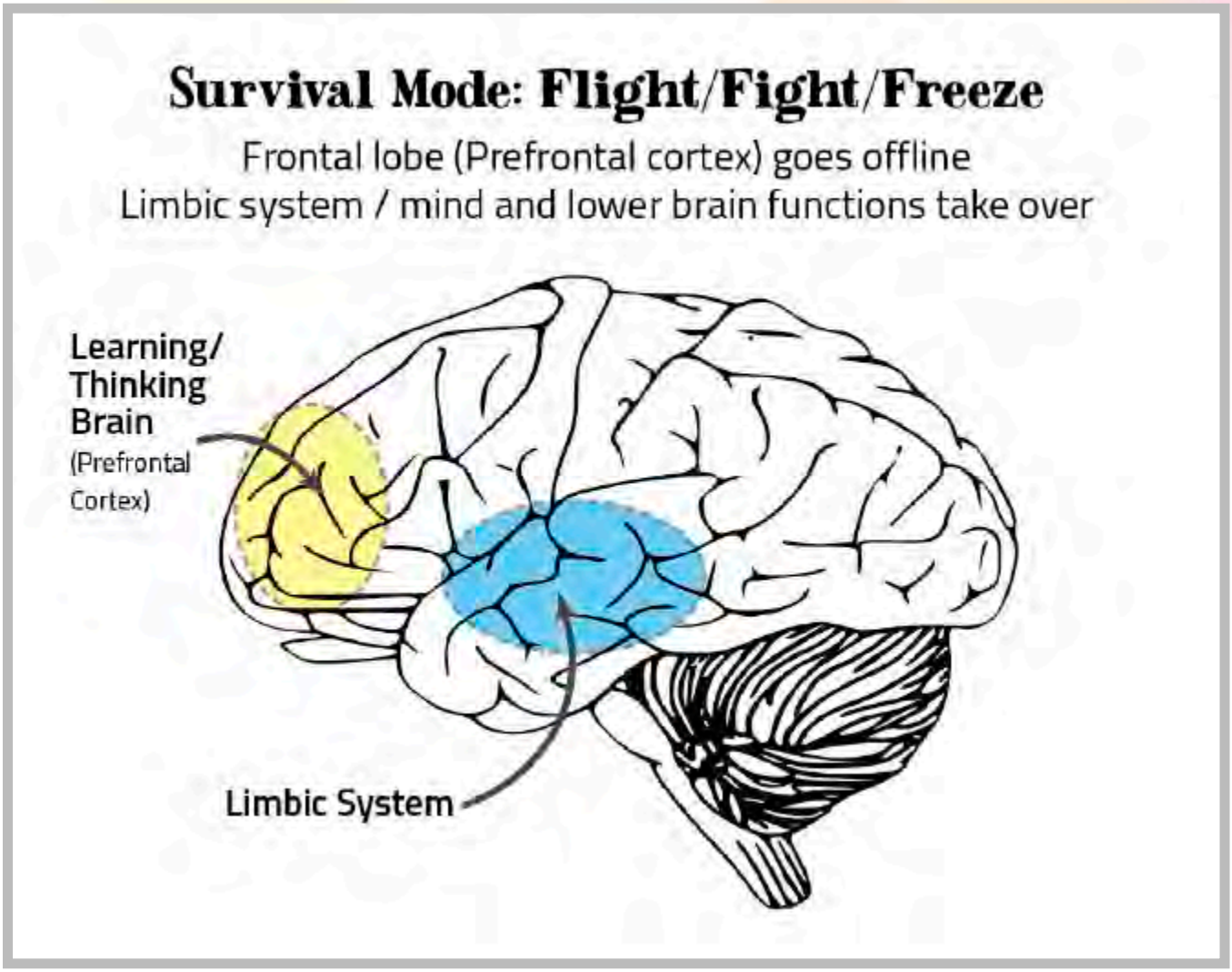
The Centers for Disease Control and Prevention's (CDC) Adverse Childhood Experiences Study, first published in 1998, measured 10 types of childhood trauma. Five types were the usual suspects: physical, sexual and verbal abuse and physical and emotional neglect. Five were family dysfunction: a member of the household who is addicted to alcohol or other drugs; a household member who is in prison; a household member with a mental illness; a mother who is a victim of domestic abuse; and loss of a parent due to separation or divorce. There are, of course, other types of adversity—for instance, witnessing a sibling being abused, being bullied at school, witnessing neighborhood violence, experiencing a natural disaster—but those were not measured. Some subsequent surveys have included other types of trauma.

Of the more than 17,000 middle-class, college-educated, majority-white, employed people with health insurance who participated in the CDC's study, 66% had experienced at least one of those 10 types of childhood adversity.

Since 2008, 22 states have done ACE surveys representing the general population; they have found results similar to those found in the CDC's ACE Study. Social service agencies, pediatricians, the city of Philadelphia and the World Health Organization have also conducted ACE surveys. In specific groups—teens who receive services for troubled youth, for instance, or students who attend an alternative high school—the incidence of child adversity is even higher.

THE FINDINGS FROM THESE STUDIES SHOW:

- The effects start early in childhood and lead to chronic disease in adulthood —including cancer, heart disease and diabetes—mental illness, violence, and being a victim of violence. People with high ACE scores have more broken marriages, more broken bones, more drug prescriptions, more depression, more auto-immune diseases, more work absences, more obesity, more teenage pregnancies and more unwanted pregnancies.
- That ACEs are as common as salt. Between half and two-thirds of those in the studies experienced one or more *types* of adverse experiences during childhood. (Physical abuse, for example, is being pushed, grabbed, slapped, or having something thrown at you often or very often, or ever being hit so hard that you had marks or were injured.)
- That ACEs tend to occur together. In the CDC's ACE Study, if a person had experienced one type of trauma, there was an 87 percent chance he/she had also experienced others.
- The more ACEs a person has, the higher the risk of medical, mental and social problems as a child and as an adult (Got Your ACE Score?). Compared to people who had none, people with four types of ACEs were twice as likely to be smokers, 12 times more likely to have attempted suicide, seven times more likely to be alcoholic and 10 times more likely to have injected street drugs.



HOW ADVERSITY AFFECTS THE DEVELOPING BRAIN

Brain science shows that, in the absence of protective factors, toxic stress damages children's developing brains. Stress alters developing brains, and whether the changes are adaptive or maladaptive for the person depends on the context. Toxic stress is the body's physiological response to events or environment, wherein the stress response is sufficient to cause maladaptive changes. This is the kind of stress that can come in response to living for months or years with a screaming alcoholic father, a severely depressed and neglectful mother or a parent who takes out life's frustrations by whipping a belt across a child's body.

In these severe circumstances, kids *need* stress hormones—a normal survival response—

to remain hyper-vigilant in their terrifying and unpredictable circumstances. Their world is one of constant danger. When they're triggered, their "survival brain" takes over and literally shuts down their ability to learn, think rationally and make decisions. The slightest provocation—a teacher's raised voice or an accidental bump from another child—may trigger them into "fight, flight or freeze" mode. They may lash out with a punch, bite, throw chairs, run away or withdraw into themselves from the outside world.

How does this happen, exactly? When you hear or see a threat, such as a vicious barking dog racing towards you, that information goes immediately from your eyes and ears to your brainstem –to the locus coeruleus–which alerts your limbic brain. That limbic brain—sometimes called "survival brain" because it's something we have in common with all animals—has kept humans alive for millions of years. That's because when there's danger the limbic brain—specifically, the amygdala—sends out a "red alert" signal faster than your thinking brain can comprehend.

That red alert knocks your thinking brain (prefrontal cortex) off-line, so that your body can automatically do all the things it needs to save your life. It also kicks the brain's hypothalamus into gear. The hypothalamus flashes two chemical messages. One tells the adrenal glands, perched on top of your kidneys, to instantly gush adrenaline to the heart, lungs and large muscles in the arms and legs to get you moving *fast*! The second message tells the pituitary gland to direct the outside layer of the adrenal glands to produce cortisol.

Cortisol is the main stress hormone. It's longer-lasting than adrenaline and sustains the effort required after the initial fight or flight by keeping blood pressure high and releasing glucose to power the muscles and brain to remain hyper-vigilant. Maybe you climbed over a fence to get away from the dog, but now you have to run to your car because the dog is digging a hole under the fence to reach you. Meanwhile, as cortisol builds up, it eventually alerts the hypothalamus that the immediate danger has passed, and to stop sending alarm signals. If there are no further red-alert messages from the amygdala, the increasing cortisol also signals the part of the nervous system that calms the body.

Trauma—such as being attacked by the dog, being beaten by a parent or enduring

overwhelming verbal abuse as a child—takes this red alert response to an extreme. That's when the helpless "freeze" response can kick in. Both systems—the actions ordered by the red alert and the part of the nervous system that gives the all-clear calming effect—work at the same time. At that point, the body has two choices: remain on super-high alert or tune out to what's happening, also called dissociating. Post-traumatic stress describes the after-effects of having all systems flooded to the point of overload: a person may roll between staring blankly into space and over-reacting to sounds or events.

There are two other important aspects of this process. First, the amygdala sends a message to the hippocampus to record this terrifying event, branding it into the brain's deepest memory. Any similar event can trigger this memory, which will in turn set off a new red alert. And second, living in a continual state of red alert resets a person's fear response at a higher level than normal, so that even a teacher raising her voice to be heard might trigger a full blown fight, flight or freeze response from a child who unconsciously associates it with a brutal and enraged parent.

If a child lives in a continual state of red alert, she or he is physiologically unable to learn, because the part of the brain that learns—the prefrontal cortex—is "off-line". Until the child has recovered, which may take anywhere from minutes to days, no amount of punishment or admonishments to work harder will change the situation. The child's behavior is a normal, adaptive response to toxic stress; it is not "willful" or intentionally directed against a teacher or parent.

The good news is that the brain is plastic, and continually changes its wiring in response to the environment. If the toxic stress stops and is replaced by practices that build resilience, the brain can slowly undo many of the stress induced changes and return to baseline. This active process of trying to return to baseline is called allostasis.

But if there is no intervention, kids can fall behind in school, fail to develop healthy relationships with peers or create problems with teachers and principals because they are unable to trust adults. Some kids do all three. With despair, guilt and frustration pecking away at their psyches, they often find solace in food, alcohol, tobacco, methamphetamines

or other drugs, inappropriate sex, high-risk sports, and/or work and over-achievement. These are examples of behavioral allostasis – behaviors that transiently turn off stress, but ultimately cause more distress in the long run. Children don't regard these coping methods as problems. Consciously or unconsciously, they use them as solutions to escape from depression, anxiety, anger, fear and shame.

These coping mechanisms can cause health problems; smoking, obviously, can lead to lung cancer. But chronic toxic stress—living in this red alert mode for months or years—can also damage our bodies.

THE TOXIC STRESS OF CHILDHOOD ADVERSITY ALSO AFFECTS OUR BODIES, WHICH RESULTS IN LONG-TERM HEALTH CONSEQUENCES.

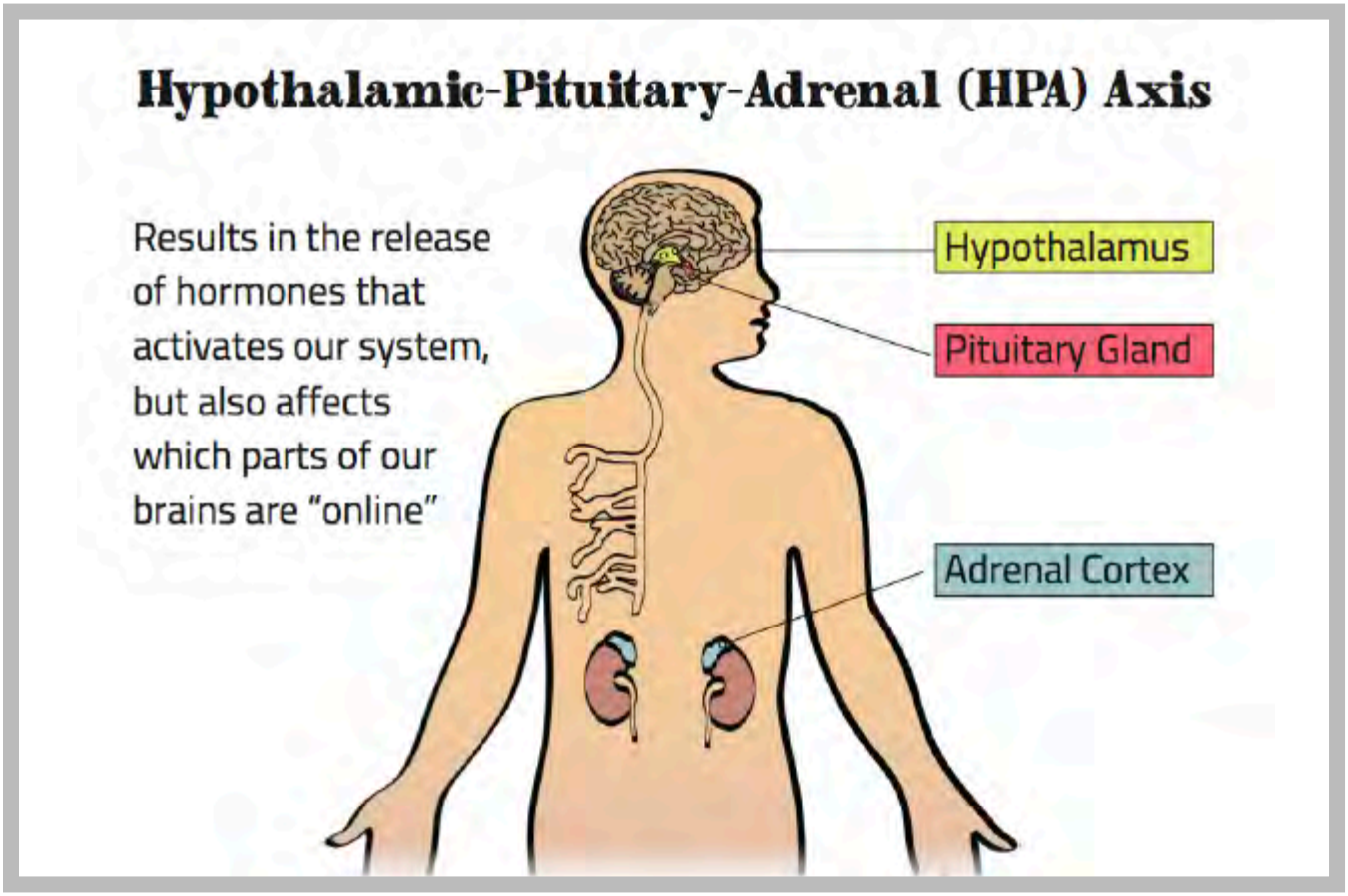


Image content thanks to J. Dorado (2014), UCSF Healthy Environments and Response to Trauma in Schools

The system that controls our stress and trauma responses is called the HPA system, for hypothalamus-pituitary-adrenal, and it normally works as efficiently as air traffic control at a busy airport.

But living in a red alert state for months or years increases allostatic load, or wear and tear on the body. In a red alert state, the body pumps out adrenaline and cortisol continuously. Over time, the constant presence of adrenaline and cortisol keep blood pressure high, which weakens the heart and circulatory system. They also keep glucose levels high to provide enough energy for the heart and muscles to act quickly; this can lead to type 2 diabetes. Too much adrenaline and cortisol can also increase cholesterol.

Too much cortisol can lead to osteoporosis, arthritis, gastrointestinal disease, depression, anorexia nervosa, Cushing's syndrome, hyperthyroidism and the shrinkage of lymph nodes, leading to the inability to ward off infections.

If the red alert system is always on, eventually the adrenal glands give out, and the body can't produce enough cortisol to keep up with the demand. This may cause the immune system to attack parts of the body, which can lead to lupus, multiple sclerosis, rheumatoid arthritis, and fibromyalgia.

Cortisol is also extremely important in maintaining the body's appropriate inflammation response. In a normal response to a bee sting or infection, the body rushes antibodies, white blood cells and other cell fighters to the site and the tissues swell while the battle rages. But too much swelling damages tissue. Cortisol controls this fine balance. So without the mediating effects of cortisol, the inflammatory response runs amok and can cause a host of diseases.

If you're chronically stressed and then experience an additional traumatic event, your body will have trouble returning to a normal state. Over time, you will become more sensitive to trauma or stress, developing a hair-trigger response to events that other people shrug off.

Biomedical researchers say that childhood trauma is biologically embedded in our bodies: children with adverse childhood experiences and adults who have experienced childhood

trauma may have a smaller prefrontal cortex (the thinking part of the brain), a more active HPA system and higher levels of indicators for inflammation than those who have not suffered childhood trauma. This is the main reason why the lifespan of people with an ACE score of six or higher is likely to be shortened by 20 years.

EPIGENETICS – WE ARE OUR EPIGENOME, NOT OUR GENOME.

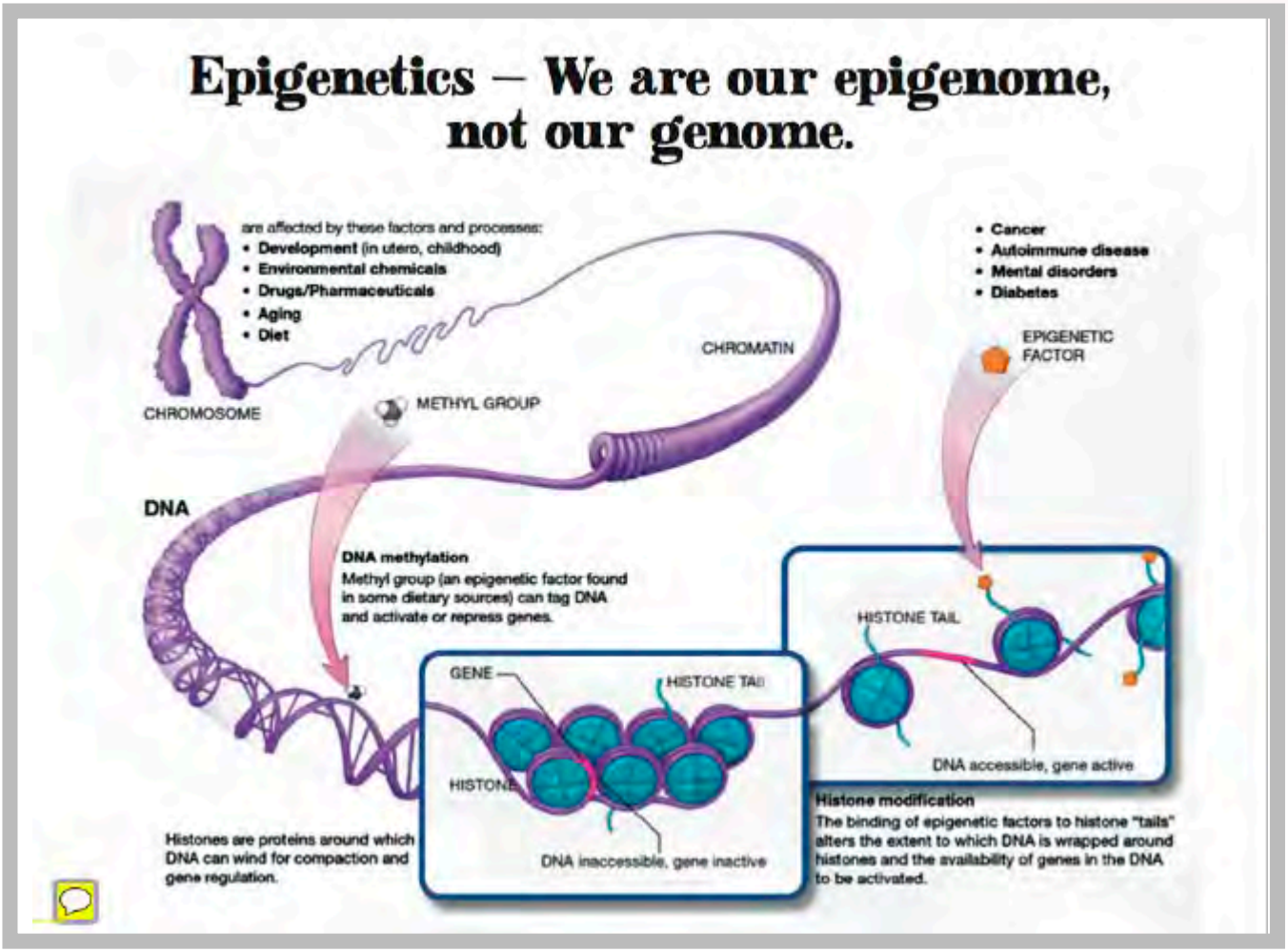


Image Content thanks to the National Institute of Health

Most people believe that the DNA we're born with does not change and that it determines all that we are during our lifetime. But the research from epigenetics—the study of how social and other environments turn our genes on and off—shows that toxic stress can actually alter our genes and cause long-term changes in all parts of our bodies and brains. What's more, these changes can be transferred from generation to generation.

Epigentics means "above the genome" and refers to changes in gene expression that are not the result of changes in the DNA sequence (or mutations). As an example, a process called methylation—the addition and subtraction of tiny groups of chemicals—can turn genes on and off. There are many types of epigenetic mechanisms, including environmental chemicals, drugs/pharmaceuticals aging and as we know now – stress. Epigenetic research into how childhood adversity changes genes is still in its early stages. However, one study of adults who had committed suicide pointed to a possible mechanism. Researchers compared the brains of adults with childhood trauma who had committed suicide with the brains of adults without childhood trauma who had committed suicide. In the brains of those who *had* experienced childhood trauma, the genes that regulated removing cortisol were 40 percent less functional—meaning that those individuals were less able to regulate stress. Another example has been documented wherein infants who were exposed to prenatal maternal depressions, have changes in the methylation of the glucocorticoid recepter genes. [Oberlander, et al, 2008. Epigenetics 3-97-106]

SUMMARY

This body of research—the epidemiology of ACEs, the effects of toxic stress on children's brains, the biomedical impact of toxic stress, and the epigenetics of toxic stress—marks a pivotal point in our understanding of human development. Researchers are identifying knowledge gaps—focusing especially on what can prevent and even reverse the damage of childhood adversity—so they can lay the scientific foundation for a culture of health.

(For a more detailed explanation of the epidemiological, neurobiological, biological and epigenetic effects of adverse childhood experiences, read *Scared Sick: The Role of Childhood Trauma in Adult Disease*, by Robin Karr-Morse and Meredith S. Wiley.)

REFLECTION QUESTIONS:

- What was the most compelling thing you learned from reading this section?
- How could it apply to your work?
- With whom do you want to share this new understanding?

TASTES OF SUCCESS

Nine communities in the United States and Canada—both large and small, all engaged in the work of preventing/treating ACEs and promoting resilience—are profiled here.

These stories provide specific, richly detailed examples of how different towns, cities, states and provinces have approached the challenge of responding to ACEs. They discuss challenges and obstacles, mis-steps and lessons learned, "aha" moments and successful collaborations.

The ACEs movement is new. We are rapidly learning from those using the science of ACEs to generate creative and effective responses in a wide range of communities.

While there is obviously no step-by-step recipe that works for every locality, we hope these stories generate hope and inspire action, no matter who you are or where you live.

THE ALBERTA, CANADA STORY

Located in western Canada, with a population of 4 million. Alberta's economy and population are growing rapidly, fueled by high birthrates and immigration, both from other countries and other provinces.

View Alberta's Success Story

THE ARIZONA STORY

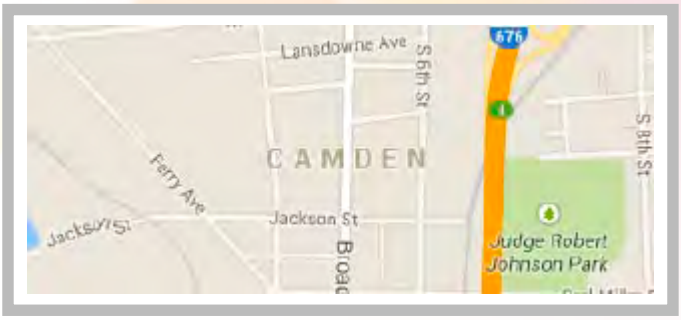
The state, with a population of 6.6 million, shares a border with Mexico. A 2012 survey showed high rates of ACEs in Arizona, especially among children aged 12-17.

View Arizona's Success Story

THE CAMDEN, NEW JERSEY STORY

A once-thriving manufacturing center now struggling with poverty, violence and abandoned housing, Camden—population 77,000—sits across the Delaware River from Philadelphia.

View Camden's Success Story



THE IOWA STORY

A state with a population of 3 million in the "American Heartland." A 2012 survey showed that 55% of Iowans had at least one adverse childhood experience, while one in five of the state's residents had an ACE score of 3 or higher.

View Iowa's Success Story

THE MAINE STORY

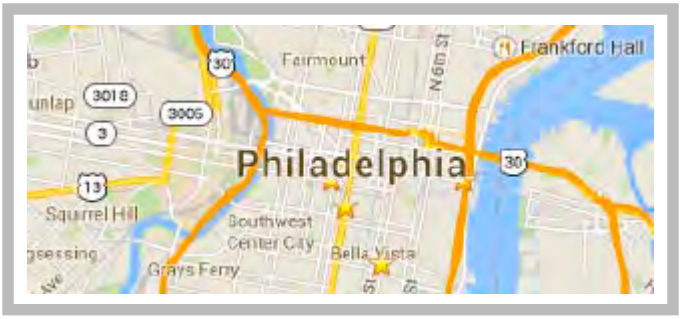
With a population of 1.3 million, Maine is the least densely populated state east of the Mississippi River; it is also New England's poorest state, with one in four children being raised in poverty (the national average is one in five).

View Maine's Success Story

THE PHILADELPHIA, PENNSYLVANIA STORY

With a population of 1.5 million, Philadelphia is the second-largest city on the east coast. After years of declining population, as the city shifted from a manufacturing center to a service-based economy, the number of residents rose slightly between 2000 and 2010.

View Philadelphia's Success Story



THE TARPON SPRINGS, FLORIDA STORY

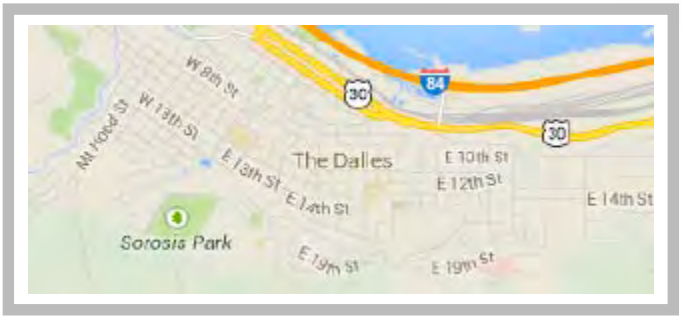
A former sponge-fishing center, Tarpon Springs is a city of 23,000 in Pinellas County, on Florida's Gulf coast. In 2008-12, 13.5% of the city's population lived below the poverty line.

View Tarpon Springs' Success Story

THE DALLES, OREGON STORY

The largest city in Wasco County—population 13,600—located in north central Oregon. A huge dam construction project in the 1950s split the city into "two sides of the track"; the districts merged only ten years ago.

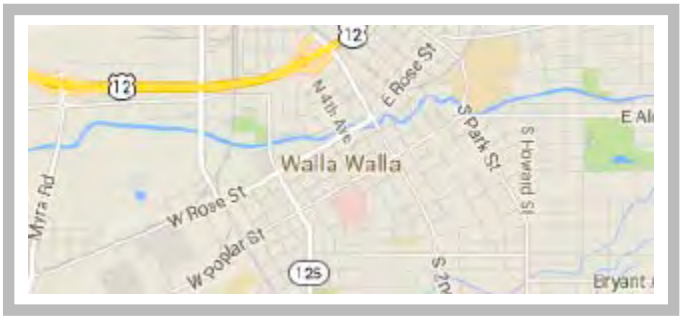
View The Dalles' Success Story



THE WALLA WALLA, WASHINGTON STORY

The largest city in Walla Walla County, Washington—population 31,700—in the state's southeastern region. Despite signs of growth—a flourishing wine industry and a rehabbed downtown—one of four Walla Walla children live in poverty, and gangs and drugs are common.

View Walla Walla's Success Story



Connect with others nationally and internationally around ACEs and Resilience – go toACEsConnection.com and join the movement.

SUMMARY OF COMMUNITIES

Location	Geography		Size	Early Foundation Support	Governmental Collaboration or Support	Gathered or Used Local Data	Institutionally-based, or Individual/ Collaborative Start-up	
	City/Town	Region					Institution	Individual or Collaborative
Alberta, Canada		✓	4 Million	✓	✓		✓	
Arizona		✓	6.6 Million		✓	✓		✓
Camden, New Jersey	✓		77,000					✓
Iowa		✓	3 Million		✓	✓		✓
Maine		✓	1.3 Million		✓	✓		✓
Philadelphia, Pennsylvania	✓		1.5 Million	✓		✓		✓
Tarpon Springs, Florida	✓		23,000		✓			✓
The Dalles, Oregon	✓		13,600		✓		✓	
Walla Walla, Washington	✓		31,700	✓			✓	

THE ALBERTA, CANADA STORY

CORE STORY OF BRAIN-BUILDING TOUCHES CHANGE-MAKERS AND CITIZENS

"Over time, we've seen a real shift in public awareness; people are seeing a role for themselves in supporting others…to be successful."
–Sheryl Fricke, executive director of the Early Childhood Development Priority Initiative for the Province of Alberta

A cartoon outline of a child – in a video – stands alone near a cracked sidewalk heaped with obstacles: giant red bricks labeled "neglect," "abuse" and "parental addiction." The voice-over says: "It's possible to fix some of the damage of toxic stress later on, but it's easier, more effective and less expensive to build solid brain architecture in the first place."

The four-minute animation—which covers toxic stress, caregiver-child interaction and the role of communities in building healthy brains—has gone viral since its release in October 2013. But the video is just one snippet of the Alberta Family Wellness Initiative (AFWI), a project aimed to better the lives of children and families in one of Canada's westernmost provinces.

KEY INGREDIENTS:

- Long-term support and vision from a private philanthropic foundation
- A clear agenda: use the science of early brain development to bridge the gap between what we know and what we do
- An initial focus on high-level change makers who could influence local research, policy and practice

The AFWI, launched in 2007 by the privateNorlien Foundation, has an ambitious agenda: to promote the use of scientific knowledge about early brain and biological development in order to change beliefs, policies and practices related to children, families and communities—in short, to "bridge the gap between what we know and what we do," according to a 2013 AFWI report.

The AFWI began its work by capturing the attention and engagement of high-level "change-

makers"—government officials, community leaders, policy experts, academics and administrators who could learn the newest science, discuss it in depth, then take that story home to influence research, policy and practice.

"In the early days, the focus of our effort was on policy-makers and professionals rather than the public. You need to start changing the thinking of those in the system who are making decisions before you start focusing on a public audience," said Michelle Gagnon, vice president of Norlien.

AFWI focuses on the "core story of brain development," a series of metaphors grounded in emerging biomedical science and developed with the help of the FrameWorks Institute and the Harvard Center for the Developing Child.

> "Brains are not just born; they are built through a child's experiences and interactions "serve-and-return" exchanges with caregivers—eye contact, singing, playing peek-a-boo—help to create a healthy foundation in an infant's and young child's brain while good stress—meeting new people, trying out for a team—helps build resourcefulness and problem-solving strategies, toxic stress, such as parental neglect or abuse, is bad for brain development sturdy brain architecture fosters social, emotional and cognitive skills—often called "executive functioning"—that help children regulate their feelings and actions, the way an air-traffic controller directs movement in the skies the community has a role, and a responsibility, in helping all young people develop and grow."

One way the AFWI chose to share and explore these key concepts was through a three-year program of symposia, with one series focused on early brain development and one on addiction. Norlien invited 100 people—leaders in education, health, social services and justice—to each series. The intensive five-day symposia combined lectures from nationally and internationally known experts in the field with small-group, interdisciplinary teams so participants could discuss how to implement what they were learning. Between symposia, attendees connected through e-mail, phone calls and networking events. As part of their commitment to the symposia process, they were required to put their new learning into practice and policy and to report back on whether those changes were making a difference.

Reflection Question #9 What kinds of education, training, supervision or mentorship could help your community become more trauma-informed?

Now the next phase has begun, launched with a week-long symposium in October 2013 that brought together the early brain development and addiction streams into one larger cohort—an effort to "take this story to the next level," Gagnon explained, by forming cross-sector innovation teams to put the "core story" into practice in education, human services, health care and the justice system.

"The basis of our work," said Gagnon, "is creating a big network of people across the province who now regard themselves as change agents in their arenas."
Already, AFWI is producing results:

- "Together, We Raise Tomorrow: An Alberta Approach to Early Childhood Development," a 2013 province-wide government initiative to support children's well-being, is based on the core story of early brain development and the need for safe, supportive communities
- Alberta's new strategy on addiction and mental health connects local change strategy to the "core story" of the lifelong consequences of toxic stress early in life.
- Every physician in the province, on learning that a patient is pregnant, now gives that woman resources on healthy pregnancy and early child development
- The Association of Faculties of Undergraduate Medicine of Canada created a series of short podcasts, based on lectures from AFWI, about early brain development, mental health and addiction, to be used in medical education
- Alberta's corrections system is shifting to a trauma-informed chronic care model of treatment for inmates with addictions
- The AFWI website, which includes information and resources on brain development, toxic stress, addiction and recovery, received just over 80,000 hits since it was launched in 2011

What led to the success of AFWI? Sheryl Fricke, executive director of the Early Childhood Development Priority Initiative (for the province of Alberta, calls it "a perfect storm." For years, she said, attempts to create an integrated early childhood strategy for the province

floundered before they reached the level of actual policy. While human service providers certainly witnessed the impact of early childhood experiences on adult behavior and health, other sectors—doctors, economists and justice officials—tended to see the theories of human development as "soft science."

Then came the emerging research on brain development, the influence of early stress and epigenetics—the idea that environment and experience can shape the expression of our genes. In 2007, the Norlien Foundation invited Vincent Felitti, co-author of the 1998 Centers for Disease Control ACE Study, to speak at an AFWI symposium. He shared the study's findings—that early childhood trauma has a corrosive effect on long-term physical and mental health—with people working in clinical practice, policy and research.

Norlien, with its generous resources and the flexibility of a private philanthropy, continued to bring that science to practitioners in a range of fields. Slowly, the conversation began to change. In 2011, Alberta's chief medical officer of health issued a report, "Let's Talk About the Early Years," underscoring the importance of a child's first 5 years and urging all Albertans to get involved in supporting children and families.

In Alberta, where frontier culture tends to prize individual responsibility and a brand of rugged independence, the AFWI had to jostle mental models, instilling the idea that everyone needs help to grow and that achieving wellness is a collective obligation.

"Over time, we've seen a real shift in public awareness; people are seeing a role for themselves in supporting others who are experiencing periods of vulnerability, and children in particular, to be successful," said Fricke.

A survey of participants in AFWI initiatives in the first 3 years bolsters her claim:

- Nearly half the respondents (participants in the AFWI's symposia) said they had observed or experienced changes in attitudes and increased awareness of the "core story" of brain development
- Nearly half the respondents said they were using research to inform their practice—for instance, through a trauma-informed approach to addiction treatment or a more family-centered approach to primary and pediatric care

- A Family and Youth Court judge said judges have become more aware of the impact of toxic stress on children and teens; one judge created a video for her colleagues on how to integrate the understanding of brain development into child placement and custody decisions

The Norlien Foundation's role as a convener is critical. "We bring in experts to talk about the science. We're a foundation that is trying to influence and catalyze change," said Gagnon. The next phase of the AFWI involves 21 "innovation teams," such as one comprised of physicians and leaders of health organizations, working to integrate knowledge of early childhood and brain development into their practices. The foundation also wants to bring the "core story" to the general public through vehicles such as the animated video on brain-building.

Changing minds, and then policy, is a gradual and time-consuming process, said Gagnon. "There's obviously resistance that you can expect when you're really trying to change long-held cultural beliefs in an area. This has taken a number of years of intensive engagement, and relationships are fundamental to that—supporting others to be change leaders in their own domains."

Across the province, that is now happening. Lana Wells, a professor of social work at the University of Calgary who participated in the most recent AFWI symposium, is rewriting her course outlines for next year, adding information on neuroscience and early childhood development to her classes on public policy and leadership.

Reflection Question #8 – What are the skills, assets and resources in your community that might be tapped in the work of preventing childhood adversity and building resilience? What skills, assets and resources do you need?

For Carlene Donnelly, executive director of the Calgary Urban Project Society, the knowledge gleaned through the AFWI enabled her to tell a persuasive story to funders and the public about her clients, who are low-income individuals and families in need of housing, education and medical care. The science of brain development has filtered into her agency's practices: one parenting program proved much more effective when 40% of services were moved into

clients' homes and communities. "It was really about understanding how to make [parents] independent, strong survivors," she said.

Participating in the AFWI also prompted Donnelly to change the way her agency hired, trained and managed staff, building a more professional mix of employees who possessed both compassion and a commitment to measurable outcomes.

"We'd always measured our success on a short stick," she said. "But the science forces you to think long-term and hold people accountable to that long-term goal…it's amazing information. Before, we saw what came from a damaged soul and brain; we didn't always understand it. Now we can explain it to parents. There's this relief. They realize it's not their fault, what happened to them. They absolutely feel now that they can change the course for their children."

ALBERTA TIMELINE

2007

Alberta Family Wellness Initiative begins with the Building Blocks for a Healthy Future conference, bringing together policy-makers and experts in child and brain development

2010

In partnership with the government of Alberta, AFWI launches two three-year symposia series, one focused on early brain and biological development and one on recovery from addiction, each with 100 invitees in a range of disciplines

2011

Alberta's chief medical officer of health issues "Let's Talk About the Early Years," underscoring the importance of a child's first five years and urging all Albertans to get involved in supporting children and families

2013

The government of Alberta releases "Together We Raise Tomorrow," a province-wide initiative to support the well-being of Alberta children, emphasizing the core story of brain development and the need for safe, supportive communities

AFWI's next phase begins with a week-long symposium that joins the two tracks (early brain development and addiction) in a forum for shared discoveries and increased collaboration

a four-minute animated video on the role of communities in building healthy brains, developed by AFWI in collaboration with the FrameWorks Institute and the Harvard Center on the Developing Child, is released and goes viral

THE ARIZONA STORY

ACE CONSORTIUM VOWS TO "GO WHERE THE FISH ARE BITING"

"We started with nothing. And now we have a small army of people who want to help."
—Marcia Stanton, coordinator of the Arizona ACE Consortium

Not long after Marcia Stanton stumbled across the original article from the CDC's Adverse Childhood Experiences Study, she heard a conference presentation by Dr. Vincent Felitti, one of the study's co-authors. She invited Felitti to do grand rounds with 100 pediatricians at Phoenix Children's Hospital, where she works.

"I thought they'd be all over this," says Stanton, a social worker in the hospital's Injury Prevention Center, where she coordinates child abuse prevention programs and promotes primary prevention. Felitti had warned her that physicians were typically slow to warm to ACE research. Not these physicians, she thought.

"After a very compelling one-hour presentation, there were only a couple of questions from the physicians," she recalls of the 2006 event. "Everyone filed out, and that was the end of it. I was shocked at how little response there was."

She sighs. "So we put our efforts in other directions."

Looking back over the last 8 years, Stanton reflects on the progress of the Arizona ACE Consortium. "We're moving ahead," she says. "But it's as if we're in a maze. We hit a wall, bounce back, reverse and go another direction. We've learned that we have to go where the interest is."

KEY INGREDIENTS:

- A unifying motto—"Strong Communities Raise Strong Kids"
- A multi-level communication strategy that included partnering with a public television and creating an online bilingual toolkit
- With no budget and one part-time coordinator, a commitment of local in-kind support, including donated meeting space and speaker fees, makes the work possible

In fact, for a grass-roots organization that has no funding and 1 part-time coordinator (Stanton spends 20% of her part-time 32-hour-a-week job on the project), the Arizona ACE Consortium has a stunning list of accomplishments:

- Seven train-the-trainer workshops in which 450 people learned about ACEs, the effects of toxic stress and resilience factors, and how to present this information to their communities.
- Tens of thousands of Arizonans who now know about the ACE Study. The first train-the-trainer workshop group alone—which included 35 people from the state's 15 regional child abuse prevention councils—did presentations in April 2010, as part of Child Abuse Prevention Month, that reached 13,000 people.
- A partnership with Eight, Arizona PBS television, which set up a web page for the ACE Consortium (view PBS show on "Trauma – Ask the Expert") and the "Strong Communities Raise Strong Kids" tool kit. The kit includes a downloadable PowerPoint presentation about ACEs in English and Spanish.

The Arizona ACE Consortium found media partner in Eight, Arizona PBS television station, which devoted a web page to Adverse Childhood Experiences (ACEs)

- A major spin-off project on childhood adversity prevention. While the consortium supports all evidence-based prevention programs, the group adopted the Triple P parenting program as a primary initiative. Triple P is a multilevel system of evidence-based education and support; the program's goal is to increase parents' and caregivers' knowledge, skills and confidence in order to reduce the rates of behavioral and emotional problems in children. The ACE Consortium is developing a statewide infrastructure with plans to offer the program to all Arizona families.
- ACE screening for families. The Arizona Children's Association, one of the state's largest providers of behavioral health, is incorporating the ACE survey into its intake process with all families.

- A state ACE survey. The Arizona Department of Health Services will include the ACE survey in its Behavioral Risk Factor Surveillance System questionnaire in 2014.

Reflection Question # 1 - In your community, which groups, agencies or individuals can you connect with that have already been exposed to the ACE study and the concepts of toxic stress and resilience?

After Felitti's visit in 2006, Mary Warren, a professor at Arizona State University and consultant with Prevent Child Abuse Arizona, teamed up with Stanton to spread the word about ACES. Stanton and Warren convinced Phoenix Children's Hospital to bring Felitti back the following year for a conference and a community round-table discussion. His visit prompted about 50 people to express interest in figuring out how to implement the research in Arizona.

Of those 50, four to six people began meeting regularly. They called themselves the ACE Think Tank. And they spent the next couple of years talking, doing presentations to whomever was interested, and, well, thinking.

First, they decided to think big; they wrote a $1,000,000 grant proposal that would screen all patients coming through Phoenix Children's Hospital for ACEs. It was turned down. "That was the last big grant we applied for," says Stanton.

Thinking small seemed the way to go. But the secret they discovered was that if you convince thousands of people to think small, that's thinking big. They used Prevention Institute's Spectrum of Prevention tool that

The Arizona ACE Consortium found media partner in Eight, Arizona PBS television station, which devoted a web page to Adverse Childhood Experiences (ACEs)

"encourages people to move beyond the perception that prevention is about teaching healthy behaviors" and identifies six levels of intervention—for instance, increasing individuals' knowledge, educating providers and influencing legislation—that may not seem related at first, but end up complementing each other.

After several years of making do with what they realized were their own considerable connections and resources, the small-group ACE Think Tank launched the statewide ACE Consortium in 2010 with several high-profile projects and events:

- The "Strong Communities Raise Strong Kids" tool kit
- The train-the-trainers workshop
- The web site
- An Eight, Arizona PBS interview with Felitti (during his third trip to Phoenix),
- A local prime-time special that featured interviews with local experts, paired with a call-in panel, "Ask a Child Trauma Expert," that took questions from the viewing public

Ace Train the Trainer Presentation from Eight, Arizona PBS

In 2011, the consortium hosted a second train-the-trainer workshop, developed a strategic plan, began a social mediacampaign, and worked with Eight, Arizona PBS on another local prime-time special, "Forgiveness: Ask an Arizona Expert."

Arizona ACE Consortium's Facebook Page – Strong Communities Raise Strong Kids

In 2013, the consortium hosted the state's first Child Well-Being Summit, which members hope will become an annual event. The demand for the train-the-trainer workshop is so great that they're now doing two a year.

In 2014, the consortium released "Overcoming Adverse Childhood Experiences: Creating Hope for a Healthier Arizona", which reported that nearly 70,000 Arizona children have an ACE score of 5 or higher. The report went to all Arizona legislators. The consortium is preparing an addendum that includes county-specific data. An ACEs Clinical Practice Work Group is developing "do's and don'ts" guidelines for organizations considering using the ACE survey as a screening tool, as well as a list of trauma-informed and culturally relevant counseling and peer support resources.

It turned out that "thinking small" meant growing and taking advantage of a network that has exposed tens of thousands of people to detailed information about ACEs. Today the consortium boasts more than 200 members statewide; 50 of those are active, and the others participate when called upon, such as to print materials for the workshops, donate space for trainings or contribute small amounts of money for speakers' fees. The consortium continues to hold quarterly meetings.

Consortium participants include representatives from Arizona State University; Head Start; Recovery Empowerment Network; Eight, Arizona PBS; Raising Arizona Kids Magazine;

Easter Seals agencies; behavioral health service/system providers and recipients; the state departments of Economic Security, Behavioral Health Services, Education and Public Health; parenting groups; Arizona Association for the Education of Young Children; Prevent Child Abuse Arizona; Mercy Maricopa Integrated Health System; Arizona AAP, First Things First, the Children's Action Alliance; representatives from the court system and domestic violence nonprofits; and many more.

Some of these organizations have incorporated ACEs, trauma-informed and resilience-building practices into their everyday work:

- In 2013, eight of the state's 15 regional Child Abuse Councils included ACE presentations and/or talks by experts in juvenile justice, mental health, substance abuse, and education about how they were implementing ACE- and trauma-informed practices. One council even offered ACE-themed mouse pads to attendees at a conference.

- Easter Seals is doing presentations about ACEs and how to overcome them. Some of those trainings target how child-care centers and schools can use the ACE Study's research to create safe environments for children and to help educate their parents.

- The educational outreach department of Eight, Arizona PBS has a grant to coordinate 12 ACE trainings around the state outside of Maricopa County (where Phoenix is located) this year.

- Because traditional stop-bullying campaigns don't focus on why students bully, the statewide bullying initiative has started including ACEs education in presentations to show how preventing ACEs can help prevent bullying.

- After the debacle in 2013 when the Arizona Child Protective Services Agency was found to have shelved 6,000 child abuse and neglect cases without investigation, and had a 10,000-case backlog, the agency was pulled out of the Department of Economic Security, and has a new director who reports directly to the governor. Two large work groups were launched to restructure the agency. Stanton, who is serving on one of those groups, says the agency is implementing prevention as one of its three main pillars, a move due in part to the consortium's work over the last few years.

- Phoenix Children's Hospital community pediatrics clinic, which sees 20,000 patients a year, has start screening parents and their newborn- to five-year-old children for ACEs.

As with any big cultural change, the picture isn't all rosy. Stanton does orientation classes with all new clinical staff (non-physicians) twice a month at the hospital. "These are large classes, 75 to 80 people," she says. "I always ask how many people know about the ACE Study. In the last two classes, there was absolutely no one who raised a hand. This research is just not permeating health education. Social workers know about it, but not health care providers."

Unfortunately, the hospital has ended orientation about ACEs; Stanton will instead offer "lunch 'n learns".

Reflection Question #2 – In your community, who has yet to learn about this information?

She also sees awareness gaps in other sectors. She rattles off a list: education, public health, behavioral health, child welfare, and business. "I'd like to do more with youth and teens," she says. "I think we're missing a big opportunity with them, as well as mommy bloggers and young parents." She pauses. "It's kind of endless."

She's also frustrated that the state has taken so long to include the ACE module in the BRFSS. The data in the 2011/2012 National Survey of Children's Health indicates that more than 25% of Arizona kids aged 0–17 have already experienced one adverse family experience, while 31.1% have experienced two or more. The nationwide average is 22.6% of children experiencing two or more ACEs.

More alarming, among older Arizona children, those aged 12-17, 44.4% have experienced two or more ACEs, compared to the nationwide average of 30.5%.
"Arizona is dramatically higher than the nationwide average," Stanton says. "This is the canary in the coal mine."

The ACE Consortium is at a significant turning point, she says. While there's an obvious momentum—"an ACE vibration," as Iowa's former ACEs coordinator Sonni Vierling describes it—much of what the Arizona consortium has done has "been by the seat of our pants. We need to get more strategic."

Although "every time we've needed something, someone in the consortium has stepped up and provided resources," the ACE Consortium is at its limits, Stanton says. To do more training in all sectors, to bring sectors together, to support changes in organizations, to work with the governor and legislature on a statewide plan, to help communities develop their own plans, to create ways to evaluate activities—all this and more requires a new level of organization and funding.

Stanton has hope that she and others in her state will meet this stepped-up challenge. "We started with nothing," she says. "And now we have a small army of people who want to help."

ARIZONA TIMELINE -

2005
Stanton stumbles on "The Relationship of ACEs to Adult Health: Turning Gold into Lead" article

2006
Phoenix Children's Hospital hosts pediatric grand rounds and community leader luncheon featuring Vincent Felitti, co-author of the CDC's ACE Study

2007
First ACEs presentation at statewide Family Centered Practice Conference; "ACE Think Tank" formed

2008-09
ACEs presentations to professional and other interested groups, including Arizona Academy of Pediatrics and Regional Child Abuse Prevention Councils; ACE Think Tank meets quarterly

2010
ACE Think Tank morphs into ACE Consortium; over 200 members statewide. Successful grant awards enable expanded community and media outreach. ACE Consortium develops Strong Communities Raise Strong Kids Tool Kit (logo, brochures, PowerPoint presentation). Inaugural Strong Communities Raise Strong Kids Train the Trainer workshop. First "Ask an Arizona Child Trauma Expert" PBS prime-time/call-in special

2011
Consortium holds 2nd annual Strong Communities Train the Trainer workshop; updates training kit.

"Forgiveness: Ask an Arizona Expert" PBS prime-time special/call-in show.

Consortium develops mission, vision, values and strategic plan.

2012
Consortium continues ACEs community and professional presentations. Child Well-Being Summit draws 125 in-studio and is live-treamed by PBS

2013
Consortium takes part in National Summit on ACEs in Philadelphia; four train-the-trainer workshops bring total of Arizona ACE trainers to 400; Arizona supports inclusion of ACE module in 2014 BRFSS

2014
More train-the-trainer workshops; release of state report, Overcoming Adverse Childhood Experiences; developing guidelines for using 10-question ACE survey as screening tool; developing state resource list for trauma-informed counselors and peer support. State doing first ACE survey through BRFSS.

THE CAMDEN, NEW JERSEY STORY

A PHYSICIAN AND A PRIEST PLANT SEEDS OF REPAIR

"What happened to us is that we've chosen to live and work in the poorest, most violent city in the country. But healing is available."
–Jeff Putthoff, SJ, founder of Hopeworks N' Camden

The priest and the physician, both practicing in the poorest city in America, came to the same realization: What they were doing was not working. The problems each was trying to address—lack of job skills and education among teens and young adults; chronically poor health and barriers to better care—persisted.

Jeff Putthoff, SJ, and Jeffrey Brenner, M.D., realized they had to dig deeper, beyond symptoms to root causes, to understand the struggles they were witnessing in Camden, New Jersey. What they found were ACEs.

KEY INGREDIENTS:

- A sense of urgency fueled by Camden's reality as the poorest and most violent city in the United States
- Visionary and activist leadership from different sectors
- Simultaneously making changes at the organizational level and building alliances across sectors for larger system change

Putthoff, a Jesuit priest known locally as "Father Jeff," is a fireplug of purpose under his casual uniform of cargo shorts and sweatshirt, earbuds slung around his neck, a blue bicycle his preferred mode of transport. He is voluble and passionate on the subject of his city. Since 2000, Father Jeff has directed Hopeworks N' Camden, an organization that offers in-school and out-of-school youth GED classes and website-design instruction—skills intended to parlay directly into jobs or college.

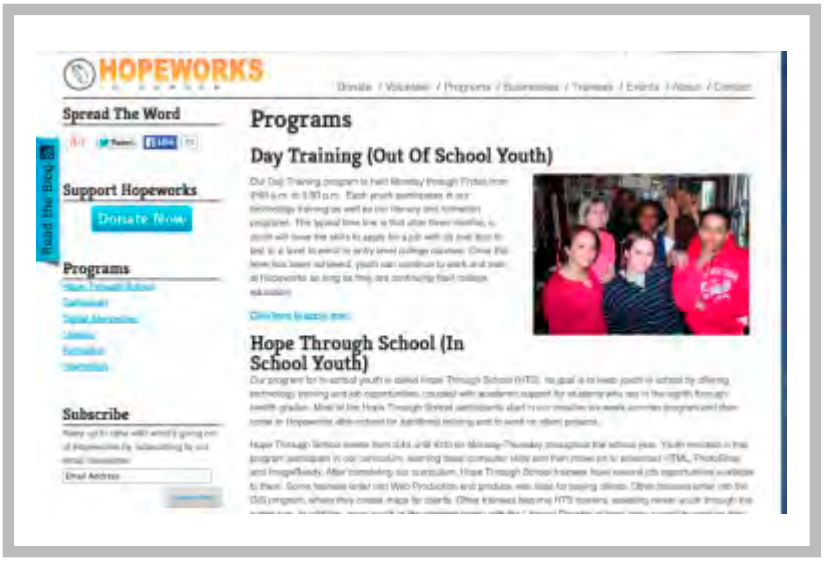
Brenner is equally driven—a physician/scholar/prophet in a slightly rumpled suit, with a calendar so crammed he must set a smartphone alarm to keep his days on track. He is founder and executive director of the Camden Coalition of Healthcare Providers and the recipient of a 2013 MacArthur "genius" grant. In 2011, he was profiled in The New

Yorker,which chronicled his innovative plan to shrink the cost of health care by focusing on the highest-risk patients, providing them with team-based interventions to keep them out of hospitals and by helping them manage both chronic illnesses and social/emotional needs.

But it wasn't until the last three years that each man learned of the 1998 ACE Study and began to apply its lessons to his work. That study, of more than 17,000 Kaiser Permanente members in California, showed that early childhood adversity—including neglect, physical and sexual abuse and parental abandonment—was both widespread and corrosive to long-term physical and mental health. Trauma, the study implied, leaves tracks in the brain. Stress can literally make people sick.

Reflection Question #5 – In addition to the ACEs counted in the 1998 Kaiser study, are there other sources of adversity particular to your community, such as neighborhood violence, racial/ethnic discrimination or the trauma caused by a natural disaster like flood or fire?

Putthoff saw the symptoms of that trauma every day. Camden earned the dubious title of "most violent city in America" in 2012, when there were 67 homicides among its 77,000 residents. That year, someone in Camden was shot, on average, every 33 hours. Two out of five Camden residents live below the poverty line. The streets are packed with nearly 4,000 abandoned homes.



Hopeworks N Camden provides training programs in a trauma-informed environment

"I've been here [in Camden] 16

years," Putthoff said. "I've been chasing the symptoms all those years, trying to change people's behavior, get them jobs, get people in school. The dawning realization was that we were not dealing with the cause."

Putthoff could see how frustration and hopelessness were wearing on the Hopeworks staff—ten full-time and four part-time employees who work to boost students' reading skills and teach them website design and GIS(geographic information systems, or digital mapping). They also reinforce workplace norms such as appropriate dress and consistent, on-time attendance.

"About three years ago, I noticed that my staff were being really mean to each other, saying things like, 'Ann, you've been late twice in a month; what's the matter with you?' It was getting nasty," Putthoff said.

After reading more about adversity and stress, Putthoff diagnosed the toxic workplace atmosphere: "It was classic secondary trauma. The organization needed to heal."

Putthoff learned about The Sanctuary Model, developed in the Philadelphia area in the early 1980s; the model is a blueprint for organizational change to create a trauma-informed community that includes not only the people seeking treatment or services, but those who provide those services. Organizations that wish to follow the Sanctuary Model make a commitment to undergo intensive training, staff development and rigorous reflection to change behavior, attitudes and practices. Three years ago, Hopeworks began that process.

Today, the principles of trauma-informed care infuse everything that happens at Hopeworks. Each morning, in a room on the second floor of Hopeworks' headquarters, an unassuming row house in the Pyne Point neighborhood, both staff and youth gather for "the huddle," a check-in designed to clarify feelings and set intentions for the day.

First, everyone takes three deep breaths "to root ourselves in our bodies," Putthoff explained. Then each participant, in turn, asks the person on his or her left four questions: "How are you feeling? How do you want to feel at the end of the day? What's your goal for today? Who can help you with that?"

"It's powerful to acknowledge feelings," Putthoff said. But it's equally important to name a specific goal and seek out someone else as a resource—for instance, "I'm going to finish exercise two in my GED book, and I'll get Jay to check my work.

"What we're saying is, 'You can have your feelings and function,'" Putthoff said.

Dan Rhoton, Hopeworks' chief impact director, explains trauma-informed care this way: Imagine two youth, Hakim and Maria. Hakim routinely shows up late; he flouts the rules by checking his cell phone incessantly during training sessions. He demands, "How long until I get my stipend?" Maria, on the other hand, reports on time every day and stays focused; instructors learn that she's caring for her siblings because her mother was deported. A conventional approach would term Hakim "a failure" and Maria "a hero," Rhoton said.

"But Hakim and Maria are the same. He's checking his phone because his five-year-old brother is alone at home. He needs his stipend because that's how he pays for groceries. Who you see depends on the questions you ask."

Hopeworks staff have learned to pose different questions. All youth take the ACE inventory, as well as an education survey that asks questions such as, "Have you felt safe at school?" in an effort to uncloak the reasons for low grades or dropping out. In contrast to programs with strict three-tardies-and-you're-out policies, Hopeworks is more flexible. "We ask, 'How can we help you to be successful?'" said Danyelle Austin, the program's academic success director.

And the big question, the one that applies not just to Hopeworks youth but to all residents and workers in this struggling city, is not "What's wrong with you?" but "What happened to you?"

"What happened to us," says Putthoff, "is that we've chosen to live and work in the poorest, most violent city in the country. But healing is available."

Putthoff is trying to spread that word beyond the walls of Hopeworks. In May 2013, Putthoff and others hosted a Trauma Summit featuring keynote speaker Sandra Bloom, co-director of the Center for Nonviolence and Social Justice at Drexel University's School of Public Health; she

is co-creator of the Sanctuary Institute.

Reflection Question #6 – Who can be your partners in the work of preventing childhood adversity and building resilience among individuals and families? Think about obvious partners and uncommon/unlikely allies and collaborators.

The chief of police attended the Trauma Summit. So did numerous neighborhood activists, clergy members, teachers and citizens eager to learn more about what ails Camden and how to fix it. Putthoff followed the Summit with a series of "Trauma Triangle" workshops to further participants' learning about the effects of adversity and ways to boost resilience. Now he is working to gather a cluster of Camden organizations to be part of a "Healing 10"—agencies that will commit to the Sanctuary Model, practice trauma-informed care and work together—in collaboration, not competition—across disciplines, to repair this broken city and its people.

Camden County Police Department Web Page reflects the engagement with the community

A year later, that work is starting to gain traction; both Rob Anda and Vincent Felitti, co-investigators of the 1998 ACE Study, spoke at Camden community events in the spring of 2014. A small group of leaders committed to the idea of the Healing 10 has been meeting regularly with Putthoff, and more than 70 people filled the room for a three-hour training on the Sanctuary process. Putthoff hopes that momentum will continue at a planned Trauma Summit in the fall.

Meantime, Hopeworks continues applying the lessons of ACEs to its own daily practice and sharing that knowledge with others. A recently formed youth trauma team, trained in ACEs theory, has presented to schools, community centers and other sites. The most powerful moments, Putthoff says, come when the youth tell their stories: one boy talks frankly about being stabbed by his father; a girl discloses her history of self-injury and drug use. They describe how understanding ACEs has helped them heal and given them a new framework for seeing the world.

"We're humanizing ACEs," Putthoff said. "People think: Oh, that's the group of youth that's a problem. They're the 'other.' The youth really cross that boundary because they share their stories. That's the gist of Felitti's [message]: in talking about what happened to you, a great power begins to move."

Education leaders in the city are also starting to embrace ACE-informed practices. TheCatholic Partnership Schools, a coalition of five Camden schools, hosted an Education Summit in 2013 that brought 300 educators to hear Paul Tough, author of How Children Succeed: Grit, Curiosity, and the Hidden Power of Character, talk about the impact of poverty on children's ability to learn. In some of those schools, teachers are usingmindfulness meditation, "peace corners" (see images) and soothing music to help children manage their emotions and learn resilience.

A second Education Summit the following spring focused on "Self-Control, Poverty, Social and Emotional Development, and the Roles They Play in Raising our Children." It featured University of Pennsylvania professor Angela Duckworth, who has written widely about the role of grit in determining children's success.

Angela Duckworth presenting a "TedTalk"

While Putthoff has allies in town—the chief of police, other human service providers and the CEO of the Camden District Council Collaborative Board, which convenes groups of residents, educators and law enforcement officials to address crime and community issues–there is not yet a citywide network that shares the language of ACEs, the understanding of trauma and a commitment to build Camden's resilience through long-term collaboration.

"I feel exhausted. I wish I could go around and give everyone a shot of penicillin," Putthoff says. "But there's not a vaccine. The change is cultural. I want to offer people an understanding of the symptoms of trauma, an understanding of where that's coming from. People understand being hurt. I see this as an incredible way to connect with people and bring resources together."

Reflection Question #2 – In your community, who has yet to learn about this information?

Across town, on the other side of the freeway, Brenner and his staff are also practicing what they've learned from emerging biomedical research on adversity and long-term health.

Several years ago, Brenner's staff interviewed a group of "high-utilizing clients"—that is, middle-aged adults whose chronic illnesses resulted in frequent emergency department visits and hospital stays. It turned out that this group had a high level of early-life trauma. That data eventually led Brenner to the 1998 ACE Study.

Reflection Question # 4 – What kinds of data and research would help you understand the impact of ACEs in your community? Does any such data already exist? If not, how could you gather it?

"It opened up a whole new lens on all our work," he said. "The ACE Study fills a gap" between the biology and physiology of stress and the ways that stress gets played out in adult decision-making.

"Alcohol, substance abuse, violence: poverty is full of bad choices," Brenner said. "But those

are coping strategies for chronic stress overlaid on early life trauma."

"So much awful stuff happens from birth to death here [in Camden], ranging from physical violence to tremendous chaos in people's families, not knowing where your next meal is coming from, substandard housing, unsafe schools…It's all-encompassing."

In an interview, Brenner recalled a patient he saw in his first year of practice, when he was just 28. The woman had diabetes; she suffered a foot ulcer and frequently came to his office with skyrocketing blood-sugar counts. "I would give her state-of-the-art medication, but I couldn't get her better," Brenner said. "Finally she came in one time and I put the chart down and said, 'Who are you?'"

The patient, it turned out, was a retired kindergarten teacher, raised in the South; she was widowed, depressed and still suffering the effects of early-childhood trauma. "You realize, in medical care, how little we really know people, how ill-equipped we are to pull their stories apart. I was practicing with half a stethoscope and one hand tied behind my back."

Today, Brenner practices differently, both as a physician and as a manager. He puts the lessons of ACEs to work in his own organization, the Camden Coalition of Healthcare Providers. "The people attracted to helping professions tend to have high ACE scores," he explains. "The ACE study made sense of why certain people were not responding well to doing this work, why they were getting enmeshed with clients and patients and with each other.

"We're much more focused now on…working with the staff that we have" to help them understand and change destructive patterns of behavior, Brenner said.

In one of the coalition's practices, the staff is working on a plan to screen all patients for ACEs, a prospect Brenner said unnerves some physicians because it challenges the medical model they've been taught. What's needed, he said, is a simple ACE-screening framework, like those used to assess for depression or substance abuse, that could be used by frontline staff. Meantime, the coalition created a short animated video (see below) showing the relationship between early childhood trauma and emergency room use.

Trauma Informed Care from Andrea Miller of the Camden Coalition of Healthcare Providers on Vimeo.

The priest and the physician continue to join forces; when CCHP brought on ten new AmeriCorps volunteers in August 2014, Putthoff and his youth trauma team took part in their orientation, training the volunteers along with new CCHP staff in ACE fundamentals, trauma and resilience.

Brenner predicts it will take another generation for physicians to learn about and embrace the ACE Study and change their practices in response. "The trauma-informed model has not yet made it over to medicine. For the medical community, it is the biggest of paradigm shifts. But it's how we are going to have to breathe."

Brenner, like Putthoff, believes that the next step is to take the trauma-informed approach to a broader group of practitioners in Camden—not only in medicine, but in law enforcement, juvenile justice, education and human services. "We're all scratching our heads about how to widen the circle," Brenner said. "In the meantime, I just want to make sure that we know what trauma-informed means here, that we're doing everything we can."

CAMDEN STORY TIMELINE - CLICK YEAR TO VIEW HIGHLIGHTS

2000

"Father Jeff" Putthoff co-founds Hopeworks N' Camden, an organization that provides in-school and out-of-school youth with GED classes, job training and website-design instruction so they can enter college or the work force

2003

Physician Jeffrey Brenner founds the Camden Coalition of Healthcare Providers, an integrated health care system designed to provide preventive and primary care while also addressing patients' social needs

2010

Putthoff and others at Hopeworks learn of the 1998 ACE Study and begin exploring the concept of trauma and its impact in Camden

2011

Brenner is the subject of a profile in The New Yorker that describes his use of data and mapping to identify "hot-spotters"—people with multiple and chronic ailments who are the heaviest users of health care—and respond with a team-based approach to help those patients manage their health, improve their stability and reduce the costs of their care

2012

Hopeworks begins a three-year process of reflection and training to become a trauma-informed, Sanctuary organization, guided by principles of nonviolence, democratic decision-making and shared responsibility

2013

Brenner receives a MacArthur "genius" grant for his model of cooperative care, now being replicated by more than ten communities across the country

Catholic Partnership Schools, a coalition of five Camden schools, hosts an Education Summit on the effects of poverty on children's learning, featuring keynote speaker Paul Tough, author of How Children Succeed: Grit, Curiosity, and the Hidden Power of Character

Putthoff and others organize a springtime Trauma Summit in Camden, attended by neighborhood activists, clergy members, teachers and the chief of police, with keynote speaker Sandra Bloom, co-director of the Center for Nonviolence and Social Justice at Drexel University's School of Public Health

"Trauma Triangle" workshops throughout the summer extend participants' learning about adversity, trauma and resilience

2014

Camden Coalition of Healthcare Providers produces a short animated video about the relationship between early childhood trauma and emergency room use

Catholic Partnership Schools hosts a second Education Summit that draws more than 300 educators to panels and workshops on how poverty shapes children's learning and growth; keynote speaker is Angela Duckworth, a University of Pennsylvania professor who has written about the role of grit in children's success

Both Robert Anda and Vincent Felitti speak at Camden community events; more than 70 people attend a three-hour training on the Sanctuary Model.

Hopeworks forms a youth trauma team to "humanize ACEs" in presentations to schools, community centers and other sites.

THE DALLES, OREGON STORY

A TOWN REMAKES ITSELF AS A TRAUMA-SENSITIVE SANCTUARY

"Our goal was to 're-script' the future...In addition to better outcomes for children, youth and families, we wanted to see a more positive outlook and more people taking pride in the community."
—Trudy Townsend, assistant to the county school superintendent

Tucked into a curve of the Columbia River, which marks the watery border between Washington and Oregon, lies the small town of The Dalles. Its claims to fame include being a major Indian trading site for 10,000 years, a camping spot for Lewis and Clark in 1805, and the terminus of the Oregon Trail.

Now The Dalles is seeking a different kind of notoriety. This city of 13,000 is the first in the nation to seek certification from the Sanctuary Institute—a model of organizational change that challenges every part of the community to examine and remake itself through an understanding of trauma.

Dalles (pronounced "dahl," with a silent "s") is a French word for "slabs" of rock around and over which the Columbia once roared. Oregonians silenced the "s" long ago. The population of this rural community, 70 miles east of Portland, is mostly white, 30% Hispanic, and less than 10% other ethnicities. "It's small enough that I'm able to call the chief of police and go out for coffee," says Trudy Townsend, assistant to the superintendent of the North Wasco County School District 21.

The community is no different from others its size: If people don't know you, they know someone who knows you. That intimacy provides a sense of

KEY INGREDIENTS:

- Recognition of past trauma—cultural, economic, political—and how it affects residents, leaders and organizations today
- Commitment to "walk the talk"—that is, to apply the research on trauma and resilience within partner agencies and to address community struggles
- Ongoing education through trainings, presentations and a monthly "learning circle" of community partners

belonging and connection that is hard to find in larger cities. But if you had told any leader—or citizen—in The Dalles in 2008 that deepening those connections and becoming a trauma-informed community was on the horizon, they would not have believed it.

SAMHSA GRANT STARTS THE BALL ROLLING

That was the year when SAMHSA (the federal Substance Abuse Mental Health Services Administration) awarded the community a five-year, $2.7 million Safe Schools/Healthy Students grant. It specified that law enforcement, mental health, juvenile justice and education agencies work together to make schools safer and students healthier. "We added the Department of Human Services," says Townsend, who was hired as project director. "One of SAMHSA's hopes for an outcome was that communities would build better relationships and systems."

www.SAHMSA.gov contains a wealth of information on behavioral health, including grant opportunities

Many communities that received the grants hired school resource officers. The Dalles did something different. With the exception of the school district, which was the grantee, the partners on the core team did not receive any direct funding. They wanted to focus on sustainable change, so they combed the agencies' data for specific problems and asked how each partner could help resolve them. For example, when data showed significant behavioral issues at the middle school among a group of students, the director of juvenile justice volunteered to greet those students at school every morning, and a targeted intervention for boys was put into place.

Reflection Question # 4 – What kinds of data and research would help you understand the impact of ACEs in your community? Does any such data already exist? If not, how could you gather it?

The core team opted to put resources into after-school programs, mental health and crisis intervention for students in the community's three elementary, one middle and one high school. "We began to look at what was going on with families," says Townsend. The services included therapists who could respond within 24 hours, five free counseling sessions for families and long-term intervention referrals. Over the five-year life of the grant, data showed a 13.2% decrease in student use of alcohol, 2.5% decrease in marijuana use, a 14% reduction in office referrals, and a decrease in physical fights. Students also reported feeling safer in school.

Behind the scenes, the grantees were building a foundation of trust that would take them on a journey they did not anticipate. The chief of The Dalles police department; the director of the Mid Columbia Center for Living, which provides mental health services; the superintendent of the North Wasco County School District; the regional director of theOregon Department of Human Services; the director of Wasco County Youth Services and the administrator of the Wasco County Commission on Children and Families met once a month for five years. "These weren't midline managers," says Townsend. This core team comprised people who could make decisions about the direction their organizations were heading. "It was really amazing to watch them form relationships and build trust."

A TURNING POINT: UNDERSTANDING THAT TRAUMA IS A GREAT EQUALIZER

In 2011, year three of the grant, core team members had a pivotal conversation about the legacy of their project and how they could improve their community. The conversation took place during a two-day planning meeting in San Diego, sponsored by the Safe Schools/ Healthy Students Initiative. Team members concluded that trauma was the great equalizer;

it impacts individuals, organizations and whole communities. They decided to pursue the notion of trauma-informed care as a common concept.

Reflection Question # 1 – In your community, which groups, agencies or individuals have already been exposed to the ACE study and the concepts of toxic stress and resilience?

"Then we went looking for a method to guide our madness," says Townsend. They found it a month later, when Maggie Bennington Davis, a psychiatrist at Cascadia Behavioral Health Care in Portland, did a one-day training on trauma-informed care. Each of the grant partners sent staff. More than 250 people packed the room.

That was the core team's first exposure to the research around adverse childhood experiences, including the CDC's ACE Study and the neurobiology of toxic stress on children's brains. Davis told them about the Sanctuary Institute, based in Yonkers, New York; the grantees were intrigued enough to investigate.

The Sanctuary Institute recognizes the "enormous stress" by human service agencies and offers a process for balancing external pressures on the agency together with support for those served.

Sanctuary, as it is commonly called, is a trauma-informed model for delivering care that takes into account the impact of exposure to violence, abuse, and other traumatic experiences on individuals, families, staff, and organizations. Hundreds of organizations have completed the three-year training required to earn certification from the Sanctuary Institute. Sanctuary has been integrated into residential treatment settings for children, domestic violence shelters, group homes,

outpatient settings, substance abuse programs, parenting support programs and schools. But never—until now—into the workings of an entire town.

Representatives of the Sanctuary Institute visited The Dalles in May and June 2012. They met with the core team and, while the group was not yet fully convinced about committing to the training, its members agreed to organize a series of events: a community assessment, a two-day intensive training and a luncheon for community leaders that included the mayor, legislators and representatives from business, economic development and social services. The two-day training was open to each of the participating organizations. Members of the faith community, regional jail and the non-profit sector joined in.

THE NICKEL DROPS ON ACES AND SANCTUARY

Then the core team, which still needed to feel certain that the model could work for The Dalles, sent representatives across the country for a five-day Sanctuary Institute training. It was there that the ACEs nickel dropped for the superintendent. "It was really a revelation," says Townsend. "The superintendent began talking about ACEs with the community outreach team, a legislative advocacy group, meeting with the mayor, and with other school superintendents. We began to spread the message about ACEs."

With the final year of the Safe Schools/Healthy Students funding approaching, the core team decided to move quickly, investing time, effort and significant funding into training and implementing the model within organizations.

"Our goal was to 're-script' the future for our community," says Townsend. "In addition to better outcomes for children, youth and families, we wanted to see a more positive outlook and more people taking pride in the community. Just as we were getting started, it seemed that disaster struck." Within a span of two weeks, the community experienced two homicides and a police-involved shooting. The last incident happened during a technical assistance visit from a Sanctuary Institute representative.

"As a community, we were in shock," recalls Townsend. "What we did as a group was a trauma-informed response. The shooting happened on Wednesday. By Saturday night,

we had organized a candlelight vigil." The local newspaper reported how the community had come together. "It was a story that marked a first step toward literally re-scripting the future," she notes.

Throughout the winter, the Sanctuary trainers worked with team members from each organization. "We did a ton of work," says Townsend. "It was a big push to the end." In May 2013, Sandra Bloom, founder of Sanctuary, spent nearly a week in The Dalles. She trained 45 people during an intensive two-day workshop and did a half-day community-wide presentation for about 250 people.

"The community training was open to anyone," says Townsend. "We did a huge marketing push. We hit every media outlet and invited everybody and his brother. We also hosted a luncheon for community leaders from government, faith community, business, non-profit, medical community and economic development. It was very successful."

Funding from the Safe Schools/Healthy Students Initiative ended in June 2013, but The Dalles' core team had made progress:

- As a group, they began to understand how past trauma had affected the community. It dated back at least to the 1950s, when The Dalles Dam was built and eventually submerged thundering Celilo Falls. The construction required a huge influx of workers; a company town was built, including its own schools and school district. "It created two sides of the track," says Townsend. Ten years ago, after a vicious debate, the two high schools and districts merged. This came just after the closing of a large aluminum plant that had, for decades, provided steady high-wage employment for low-skilled workers. The Dalles took a huge economic hit; many families left or fell into poverty.
- Leaders acknowledged how deeply the community felt about current trauma—not only the recent violence, but the acrimony that occurred when a state law barring Native American mascots was passed. The Dalles-Wahtonka High School Eagle Indians logo, which shows both a sharp-beaked bird and a face in profile wearing a feathered headdress, will be replaced by a new symbol—one determined by the community.
- All major social service organizations have agreed to implement Sanctuary. This includes the school district, Mid Columbia Center for Living, the regional child welfare office of the Oregon Department of Human Services, Wasco County Youth Services Department, the Northern Oregon Youth Corrections Facility, as well as many smaller non-profit

organizations such as the Haven From Domestic Violence. With a small amount of coordination, community partners come together each month in a learning circle where they take turns offering Sanctuary training to keep it fresh and introduce new partners to the model.

- Core group members have done many presentations about Sanctuary to local government, including the county board of commissioners and city government, intergovernmental organizations and statewide partners.
- The Dalles' experience has inspired the Oregon Department of Health Services to explore the Sanctuary Model as a statewide approach to culture change within its child welfare division.

Significant changes have occurred in the schools. The first step the district took was to engage its leadership; instead of the occasional monthly meeting, the leadership team now meets twice a month at 6 a.m., a good hour to put trauma-informed practices to the test. The team includes directors, principals, vice principals and the superintendent. A smaller cabinet team meets every week and practices the Sanctuary commitments. The district also trained school board members in Sanctuary principles.

"We really concentrate on working through the issues using the Sanctuary problem solving method," says Townsend. "If we have an issue that we know to be controversial and likely to have traumatic implications, we apply the processes. For example, we took a trauma-informed approach to changing the school mascot," forming a committee dedicated to Sanctuary principles including democracy, open communication and nonviolence. That was reflected in how a local news organization covered the issue, quoting the school board chairman who used Sanctuary Model language.

Reflection Question #10 – When you envision a resilient community, what do you see? How would it be different from what currently exists? How will you get from here to there?

The district is also doing more training—in September 2013, Maggie Bennington Davistrained all 300 school district staff in trauma-informed practices—and is changing its expulsion

procedures. In the past, during an expulsion hearing for a child with explosive behavior issues, the expulsion panel may have "listened to a teacher's horrified story and expelled the child," says Townsend. Now the superintendent requires more digging into a student's history, looking at other organizations the student is or is not engaged with and for triggers surrounding the event. The result may still be expulsion, but the approach has changed from "what's wrong with this kid?" to "what's happened to this kid?" And the expulsion, which used to merely kick a kid out of school, now comes with a plan that helps the child and the family.

When there are problems among staff members—from the school district and mental health, for example—and those staff members rant to their bosses, the leaders can call each other and find a way to solve the problem. "Both have the same concept of care in mind," says Townsend. This has reduced chaos and increased equanimity in all of the organizations participating in Sanctuary.

SAMHSA GRANT ENDS; COMMITMENT TO SANCTUARY CONTINUES

Still, these are baby steps. There are pockets of early adopters in The Dalles and people who don't buy into the trauma-informed concept at all. And because the SAMHSA grant ended, so did some of the therapeutic resources provided to students. Families no longer have access to free counseling, though the school still provides a referral service. (View the Dalles Chronicle articlehere) Because of the community's commitment to Sanctuary, the school district found a way to maintain a small level of coordination while the core team looked


The Dalles Chronicle

Safe Schools yields lasting benefit

The Dalles Chronicle highlights in this article the results of the Safe Schools – Healthy Students grant: "Safe Schools Yield Lasting Benefit"

for additional funding. The funding gap lasted only six months. At the beginning of 2014, the Oregon Health Authority provided an 18-month grant to the Mid Columbia Center for Living. The funding has been used to continue Sanctuary training and expand the effort to cover neighboring communities. "It's a band-aid to keep us going," says Townsend. "I need to keep looking for funding."

During the first six months of the grant, 375 people were trained in the psychobiology of trauma, mental health first aid, and collaborative problem-solfing. In August, 55 people from nine new organizations were trained in Sanctuary.

As the number of people and organizations increased, they decided to launch a web site –CreateSanctuary.org — to post information about training and events and to share information about organizations' achievements.

"There is a ton of stuff going on all the time," says Townsend. "There have been book clubs and study groups. A local physician attended one of our meetings and was inspired to write a beautiful article in her church newsletter about trauma-informed care and our local efforts."

In addition, in March 2014, the Mid Columbia Center for Living joined the National Council on Behavioral Health's 2014-2015 Trauma-Informed Learning Community. "Actually, we joined as a collaborative," explains Townsend, "but it is the Center that is most engaged. We joined because they have different screening tools that we're interested in learning about. And it fits, because they use a lot of Sandra Bloom's work."

Reflection Question #7 – What would you or your organization do to prevent ACEs and boost resilience if you had absolutely no budget? What would you do if funds were unlimited?

"We have come a long way in a very short time," says Townsend. "And we have a long way to go. We're committed to implementing this community wide. We're re-scripting the way our community reacts to trauma."

THE DALLE TIMELINE - CLICK YEAR TO VIEW HIGHLIGHTS

2008

SAMHSA awards North Wasco County School District a five-year, $2.7 million Safe Schools/Healthy Students grant

September 2011

Core team has conversation about project legacy; identifies trauma-informed care as concept

October 2011

Core team learns about ACE research and Sanctuary Model

May-June 2012

Sanctuary Institute representatives visit The Dalles. Team organizes community assessment, two-day training, luncheon

July 2012

Core team members participate in five-day training at the Sanctuary Institute in Yonkers, New York

May 2013

May 2013: Sanctuary founder Sandra Bloom visits The Dalles to lead two-day workshop, half-day presentation for the community, and luncheon with community leaders

June 2013: Safe Schools/Safe Schools Healthy Students grant ends; school district maintains low level of coordination

September 2013

All 300 school district staff receive training in trauma-informed practices

January 2014

Oregon Health Authority awards 18-month grant to Mid Columbia Center for Living to continue Sanctuary

training. During the first six months, 375 people completed ongoing training.

August 2014

Nine new organizations join Sanctuary collaborative.

CreateSanctuary.org web site launched for Columbia River Gorge area.

THE IOWA STORY

STATE DATA FUELS THE ACE CONVERSATION

"For us, one of the most compelling results of the research is that trauma doesn't discriminate."
–Suzanne Mineck, president of the Mid Iowa Health Foundation

Most Iowans didn't learn about the Centers for Disease Control's ACE Study until early 2011. But in the three years since then, the state has completed two ACE surveys, one of them published, with a third survey underway and a fourth scheduled for 2015. Iowa has hosted three ACEs summits; two statewide summits in 2014 focus on ACEs in early childhood, and education and juvenile justice. And nearly every sector—including health care, education, social services and corrections—is busy answering the question: How do we integrate this knowledge into what we do?

"To this day, I can't find out who knew to bring him here," says Suzanne Mineck, president of theMid Iowa Health Foundation, referring to physician Robert Anda, co-principal investigator of the CDC's Adverse Childhood Experiences Study. Anda was invited to give the keynote at the state's annual Early Childhood Iowa Congressin 2011.

"The ballroom was packed—maybe 300 people," Mineck recalls. "After his presentation, a group of us walked out and looked at each other. We decided that what we'd heard was really important, and we needed to do something with it."

KEY INGREDIENTS:

- Created a sense of urgency by reviewing local and national data on ACEs
- Convened summits, drawing large crowds and exposing local leaders to national experts on trauma and resilience
- Received support from a small and nimble foundation that could conduct local research and data collection

Over the next few months, the ACE Study kept coming up in "water-cooler" conversations among people in Iowa's health and child welfare communities. So the health foundation decided to bring two questions to a small group of state and community leaders:

"Is this relevant to the work in our state? If the answer is 'yes,' what are we going to do about it?"

Fielding those questions were Sonni Vierling, state coordinator for the 1st Five Healthy Mental Development, a project of the Iowa Department of Public Health, and representatives from the Polk County Health Department, Orchard Place Child Guidance Center, United Way of Central Iowa, and Prevent Child Abuse Iowa.

Reflection Question # 1 – In your community, which groups, agencies or individuals have already been exposed to the ACE study and the concepts of toxic stress and resilience?

"Data is what led the conversation from the beginning," says Mineck. The CDC's data plugged real science into what many on the front lines of health and social services already knew, but the numbers also begged the question: Does Iowa have the same incidence of childhood adversity?

Iowa's Department of Public Health was willing to include the ACE survey in the Behavioral Risk Factor Surveillance System (BRFSS) that all states use to measure rates of obesity, smoking, cancer, teen pregnancy and other health issues. But it would cost $24,000 to do the survey.

Reflection Question # 4 – What kinds of data and research would help you understand the impact of ACEs in your community? Does any such data already exist? If not, how could you gather it?

"One of the benefits of a small foundation is that it can be very nimble," says Mineck. "For the first time, the foundation made a commitment to fund the majority of the data collection, and the Department of Public Health scraped together additional dollars for the rest."

The next step was to bring together a larger group of stakeholders, mainly to find out if other people shared the initial group's conviction that the ACE Study and its implications mattered immensely.

The group scheduled an invitation-only meeting for October 2011 and invited Anda for an encore presentation. About 200 people attended the state's first ACEs summit.

"We had identified around 30 department and coalition leaders," says Mineck. They included representatives from the state's health systems, community organizers, policy advocates, safety net providers, the United Way of Iowa, Visiting Nurse Services in Des Moines, 1st Five, research institutions and representatives from the domestic violence, substance abuse, and home visiting divisions of the state's Department of Public Health.

"After Dr. Anda's presentation, those leaders gathered in a room, and we posed the question: 'Are you interested in taking this work forward in Iowa?' The resounding response was 'Yes!'"

That was the beginning of the Central Iowa ACEs 360 Steering Committee, which included representatives from fifteen state and local agencies. Vierling became its coordinator.

From there, the committee held a strategic visioning session to determine its goals and objectives. Their first priority was to educate, educate, educate….as many people as possible about ACE and neuroscience research.

The group planned a second ACEs Summit for June 2012. It was free to attendees—some of the steering committee members picked up the cost—and open to anyone. Anda came back once again; another speaker was Laura Porter, former director of the Washington State Family Policy Council. The council had led that state's efforts to disseminate research surrounding adverse childhood experiences and to foster a range of community-based, trauma-informed, resilience-building projects.

"We sent the invitation to the initial group and asked them to forward it to anyone they thought would benefit," says Mineck. "It was fascinating to watch the e-mails webbing through our state. People were getting the invitation sent to them from eight to ten different people."

Reflection Question #2 – In your community, who has yet to learn about this information?

The networking worked: 800 people showed up for the half-day summit. "Eighty percent of Iowa's ninety-nine counties were represented, as were all different sectors," says Vierling. People came from public health, human services, education, early childhood services, foundations, non-profits, law enforcement and criminal justice.

"The biggest surprise from that summit was the sheer number of people who wanted to be there," says Mineck, "people who took the time and paid their travel expenses to come. I was most thrilled with the broad cross-sector representation."

Another surprise was that learning the research around childhood trauma became a personal journey for many people, she notes. "We had been warned that people hear this on a personal level first and can then move to a professional level. That continues to be humbling, and a critical aspect to remember, as we continue to educate our communities."

The conference focused on ACEs 101: the epidemiology, the brain science and how organizations were turning the research into practice. In the months following the summit, participants took what they'd learned and began spreading that knowledge around the state. The Central Iowa 360 Steering Committee developed a web site with resources to support the effort.

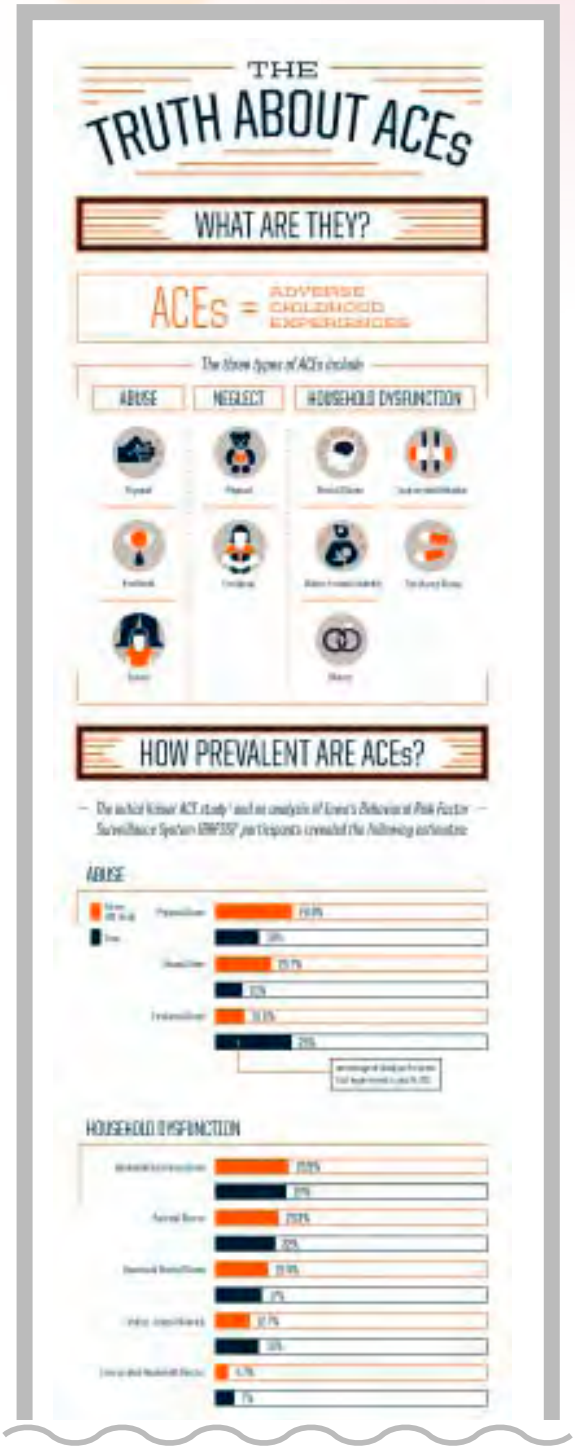
In October 2013, the committee hosted the third ACEs summit. This time, they charged $25 to cover lunch. "It was sold out," says Vierling, who is now the vice president of the Integrated Health Program at Orchard Place in Des Moines. "Because we had only so many seats for lunch, we capped attendance at 625. We had to turn people away."

This time, specific groups were targeted, and people were ready to delve beyond the basics, says Vierling. "It wasn't ACEs 101."

Pediatrician Nadine Burke Harris, founder of the Bay Area's Center for Youth Wellness (CK) had breakfast with thirty health practitioners, gave a keynote address at the conference, then was whisked to Des Moines University for a lunch with more than a hundred medical and nursing students. Porter, from Washington, who'd been invited for a second appearance, had breakfast with representatives from the Department of Education before giving her presentation to the 650 attendees.

The steering committee also presented the 2012 Iowa ACEs data in a report, "Adverse Childhood Experiences in Iowa: A New Way of Understanding Lifelong Health." The survey, whose findings were similar to the original ACE Study, showed that 55% of Iowans had at least one adverse childhood experience, while 1 in 5 of the state's residents had an ACE score of 3 or higher. The report also included a county-by-county breakdown of ACEs.

The numbers showed that Iowans experienced more emotional abuse than physical and sexual abuse, while adult substance abuse was higher than other household dysfunctions. "It was surprising that emotional abuse was so high," says Vierling, "higher than other states."



Infographic of Iowa's ACE and BRFSS data.
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Among the telling graphics in the report was one showing that 5 out of every 30 students in a typical Iowa classroom lived with a parent who had an ACE score of 4 or higher. Children living with parents who have high ACE scores may be in situations of toxic stress; the kids' behavior in school—acting out, withdrawing, failing academically—may indicate that they are under stress, too.

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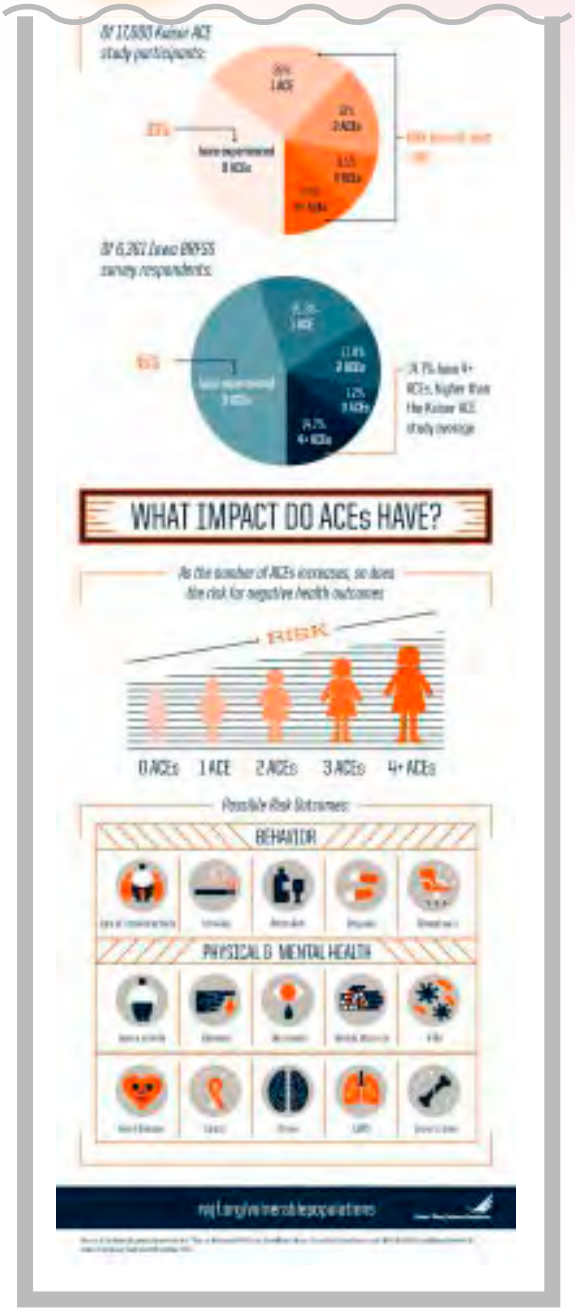


The steering committee decided to include in the report stories about people who had experienced many ACEs but also had resilience factors such as the presence of a stable, nurturing adult. These individuals were working to lead balanced, successful lives. "It's important to weave these stories in," says Vierling. "The report—and the day—ended on a feeling of hope. This is going to take a lot more work, but there's still hope."

In 2013, when the 2012 data was being analyzed, the steering committee learned that the CDC's ACEs BRFSS module did not contain questions related to neglect, as the original study had. The 2013 data was already being gathered, but, working with Anda, the steering committee was able to identify and secure funding for six neglect questions to be included in the 2014 survey. The total cost for this year's survey is $40,000.

Iowa's data has had a two-fold impact: The state-specific numbers are an affirmation of what many people already knew. And they are convincing legislators.

"It's hard to deny that this is an issue for our state when you can see the data and the map," says Mineck. "It's relevant whether you live in a very rural or urban community. It brought legitimacy to the conversation."

Over the last two years, the steering committee has engaged people from other sectors, including representatives from a job-placement coalition for people with substance abuse and criminal backgrounds. "The impact of trauma was quickly recognized by the leaders of that coalition," says Mineck, especially on why people with trauma backgrounds were having difficulty keeping a job.

And although they don't sit on the steering committee, the corrections, criminal justice and juvenile court judges are involved in the state's ACEs conversation. The state corrections department is including trauma-informed practices in its mental health services for prisoners, with the hope that it will reduce recidivism.

The challenge now? To get beyond the initial conversations, says Mineck, to identify what implementing trauma-informed and resilience-building practices mean. Some of the current work:

- Prevent Child Abuse Iowa is staffing an initiative that is doing grassroots work to create community conversations around ACEs.
- The Iowa Foster and Adoptive Parents Association is making its entire curriculum trauma-informed.
- A Central Iowa trauma-informed stakeholders group is educating children and family support services workers on the impacts of toxic stress and appropriate trauma-informed practices.
- Des Moines Public Schools are beginning to provide training for teachers, administrators, support workers and staff around ACEs and trauma.
- United Way of Central Iowa is educating all of its agency organizations to become ACE-informed, to help them identify how the research connects with their mission and priorities.

"There's a lot of conversation around trauma in the Department of Human Services," says Mineck. In 2013, news stories uncovered that a state-run facility was using restraint and

seclusion irresponsibly. Some girls had been put in small concrete cells for a year, with only limited access outside. The center was closed.

"The shining side of that tragedy is that there's a pretty good conversation around trauma, now," she says.

The Mid Iowa Health Foundation is using the research to inform all of its grant-making. "Preventing or addressing adverse childhood experiences has become the lens to determine our current funding partners right now," says Mineck. An organization for teen mothers is becoming trauma-informed; a homeless shelter is adopting the Sanctuary Model so that its entire organization operates with sensitivity to trauma and its impact. The health foundation has also helped support the development of an ACEs online module for adult learning, aimed at people who are working with vulnerable children and adults. Prevent Child Abuse Iowa has also been doing a "Community-based prevention response to ACEs" initiative. Here is a link to that program.

Two big questions stand out are: With what organization should the ACEs steering committee now live? And what is the role of the legislature in the state's effort to prevent childhood trauma and change systems so that they no longer hurt already traumatized people?

Steering committee members haven't answered the first question yet. "We struggle with that every time we come together," says Mineck. "Because we have been very intentional about keeping this work multi-sector, selecting one lead organization hasn't seemed to be a good fit thus far."

And although the legislature has been receptive to learning about the research around adverse childhood experiences, members keep asking for "the one thing" they should do.

"That's about impossible," Mineck says. "The reality is the responses to ACEs are wide-ranging and long-term. We need to do a better job articulating to the legislature where those opportunities for impact exist." So far, there's talk about recommending that the Department of Education begin training teachers about trauma-informed practices. The Department of

Corrections has asked the legislature for additional funding for trauma-informed mental health. And there's a movement to start and fund a children's mental health system.

The message is working, says Mineck, because the legislature allocated $50,000 to cover the collection and analysis of a 2015 Iowa ACEs survey through BRFSS.

The awareness that has emerged in Iowa about childhood trauma and its short- and long-term consequences has been nothing short of amazing, says Mineck. She cites three elements that contributed to the rapid shift:

- The people around the table were leaders who were in a position to make decisions
- They were experienced in other initiatives, so they knew how to move a conversation forward into action
- The leaders represented a cross-section of sectors from the state.

"Many of us look at those who have stepped in who want to be a part of this, and we've been hard-pressed to find people who don't have a story" involving personal or family trauma, says Mineck. "It's important to find some way to share that. For us, one of the most compelling results of the research is that trauma doesn't discriminate. People in all different neighborhoods, groups and socio-economic status are impacted by this. It levels the room."

IOWA TIMELINE - CLICK YEAR TO VIEW HIGHLIGHTS

2011
Robert Anda does presentation about CDC's ACE Study at the Early Childhood Iowa Congress; 300 people hear about the research, many for the first time
Ad hoc steering committee begins meeting; Department of Public Health agrees to include ACE survey in state's BRFSS (Behavioral Risk Factor Surveillance System), partially paid for by Mid Iowa Health Foundation
Anda invited back for first Iowa ACEs Summit, an invitation-only meeting of stakeholders; 200 people attend
Central Iowa ACEs 360 Steering Committee founded, with about thirty people; group begins meeting, plans second ACEs Summit and makes commitment to do three years of ACE surveys
2012
Second ACEs Summit open to anyone in state. Anda and Laura Porter, former director of Washington State Family Policy Council, are major speakers; 800 people from eighty percent of Iowa's counties attend. Focus is basic information: "ACEs 101"

2013

Third ACEs Summit. Sold-out attendance; 625 people gather to talk about next steps. Steering committee presents first Iowa ACEs survey from 2011 data

Trauma-informed/resilience-building practices start to be implemented in schools, homeless shelters, prisons, mental health treatment and communities

2014

Fourth state summit focuses on ACEs: 2014 Child Abuse Prevention and Family Support Conference hosted by Iowa Department of Public Health and Prevent Child Abuse Iowa. The three-day conference attracts 500 people. Workshops focus on how to use ACEs research in practice.

ACEs Iowa creates online learning module for ACEs and trauma-informed/resilience-building practices; Prevent Child Abuse Iowa starts "Community-based prevention response to ACEs" initiative.

Iowa Legislature allocates $50,000 to cover collection and analysis of 2015 ACE data through BRFSS.

Steering committee members and people from Iowa regions create group on ACEsConnection.com.

Developing Brain, Developing Accountability conference for educators and people in the criminal justice systems, to look at how brain science informs current punitive measures, and at new concepts to help youth succeed.

THE MAINE STORY

NETWORK URGES EVERYONE TO "JOIN THE CONVERSATION" ABOUT RESILIENCE

"[Our goals are] to get funding so we can really move things forward and bring more people on…so we can change how we think about trauma in our state." —Leslie Forstadt, co-facilitator of the Maine Resilience Building Network

Sue Mackey Andrews will talk to anyone about ACEs: Pediatricians. Early childcare workers. Parent advocacy groups. And those on the front lines who work with kids, like the longtime school bus driver from rural Maine, a gruff and taciturn man who insisted, during a half-day school district inservice, that trauma and resilience had nothing to do with his work.

The driver also told Andrews that he would not start the bus each day until he had made eye contact with every single child and greeted him or her by name. And that, Andrews responded, was exactly the relevance of his work to build resilience.

KEY INGREDIENTS:

- Early government support with ACEs declared a priority by the Children's Cabinet in 2005
- A focus on resilience rather than trauma – as reflected in the coalition's name
- A commitment to the "collective impact" model with Maine Resilience Building Network (MRBN) as the "backbone"

The tagline of the Maine Resilience Building Network (MRBN), which Andrews co-facilitates, is "Join the Conversation." The group, formed in the spring of 2012, brings together practitioners in medical care, education and behavioral health, along with those working in business, law enforcement, the military, juvenile justice and faith communities.

Since its early meetings, where a half-dozen people, all of them doing ACE-related work, brainstormed a name for their new network, MRBN has grown to include 77 members, with reach into all of Maine's sixteen counties.

From the beginning, said Andrews and MRBN co-facilitator Leslie Forstadt, associate

professor with the University of Maine Cooperative Extension, the group agreed that the message should focus on wellness and healing rather than illness and trauma.

The word "resilience" had to be part of the name because, said Andrews, "We talk about how it's never too late to realize your ACEs and, through support and personal discovery, overcome them." The term "building" captured the sense of a growing effort, and "network" aptly described how individual sites would function autonomously while sharing their innovations, challenges and questions.

MRBN began small, growing mostly by word-of-mouth and remaining committed to a model of "collective impact"—the understanding that no single agency or program can solve a complex social problem, but each can work to advance a shared mission. The collective impact model calls for a "backbone organization" that does the work of convening and communicating among members; together, Andrews and Forstadt are the spine of MRBN.

This is MRBN's mission: "To promote resilience in all people by increasing and improving our understanding of traumas and stressors such as ACEs and why they matter." And while the network has grown to include geriatricians and experts in adolescent medicine, its focus is primarily on children, pre-natal to age five, and their families—which, today, includes teen parents and grandparents who are raising children. "That's where we felt we could have the biggest impact," Andrews said.

Even before MRBN, Maine was primed to think about trauma and resilience. The state is New England's poorest, with one in four children being raised in poverty (the national average is 1 in 5). In the rural "rim" counties, the child poverty rate is a sobering one in three. Unemployment is higher than in nearby Vermont and New Hampshire; many children lack school readiness, and the incidence of domestic violence is on the rise.

> Reflection Question #5 – In addition to the ACEs counted in the 1998 Kaiser study, are there other sources of adversity particular to your community, such as neighborhood violence, racial/ethnic discrimination or the trauma caused by a natural disaster like flood or fire?

Prior to the 1998 publication of the Centers for Disease Control Adverse Childhood Experiences (ACE) Study co-authored by Robert Anda and Vincent Felitti, Maine had received several federal grants for trauma-related work with children and adults, including one called the "We Remember" project, given to the Passamaquoddy Tribe to create a community-based, culturally competent system of care for children with severe emotional and behavioral disorders. By the time Felitti first visited the state, in 2005, his work brought confirming data to what many practitioners had been witnessing for years.

Andrews remembers that "aha" moment. "When I first heard Dr. Felitti talk, I remember thinking not only how it applied to my professional work but also to my family of origin." That happens often, she said, in educational sessions about ACEs, which encourage participants to reflect on their own experience as a way of understanding the research about early adversity and its impact on health and behavior.

But a single "aha" is not enough to change minds—let alone practice and policy—across a state of 1.3 million people. Since 2005, Felitti and other nationally known experts on trauma and resilience, including Jack Shonkoff of the Harvard Center on the Developing Child, have visited Maine numerous times. Felitti has spoken to the Child Abuse Action Network and the Maine Academy of Pediatrics; he has talked with juvenile justice officials, social workers and psychiatrists. He was interviewed on Maine Things Considered, a public radio program.

These visits brought the research on ACEs to a variety of Maine audiences. Adversity and resilience became more familiar concepts to practitioners, who learned through multiple exposures to the information and opportunities to ask questions.

Initially, Maine's work on adversity and resilience gained support at the highest levels of state government. By 2005, the governor's Children's Cabinet had declared addressing ACEs in policy and practice to be one of its top 3 priorities. The Maine Children's Growth Council, formed by statute in 2007, reflects an understanding of ACEs in its mission to develop and maintain "sustainable social and financial investment in healthy development of [Maine's] young children and their families."

Even so, knowledge about ACEs was slow to spread. In 2011, the Health Accountability Team of the Maine Children's Growth Council conducted a statewide survey to learn whether practitioners knew about the ACE research and if they were applying it in their work. They surveyed health care providers, early care and education providers, legislators, mental health professionals, law enforcement officials and members of the business community.

The Maine ACEs Study, published in December 2011, found that fewer than 1/2 the respondents knew about Anda's and Felitti's original ACE Study, though nearly all thought it was "important" or "very important" to understand how early trauma shaped adult outcomes.

Reflection Question # 4 – What kinds of data and research would help you understand the impact of ACEs in your community? Does any such data already exist? If not, how could you gather it?

The state study also drove the national data home. Applying the CDC's ACE Study ratios to Maine children in foster care, the Maine study estimated that—if those children received no intervention and their adverse experiences continued to bother them—20 of every 1,000 children would become obese; 40 would attempt suicide, 70 would engage in illicit drug use, 80 would have unintended pregnancies and more than 100 would suffer depression.

Reflection Question #6 – Who can be your partners in the work of preventing childhood adversity and building resilience among individuals and families? Think about obvious partners and uncommon/unlikely allies and collaborators

What's more, Maine put a price tag on that suffering. A "return on investment" study showed that the state spent over $3.5 billion annually on outcomes relevant to ACEs, including the treatment of obesity, diabetes, cancer, depression, substance abuse and sexually transmitted infections.

Once the Maine ACE Survey was finished, the Health Accountability Team gathered the study's authors along with practitioners from about half a dozen sites statewide who were doing work related to ACEs. They held a day-long retreat, and from that, MRBN was born.

"We wanted to harness the great work that was already happening around the state to get people on the same page and help them feel they were part of something bigger," said Forstadt, MRBN's co-facilitator.

MRBN meetings now happen about five times a year, with extensive electronic communication, subcommittee meetings, information sharing and site visits in-between. The collective impact framework shapes the network's philosophy and practice. Early on, the group received $47,000 from the Bingham Foundation, a local philanthropic group; the original intent was to use some of those funds to give $1000 to each of 20 sites, a way of "seeding local resources," Andrews said.

But after some time and discussion, the group decided instead to fund collective projects such as ACEs Summits—educational events held around the state—and a family resilience support curriculum, currently in the pilot stage.

The ACE Summits have proven to be an effective vehicle for spreading information and catalyzing action. Because a presentation that focuses only on adversity can be "a little heavy," Forstadt said, "and leave folks without tools for what to do," the ACE Summits combine a session on "ACEs 101" with a longer focus on resilience and intervention.

"For every 35 people you present to, there will be at least one or two who are really jazzed," Forstadt said; the Summits aim to give those people strategies, skills and concrete ways to get involved. MRBN has conducted seven ACE Summits, with 14 scheduled for 2014; Andrews has fielded requests from school districts, tribal groups and county governments.

Meantime, MRBN has helped to support local innovation around ACEs, such as the "resilience bookmark," a glossy card with a succinct definition of resilience, developed by theG.E.A.R. Parent Network, a parent support and educational network that is also a member of MRBN. Two school systems want to pilot an ACE screening as part of their

in-home visits to all pre-kindergarten children, and a dozen pediatric or family practices statewide are interested in incorporating an ACE screening.

And the conversations continue. Andrews and Forstadt are working to build a speakers' bureau to provide consistent trainings that can be offered statewide; the MRBN website directs users to news and resources about ACEs. Forstadt wrote an op-ed about ACEs for the Bangor Daily News, Maine's second largest newspaper.

"ACEs don't belong to any one group or discipline in our state," Andrews said. "When we do a session or a meeting at the local level, it's done on an inter-agency, inter-disciplinary basis."

While that diversity is a strength, it also requires faith in the collective impact framework and respect for the different ways that various organizations approach the work. "Collective impact honors diversity of thought, what people bring to the table, and it acknowledges that this kind of work takes time," Andrews said.

The G.E.A.R. Parent Network provides downloadable posters, pamphlets and bookmarks to share messages for parents

As MRBN grows, one challenge is to ensure that new members understand and are faithful to the network's mission, which includes responsible and sensitive use of any ACE

screenings. Recently, an organization interested in MRBN membership said it planned to use the ACE survey for data collection only, not to foster conversations or interventions with clients.

That violated MRBN's commitment to avoid inflicting further trauma; Andrews talked with the group's membership and decided that organization was not suitable for MRBN. "Now I do an orientation to MRBN at every other meeting and go over what we expect."

Data collection has also been a challenge. While Andrews and Forstadt receive evaluations from every ACE Summit, they lack a way to track sites' innovations and outcomes. "We had a very static data collection tool that I wanted everybody to use, and it just didn't work," Andrews said. "Now I'm sending notes: what's the one thing that's happened in the last 30 days with your ACEs work that you really want to share or celebrate?"

Andrews continues to seek funding for MRBN: enough to keep the website current, host more ACE Summits, train speakers and support the family resilience curriculum. She'd like to replicate the CDC's ACE Study in Maine, to obtain a clear sense of how ACEs impact children and adults statewide. She is paid to work five hours a week for MRBN, but puts in at least 20 more as a volunteer. Forstadt, on faculty with the University of Maine Cooperative Extension, is not paid by MRBN for her time, though she was contracted to conduct the Maine ACE Survey.

Reflection Question #7 – What would you or your organization do to prevent ACEs and boost resilience if you had absolutely no budget? What would you do if funds were unlimited?

At just 18 months post-inception, "MRBN is not even a toddler," said Forstadt. "We have yet to see where this is going to go, and it's exciting to have this identity: a logo, a website, a presence and an impact statewide.

"[Our goals are] to get funding so we can really move things forward and bring more people on…so we can change how we think about trauma in our state." Andrews agrees. "I do think

this is the most potentially high-impact research on health, education and prosperity that we have in front of us right now. It has relevance in every corner of the work that gets done in our state, and the cost savings in that could be realized in health care and public safety are huge. Equal to that are the human savings that could be realized if we just supported people in a better way."

Reflection Question #10 – When you envision a resilient community, what do you see? How would it be different from what currently exists? How will you get from here to there?

MAINE TIMELINE

1997

Passamaquoddy Tribe receives a five-year grant from the Substance Abuse and Mental Health Services Administration (SAMHSA) for the Kmihqitahasultipon ("We Remember") Project to create a culturally competent, community-based system of care for children with emotional and behavioral disorders

2005

Governor's Children's Cabinet declares ACEs as one of its top three priorities

2006

Vincent Felitti, co-principal investigator of the CDC's ACE Study, presents at Child Abuse Action Network conference

2007

Felitti returns for presentation at Maine Academy of Pediatrics

2009

Child Abuse Action Network conference focuses on ACEs as common pathway to parental domestic violence, substance abuse and mental illness, and to children's attachment difficulties

2010

Felitti presents at Maine Medical Center/Portland and is interviewed on Maine Things Considered (public radio)

2011

Maine Children's Growth Council's Health Accountability Team receives funding to support the Maine ACEs Study, published later that year

2012

Maine Resilience Building Network (MRBN) holds its first meeting and begins outreach/educational sessions (32 that year)

Felitti returns to conduct four seminars on ACEs with juvenile justice officials, health care providers and others)

2013

MRBN meets monthly and holds 42 outreach sessions statewide

MRBN and Maine's federally funded trauma initiatives meet to ensure coordination of efforts

Maineaces.org website goes live

2014

MRBN plans to conduct 14 ACE Summits around the state, requested by school districts, county governments, tribal groups and others

THE PHILADELPHIA, PENNSYLVANIA STORY

PATHS OF EDUCATION AND ACTIVISM CONVERGE IN "ACES EPICENTER"

'There have been people here educating about [ACEs and resilience] for some time, each in their own domains. When they work hand in hand, you can really start to see some widespread change."
—Sandra Bloom, co-chair of the Philadelphia ACE Task Force

The women and men gathered for a training on trauma and resilience were recovery counselors and social workers, charter-school teachers and prison administrators. But to Stephen Paesani, the child and adolescent training specialist who was leading the session, every person in the room was a potential protective factor in a child's life.

"When a child experiences adversity or trauma, he goes into the fight-or-flight stance," Paesani explained. "That's going to impact brain development.

"But no matter what happens, all of you can be the agents for resilience."

KEY INGREDIENTS:

- Simultaneous, long-term training efforts about ACEs and resilience in different sectors and public systems
- Support from local and national philanthropic organizations
- Development of the Philadelphia ACE study – that included a qualitative and quantitative portrait of stresses affecting Philadelphia residents.

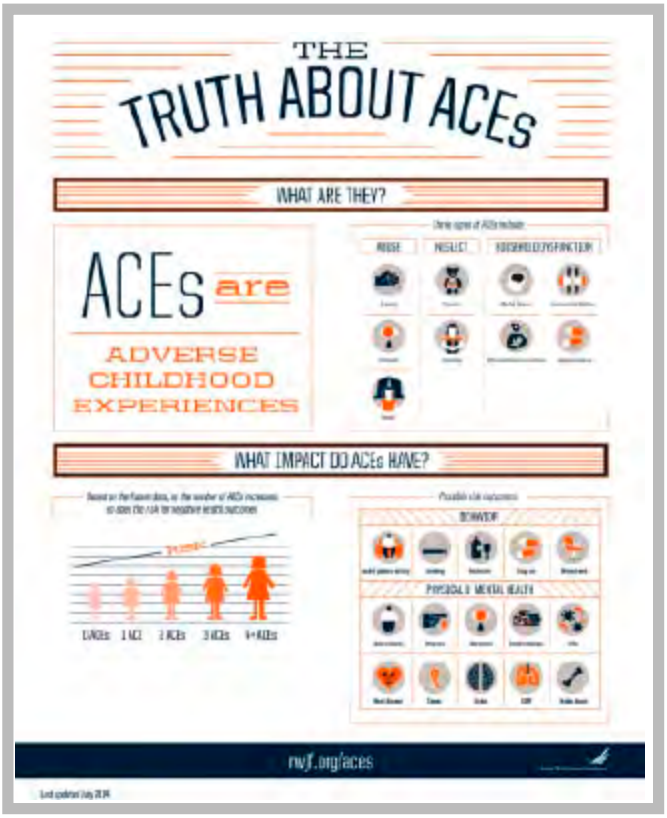
Paesani works for Philadelphia's Behavioral Health Training and Education Network(BHTEN), which provides training to practitioners and community members, part of the city's effort to infuse mental health and substance abuse services with principles of recovery, resilience and self-determination.

Reflection Question # 1 – In your community, which groups, agencies or individuals have already been exposed

to the ACE study and the concepts of toxic stress and resilience?

But BHTEN's trainings are just one piece of the Philadelphia ACEs story. In this city of 1.5 million—a city rife with disparities of class, education and health, with pockets of multi-generational poverty and trickle-down trauma—the last decade has seen a steady effort to bring understanding of adversity, trauma and resilience to thousands of front-line workers, supervisors and administrators across the map of human services.

This work is not the result of a top-down initiative or a single funder's vision for change. It is, instead, the gradual flowering of multiple seeds, planted by activist leaders in pediatrics, public health, behavioral health, child welfare, justice and education.



Today, Philadelphia is home to the ACE Task Force, a group of fifty practitioners intent on putting the knowledge of brain development, adversity and resilience to work in pediatric and primary care clinics, child abuse prevention networks and early childhood programs. The social network site ACEsConnection.com launched a Philadelphia group in 2014 whose members now share questions, successes and challenges both online and at recently formed meet-ups events.

And thanks to the Institute for Safe Families, with support from the Robert Wood Johnson Foundation, Philadelphia was the site of the first National Summit on ACEs in May 2013, attended by 160 physicians, academics, social workers and human service administrators. There, speakers called the ACEs movement "a revolution" in thinking about health and illness, human suffering and strength.

In Philadelphia, that revolution began even before the groundbreaking Centers for Disease Control ACE Study demonstrated the lifelong impact of early adversity.

In the late 1980s, psychiatrist Sandra Bloom and her colleagues began to talk about the adults they were treating at a small inpatient psychiatric center, patients with multiple personality disorder and other complex diagnoses. Many showed symptoms of post-traumatic stress disorder (PTSD). They hadn't lived through war or survived a typhoon. But they did have one thing in common: they'd been abused as children.

"So in 1998, when the ACE Study came out…it was confirming everything we had been seeing for decades," Bloom recalled. In the fifteen years since, "I have watched the development of a movement," she said. "There have been people here educating about [ACEs and resilience] for some time, each in their own domains. When they work hand in hand, you can really start to see some widespread change."

Philadelphia is often described—for better and for worse—as a "city of neighborhoods," with strong ethnic and local allegiances and a powerful sense of turf that can thwart effective collaborations. The story of Philadelphia's efforts to prevent childhood adversity and build resilience is not a single narrative, but multiple stories unfolding simultaneously. Only recently have those stories begun to converge.

FROM THE "BRAIN GROUP" TO THE FRONT LINES: TRAINING ACROSS FOUR SYSTEMS

In the early 2000s, a group of Philadelphia professionals from health, education and human services became inspired by the work of Bruce Perry, a neuroscientist and founder of theChild Trauma Academy in Houston Texas. Perry's research focused on how traumatic stress leaves tracks in the developing brain and affects the health of the child. This informal, unfunded "brain group" wanted to translate that science into practice. The Annie E. Casey Foundation stepped up with funding which enabled the group to bring Perry to Philadelphia several times between 2004 and 2006. Perry presented to policy makers and other local stakeholders, raising their awareness about ACEs and the impact of trauma, and building momentum for further action.

The group—which later grew into theMultiplying Connections Initiative—decided to focus on children age zero-to-five, the period that holds both the most potential for harm and the greatest possibility of repair due to brain plasticity, said Leslie Lieberman, director of Multiplying Connections, which is part of the non-profit Health Federation of Philadelphia.

Multiplying Connections, an initiative of the Health Federation of Philadelphia, has developed materials and trainings on working with the 0 – 5 age range in children

The goal, Lieberman said, was to build the capacity for trauma-informed care in four systems: the school district, public health, human services and children's mental health.

First, the trainers had to educate themselves. Twenty individuals representing those systems spent a year-and-a-half learning about neuroscience, trauma and recovery. With support from the William Penn Foundation, they developed a curriculum called "Becoming Trauma Informed"; in the first four years, they trained nearly 1,000 professionals across the four systems.

Reflection Question #9 – What kinds of education, training, supervision or mentorship could help your community become more trauma-informed?

When those professionals said they wanted more concrete tools to help them address the impact of trauma and adversity Multiplying Connections partnered with the Institute for Safe Families and epidemiologist Linda Chamberlain, PhD, to produce the Amazing Brain Books. A series of "user-friendly", beautifully illustrated booklets that explain complex concepts about brain development and how it is affected by exposure to trauma and adversity as well how to promote resiliency and protective factors.

As the training rolled out, professionals recognized that they needed better supervision to support their learning about trauma informed care and put it into practice. Multiplying Connections returned to William Penn in 2011 with a new proposal: to conduct intensive trainings on reflective supervision while also expanding the reach of the basic trauma training.

When Multiplying Connections begins work with a new agency, Lieberman said, the first step is to imagine the experience through the eyes of a patient or client: "How are people greeted? What does the physical setting look like? Are there signs telling you what not to do? Are there people in uniforms? [Being trauma-informed] is being very thoughtful and intentional about all those questions."

Reflection Question #10 – When you envision a resilient community, what do you see? How would it be different from what currently exists? How will you get from here to there?

Trainers encourage participants to come to workshops in pairs, because research shows people are more likely to create change if they attend a training with someone else from the same organization.

Multiplying Connections has worked with providers of homeless services, Head Start teachers and after-school program staff. Lieberman says "it starts with a conversation with an organization, an assessment of their readiness and what kinds of resources they have. At minimum, it's a two-year process. But I think it takes five, ten or fifteen years for system-level, citywide change."

In the meantime, she said, the ACE Study has "brought scientists to the table; it's brought economists to the table. Public health folks. Physicians. It's definitely broadened the conversation."

EDUCATING A CHILD'S FIRST TEACHERS

When Suzanne O'Connor, a manager at United Way of Greater Philadelphia, attended the 2013 National Summit on ACEs, she felt as though decades of work on adversity and resilience had finally gained "official" status.

Since 2009, the Healthy Parenting Initiative (HPI), a project funded by United Way and a local philanthropist, has trained the people who nurture infants and children, including early childhood education teachers, aides, administrators and clinicians. They learn about brain development and attachment, trauma, protective factors and recovery.

There is also a six-week program called Nurture the Parents, aimed at parents of pre-school children and offered through childcare centers. In 2013, HPI expanded to include training courses for 180 Philadelphia School District staff.

In addition, a program for a small group of clinicians examines how a new assessment tool, called the Neurosequential Model of Therapeutics, does "brain-mapping"—essentially, pinpointing areas where, due to trauma, the brain may not have developed in a healthy way. Practitioners can then target their interventions—gross motor activities with water and sand, for instance, or rocking chairs and weighted blankets—to help particular children.

Reflection Question # 4 – What kinds of data and research would help you understand the impact of ACEs in your community? Does any such data already exist? If not, how could you gather it?

Some Healthy Parenting Initiative courses are offered for college credit. And a small research study has shown that the new knowledge makes a difference. "The training influenced the way teachers perceived children's behaviors," O'Connor said. The next phase of research will look at how children themselves are affected when their caregivers—whether parental or paid—learn to think differently about the causes of behavior.

Years before the Healthy Parenting Initiative, when O'Connor headed a Philadelphia child

care center whose teachers received trauma training, she noticed an immediate effect. "Instead of looking at the parent who dropped off a kid who was crying or who had a dripping nose, and thinking the mom didn't care, now [the staff] thinks, 'I wonder what's going on?'

"HPI is changing the culture by training teachers to understand how stress impacts parents, how not to blame and shame them and by building a more helpful and compassionate early childhood education workforce."

THE REVOLUTION STARTS HERE

For years, the directors of the Institute for Safe Families (ISF) had been using theories of trauma and recovery to inform their work in preventing family violence. But when they invited Robert Anda to discuss his work with 400 practitioners in 2006, his words prompted a new urgency.

"Anda's talk was riveting…The big existential question was, 'How can people hurt each other so much?'"

"Anda's talk was riveting," recalls Martha Davis, former executive director of ISF (and now part of the Vulnerable Populations team at the Robert Wood Johnson Foundation). "The big existential question was, 'How can people hurt each other so much?' The idea that hurt people hurt people was a really helpful concept. It helped us stop blaming people for all the choices they were making, and it opened up this whole other realm of compassion."

The "Amazing Brain" Series of 5 booklets provides accessible, teachable information for people on brain development and the opportunities for positive impact. The 2013 booklet "Apps for Raising Happy Healthy Children" includes smart phone app links

Conferences and training sessions were one way to share the new research on ACEs, trauma and resilience. In 2008, ISF and its collaborative developed another

method—one that parents could literally hold in their hands. The "Amazing Brain" brochures, written by epidemiologist and trauma specialist Linda Burgess Chamberlain, explain trauma, child and adolescent brain development and the essential role of caregivers in clear, positive language.

"You can help your baby build brain connections by talking, hugging, singing, reading, playing and exploring the world together," one brochure advises. The colorful, five-booklet series, which includes "The Amazing Brain: Trauma and the Potential for Healing" and "Apps for Raising Happy, Healthy Children," has received enthusiastic acclaim nationally from providers and parents.

In April 2012, ISF convened the ACE Task Force, a group of pediatric practitioners who wanted to put ACEs theory into practice. The task force soon grew to include specialists in behavioral health, child abuse prevention, education and domestic violence. Lieberman, head of Multiplying Connections, joined; so did O'Connor, from United Way. Bloom is one of three co-chairs, along with Joel Fein, a pediatrician at The Children's Hospital of Philadelphia, and Lee Pachter, chief of general pediatrics at St. Christopher's Hospital for Children. The group meets quarterly.

"The task force brings together diverse and possibly competitive organizations around a topic they are passionate about and allows them to converse about it in a non-threatening way," said Joel Fein, a pediatrician at The Children's Hospital of Philadelphia and one of the group's co-chairs. He said ISF—with neither funding to offer nor a reason to compete—played a critical role as a neutral convener, a role that is carried on now by the Health Federation of Philadelphia.

Reflection Question #7 – What would you or your organization do to prevent ACEs and boost resilience if you had absolutely no budget? What would you do if funds were unlimited?

But the task force's accomplishments go beyond talk. Members of the group, with funding from the Robert Wood Johnson Foundation, conducted the Philadelphia ACE Study with more than 1,700 participants to look at the childhood stresses particular to growing up in an urban area.

The task force doesn't demand that its members use the same protocols or training materials; instead, it gives them a shared language and purpose, along with the reminder that no one organization can solve complex social problems alone.

Outside the ACE Task Force, other practitioners are addressing ACEs in a variety of ways. Kenneth Ginsburg, a pediatrician whose national and international work focuses on adolescent resilience, is directing a project involving five Philadelphia-area youth-serving agencies, an attempt to zero in on the key ingredients of nurturing adult relationships with youth. "We know on paper that connection is the most valuable thing [for children]," he said. "When parents don't give that, other adults have to chime in. So, what does it look like to be able to turn a kid's life around? We're working to hunt down that secret sauce, to be able to replicate it and teach other people."

Two other projects are Drexel's Healing Hurt People and the Children's Hospital of Philadelphia Violence Intervention Prorgram, founded by emergency room physicians Theodore Corbin and Joel Fein, respectvely. They are team-based, trauma-informed approach to helping patients seen in emergency departments for gunshot, stab or assault wounds. The program helps connect those patients to resources for housing, education, legal services and emotional support.

And there is evidence that ACE awareness is percolating into new realms of the city. In early 2014, the U.S. attorney in Philadelphia held a forum on the traumatic impact of violence, attended by hundreds of professionals in criminal justice, education and social services. Two days later, the city's public radio station and the Children's Crisis Treatment Center co-hosted a community discussion—the first of several—on children and toxic stress. There, Arthur Evans, PhD, the commissioner of Philadelphia's Department of Behavioral Health and Intellectual Disability Services (DBHIDS) suggested that Philadelphia was becoming an epicenter of ACE-informed work and emphasized the work that his department has been doing for nearly a decade to both build capacity for behavioral health organizations in Philadelphia to provide services from a trauma informed approach as well as make trauma treatment for children and adults more available and accessible.

The Philadelphia ACEsConnection group, in its first six months, drew more than 130 members, including younger professionals, students, and people working in education, medicine, juvenile justice and philanthropy. The group has also sponsored two "meet-ups" with speakers and opportunities for informal networking. "I think this is going to be an effective way to reach the next generation of people doing this work," said Lieberman. At one of those meet-ups, the city's largest charter school operator described a plan to bring a trauma-informed approach to every aspect of his system, from student discipline to teacher support.

Meanwhile, the ACEs Task Force is developing an action plan focused on three priorities: to educate the community about ACEs; to develop a deeper understanding of practical and successful interventions and to incorporate ACEs research into the curricula of undergraduate and graduate institutions.

And the work goes on—in training rooms where front-line workers absorb ACEs 101; in pediatric clinics where residents learn that a patient's lack of eye contact may be a sign of fear, not disrespect; and in one especially raw corner of the city, where the Eleventh Street Family Health Services puts ACE theory into daily practice.

The clinic sits in one of the city's poorest neighborhoods, a short hop in miles and a long distance in resources from the glittering towers of Center City. But a 54-year-old patient named Teresa calls it home.

Teresa (not her real name) was molested and raped by her father starting at the age of eight. By the time Teresa was a young adult, she recalled, "I lived in terror. I couldn't talk to people. I had a powerful sense of shame about who and what I was."

She sought care at Eleventh Street because she needed contraception; a thorough exam showed that she also needed thyroid medication. When Teresa told her story, the nurse-practitioner suggested she work with a dance/movement therapist at the center, where primary care is integrated with behavioral health, arts therapies, parenting classes and peer support groups for smoking cessation, pain management and weight control.

Eleventh Street aims to develop "micro-systems" around each patient, assembling a team of practitioners based on each person's goals. The center is also in the midst of a three-year process of becoming a Sanctuary organization, applying principles of trauma and resilience in every interaction, from the way receptionists answer the phone to the way managers conduct meetings.

As for Teresa, she's still dancing. "I learned that my scars were just scars; they were not my essence. And I will never forget how I was received here, even by the receptionist at the front desk. It was with love."

PHILADELPHIA TIMELINE - CLICK YEAR TO VIEW HIGHLIGHTS

2004

An informal, unfunded "brain group" of professionals in health, human services and education spends more than a year educating themselves about the newest science on brain development and trauma

2006

The Institute for Safe Families (ISF) invites Robert Anda to Philadelphia to discuss the results of the 1998 ACE Study; he speaks to an audience of 400 practitioners

2007

The "brain group" develops into Multiplying Connections and creates a curriculum, "Becoming Trauma Informed," to train front-line workers and supervisors in four arenas: the school district, public health, human services and children's mental health; in the first four years, 1,000 people are trained

2009

Healthy Parenting Initiative, funded by United Way, provides training in brain development, trauma, protective factors and resilience to early childcare workers and to parents

2011

Multiplying Connections, with a grant from the William Penn Foundation, expands its training to include reflective supervision, which helps staff deepen and sustain trauma-informed practices. By 2013, 2,500 people will receive the foundational training and 50 supervisors will receive the training in reflective supervision

2012

ISF convenes the ACE Task Force—initially a group of pediatricians that quickly grows to include specialists in behavioral health, child abuse prevention and domestic violence—to share and further efforts to put the science of ACEs into practice

2013

ISF, with support from the Robert Wood Johnson Foundation, hosts the National Summit on ACEs, with 160 leaders from around the country in attendance. Findings from the Philadelphia Urban ACE Study are released.

National Collaborative on Adversity and Resilience (NCAR), hosted by ISF and the Robert Wood Johnson Foundation, holds a two-day retreat to develop specific strategies for advancing the national movement on ACEs

2014

Development of a Philadelphia group on ACEsConnection.com enables local practitioners to share ideas, challenges and research regarding ACEs and resilience

U.S. attorney in Philadelphia holds forum on the traumatic impact of violence, attended by hundreds of professionals in criminal justice, education and social services

The city's public radio station and the Children's Crisis Treatment Center co-host a community discussion on children and toxic stress. The commissioner of Philadelphia's Department of Behavioral Health and Intellectual disAbility Services (DBHIDS) suggests that Philadelphia is becoming an epicenter of ACE-informed work

THE TARPON SPRINGS, FLORIDA STORY

A CITY EMBRACES THE MESSY PATH TOWARD PEACE

"We want to empower people to do something, without having them think that they have to solve all the violence in the world."
—Robin Saenger, former vice-mayor of Tarpon Springs

Tarpon Springs, Florida, once known as the nation's sponge-fishing capital, today boasts a new designation: the first city in the country to declare itself a trauma-informedcommunity.

It isn't that the 24,000 residents of the scenic Gulf Coast town know more than the rest of us about emergency room techniques, spend their time crunching spreadsheets of violence data or watch more episodes of "America's Most Wanted."

KEY INGREDIENTS:

- A passionate instigator who has influence – who was also in a position to foster change
- A clear mission developed and agreed upon by key community members
- A commitment to openness and tolerance of a "messy," non-linear process

Being a trauma-informed community means that Tarpon Spring has made a commitment to engage people from all sectors—education, juvenile justice, faith, housing, health care and business—in common goals. The first is to understand how personal adversity affects the community's well being. The second is to institute resilience-building practices so that people, organizations and systems no longer traumatize already traumatized people and instead contribute to building a healthy community.

BEGINNINGS: A GOAL TO STOP VIOLENCE

The journey officially began in February 2011, when the Tarpon Springs City Council signed a memorandum of understanding to marshal the community to address and prevent childhood and adult trauma.

The results have been profound. Trauma-informed practices have been implemented in small and large ways in a variety of organizations, including an elementary school, an ex-

offender re-entry program and the local housing authority. The Pinellas County Department of Health recently decided to incorporate in its Community Health Improvement Plan a goal of providing trauma-informed information in all of its county health facilities.

"Once you bring the community into it, you just don't know how it's going to grow," says local artist Robin Saenger.

But the unofficial journey began in the middle of 2010. Saenger, who was Tarpon Springs' commissioner and vice-mayor from 2005 to 2011, wanted to figure out a way to reduce the increasing levels of violence in her community. She talked with a friend, Andrea Blanch, a senior consultant at the National Center for Trauma-Informed Care, about her goal.

Peace4Tarpon website introduces the ACE Study and the work that Tarpon Springs is doing to be a Trauma-Informed community

"She listened," says Saenger, "and then said: 'You're talking about a trauma-informed community.'" Blanch explained how many of the issues facing Tarpon Springs—homelessness, domestic violence and substance abuse—stemmed from childhood adversity. And the Peace4Tarpon Trauma-Informed Community Initiative was born.

"My belief is that trauma is universal," says Saenger. "Everyone's experienced trauma in one form or another, and usually does on a regular basis throughout the course of a lifetime," whether that stems from being in a car accident, witnessing domestic violence or having a loved one with substance abuse problems. And everyone is affected by the consequences of that trauma, including the cost of emergency health and social services, school dropout rates, local violence, and absenteeism on the job.

So, how did the people in this city embrace such a radical concept in such a short time? "The nickel dropped" for Mayor David Archie and the board of commissioners on the day in 2010

that Blanch did a presentation about the CDC's ACE Study and trauma-informed care, says Saenger.

"I could tell that [the mayor] completely grasped the concept, and as a city leader, was in a position to do something about it. He's also director of Citizens Alliance for Progress, a neighborhood family center, and he realized that trauma is the root cause behind many of the challenges faced by neighborhood residents."

Saenger met with the police chief and city manager to talk about what Tarpon Springs was doing right and where it could use some help. They put together a list of 30 people they thought would be interested in the Peace4Tarpon initiative. This group met and formed a steering committee that includes representatives from churches, the school district, the library, St. Petersburg College and the Juvenile Welfare Board. It also includes the police chief, the mayor, the city manager, directors of the community health center and the housing authority, the sheriff department's ex-offender program and a growing number of community members.

In early 2011, the local Rotary Club held a community education day and chose trauma as the topic. Six days later, as a result of the steering committee's work, a memorandum of understanding was signed by the Tarpon Springs Community Trauma Informed Community Initiative to, among other things, "increase awareness of issues facing members of our community who have been traumatized to promote healing."

Reflection Question #3 – What are some ways you can educate others about ACEs, toxic stress and resilience? Who can help you in this effort?

For the last three years, four subcommittees—community action, health and wellness, children's initiative and social marketing—have met regularly to move the Peace4Tarpon initiative ahead, inch by inch. An education committee was added recently; ad hoc committees take on short-term projects.

EARLY ADOPTERS: HOUSING AUTHORITY AND SCHOOLS

The biggest changes have occurred in a local housing authority and the local elementary school. Pat Weber, a longtime community organizer and executive director of the Tarpon Springs Housing Authority, was at the Tarpon Springs City Council meeting when Blanch and Saenger presented the ACE Study. "It was just incredible to me," Weber recalls. "I said to myself: 'Well there's the proof.' When [Saenger] said, 'We need to do something,' I said, 'I'm in!'"

Weber had already coached her staff members, who manage 225 units of public housing, to think about people as people instead of as problems. "They don't keep their house messy because they want to have cockroaches," she tells them. "There's a reason for everything. In our housing authority, it's trauma."

The housing authority already had a long-time partnership with the local police department. Together, they'd turned a former church into a community center for the Cops 'n Kids program, which serves 75 kids. An officer is assigned full-time to the center, and the housing authority provides staff to develop programs. The center is open after school until 6:30 p.m. and all day during the summer. "For the kids, this center and those people are like their family," says Weber. And although the police department isn't yet

The City of Tarpon Springs video on taking steps to become a "trauma informed community" with Robin Saenger – former Vice Mayor of Tarpon Springs – and Dr. Andrea Blanch — Senior Consultant with the National Center for Trauma Informed Care

trauma-informed, the police chief attends the Peace4Tarpon meetings and sends officers to the trainings.

As a result of being involved with Peace4Tarpon, Weber provided training for her staff—a workshop called "Why Are You Yelling At Me When I'm Only Trying To Help You?" Now, she says her agency is much more tenant-supportive.

Reflection Question #9 – What kinds of education, training, supervision or mentorship could help your community become more trauma-informed?

When the Suncoast Center, which provides mental health, child and family services, wanted to open a North County branch in Tarpon Springs, Weber volunteered two apartments. She doesn't charge rent; in exchange, one of their therapists meets with a group from the Cops 'n Kids program two or three times a week. Adults and children who live in the apartments also have access to free or low-cost counseling from one of the eight Suncoast therapists on location. The agency has a home visiting program and provides parenting training.

St. Petersburg College, also a member of Peace4Tarpon, provides tutors for kids in the housing authority. And the local 4H organization, also a member, is planning to work with apartment residents to plant a large garden. "All this is happening because they understand what ACEs are and the importance of doing something about it," says Weber. "Three years ago, that wasn't there."

Most of the children who attend Tarpon Springs Elementary School have family incomes close to the federal poverty level; many live in public housing nearby. The school began its trauma-informed approach by asking students and families what they needed. The answers were basic: uniforms, eye exams, food. Through Peace4Tarpon, the school now has a uniform bank. Kids receive regular hearing and eye exams, free eyeglasses, weekend snacks, a meals program and transportation to school events.

Reflection Question #5 – In addition to the ACEs counted in the 1998 Kaiser study, are there other sources of adversity

particular to your community, such as neighborhood violence, racial/ethnic discrimination or the trauma caused by a natural disaster like flood or fire?

"The community knows that if kids are worried about things, they're not going to be able to focus on learning," says Wendy Sedlacek, chair of Peace4Tarpon's children's initiative subcommittee. She's also the family and community relations coordinator for the Pinellas County Public Schools Office of Strategic Partnerships. When teachers participated in a three-hour poverty workshop, she said, "they examined the types of trauma that poverty can cause on multiple levels. In their breakout sessions, teachers were put together as a family, with people playing different roles. Every fifteen minutes, something changed in their lives, and they had to figure out how to survive. It was very enlightening. They learned there are a lot of choices that people make that are traumatic, because there's no other choice."

That workshop and a "trauma-informed care wheel" have provided teachers with a betterunderstanding of different types of trauma, the symptoms and behaviors kids may express as a result, and how those traumas may be triggered in the classroom.

Peace4Tarpon put together a guide of community resources for families—everything from food banks to help moving belongings from one home to another. The Tarpon Springs city manager encourages all city employees to volunteer as mentors or tutors at the school, just a block from City Hall.

During this school year, Peace4Tarpon community members, parents and school staff—all

trained in community support—visited families twice in their homes. They asked questions such as, "Do you feel comfortable about the educational experience your child is receiving? Does your child need a desk? A mentor? In what other ways can we support you?"

Unfortunately, the principal and vice-principal at Tarpon Springs Elementary left at the end of the school year, and "we're starting all over again" in educating a new principal, says Saenger.

MANY OTHER PIECES OF PEACE4TARPON

Peace4Tarpon has made a difference in other ways:

- After the Pinellas Ex-offender Re-entry Coalition screened participants in its support groups for ACEs, Denise Hughes-Conlon, outpatient clinical director, changed the curriculum for the women's groups to Seeking Safety, which specifically addresses trauma. The women learn information that they can use daily, such as how to say no and how to create everyday boundaries.
- Wells Fargo Bank plans to sponsor a financial literacy program for people in public housing, something Saenger sees as vital, because "financial health is often a reflection of someone's trauma history."
- Judge Kimberly Todd is interested in having Peace4Tarpon provide assistance on developing community service diversion programs for youth offenders.
- Peace4Tarpon co-sponsored "Being a Better Bystander" training for Tarpon Springs residents to educate them on how to safely help someone who is experiencing domestic violence or child abuse. "Last year in Pinellas County, there were thirteen domestic violence homicides," says Saenger. "What was brought to light was that, in every case, people knew" about the problems before they escalated to murder. It's also sponsoring monthly training for community members about child sex abuse.
- The Pinellas County Department of Health is working with Saenger to facilitate three grand rounds for physicians. For the first one — for pediatricians at All Children's Hospital in St. Petersburgh — Saenger recruited Dr. Nancy Hardt, who has taught students at the University of Florida College of Medicine in Gainesville about ACEs research.
- Two Peace4Tarpon partners who are licensed mental health counselors participate in the Give an Hour program to provide free counseling for military veterans.
- Tarpon Springs was selected as a finalist in the 2014 All-American City Awardshosted by the National Civic League, partly based on the work of Peace4Tarpon

Mostly, Saenger says, people are talking, doing presentations and increasing awareness about ACEs and resilience. "We tell people to bring what peace/piece you can to Peace4Tarpon. We want to empower people to do something, without having them think that they have to solve all the violence in the world."

She points out that all accomplishments to date have been done without a large grant. In fact, she thinks a big pot of money—or a top-down countywide initiative—would have killed Peace4Tarpon. "You don't throw too much fertilizer on a new plant," she says. "And you have to grow this from the ground up."

Reflection Question #7 – What would you or your organization do to prevent ACEs and boost resilience if you had absolutely no budget? What would you do if funds were unlimited?

Not everyone jumped on the trauma-informed bandwagon immediately. For example, a local principal who attended a few early steering committee meetings didn't see the initiative as particularly useful, telling Saenger, "We don't have that issue at our school."

Saenger's response? "There's a saying: It's rude to awaken someone who's sleeping," meaning that people will come to understanding in their own time. "I've seen over and over that when people 'get it,' they become passionate and engaged partners almost immediately. They see the promise and power of this initiative."

A few months ago, that principal sent a school staff member to a Peace4Tarpon meeting.

THE STOP-AND-START NATURE OF CHANGE

Saenger is patient with the start-and-stop nature of change, and she has sensed a new kind of compassion moving through the community. She tells a story about a young local man who burned down his uncle's pawn and gun shop, then went home and killed his uncle (with whom he lived), his uncle's girlfriend, his grandmother and finally himself.

"Rather than going into attack mode on the young man, people asked other questions," she

says, focusing on the likelihood of his traumatic history, why he was living with his uncle instead of his parents and how the community had not noticed his growing dysfunction. "People were asking 'Where did we miss the boat?' and 'What happened to him?' instead of 'What's wrong with him?'"

In just three years, Peace4Tarpon has become an integral part of the community. Monthly steering committee meetings are open to anyone. About half of the 60 members of the committee show up each time. "It's never the same 30," says Saenger. "and that works out fine."

At the beginning, participants were mostly community leaders. "Now a lot more residents are getting involved," she says. "It's an interesting shift…It's what we're going for, but watching it evolve is interesting. It's just so messy. It's not a straight line. It's not something that can be mandated and it's not always a comfortable path, but it's about the process, and that's where the juice is.

"I've noticed that a lot of trauma-informed approaches are very, very rigid," she continues. "That rigidity doesn't work. We invite people to our table and their presence is always welcomed and honored, no matter what they offer. Yoga, reiki, art therapy…it all contributes to the big picture."

Word of Tarpon Springs' work has spread. Walla Walla, WA, used Peace4Tarpon's memorandum of understanding as a model. And in Kansas City, MO, Trauma Matters KC has more than 100 people who have signed a similar memorandum. People in Traverse City, MI, Topeka, KA, Meadville, PA, Gainesville, FL, Warwick RI, and Missouri state government have sought advice from Saenger about how to start similar projects.

"This is a long-term initiative," says Saenger. "There's not an end date to this. When everybody's participating, there will be a cumulative impact."

TARPON SPRINGS TIMELINE - CLICK YEAR TO VIEW HIGHLIGHTS

2010

Robin Saenger, artist and vice-mayor of this city of 24,000, realizes that many of the city's problems—homelessness, violence, substance abuse—stem from experiences of trauma

Saenger seeks expertise from Dr. Andrea Blanch, a senior consultant at the National Center for Trauma-Informed Care, to learn what it would mean to create a trauma-informed community

July: Blanch presents to Tarpon Springs mayor and city commissioners

Saenger meets with the city's police chief and manager, then formed a steering committee that includes representatives from churches, the school district, the library, city government, the housing authority, community health centers, Boys & Girls Clubs, the sheriff's department's ex-offender program and other community members

2011

A community education day, funded by the Rotary Club, focuses on trauma, with workshops and discussions. Six days later, community partners sign a memo of understanding pledging to "increase awareness of issues facing members of our community who have been traumatized to promote healing

Peace4Tarpon Trauma-Informed Initiative steering committee begins to meet monthly; four subcommittees meet to move initiatives ahead

2012

Peace4Tarpon website launches, along with a Facebook page

Housing Authority trains workers in trauma-informed practices

Tarpon Springs Elementary School becomes a community school

2013

Suncoast Center, a mental health, child and family services agency, opens branch in Housing Authority apartment complex; in exchange for free rent, center provides free or low-cost counseling to residents

Tarpon Springs Elementary School teachers participate in three-hour poverty workshop, learning about trauma symptoms, behaviors and triggers

Other communities, inspired by Peace4Tarpon, use memorandum of understanding as model

December: visioning day reviews accomplishments to date; sets commitment to continue efforts

2014

July: Peace4Tarpon hires first paid staff member, a part-time program director whose salary is paid by the Housing Authority.

August: New MOU written that simplifies language and asks members to make a commitment to fill out the 10-question ACE survey, a 15-question resilience survey, to join ACEsConnection.com, and to bring a trauma-informed perspective to their individual lives and to their workplace.

THE WALLA WALLA, WASHINGTON STORY

CHILDREN'S RESILIENCE INITIATIVE DRAWS SPOTLIGHT TO TRAUMA-SENSITIVE SCHOOL

"The key is finding champions in the right places."
—Teri Barila, co-facilitator of the Children's Resilience Initiative

In Walla Walla, Washington, the journey to implement ACEs research has been akin to a wild ride on a transformer roller coaster that arbitrarily changes its careening turns, mountainous ascents, and hair-raising plunges. And sometimes the ride just screeches to a frustrating halt.

The odyssey began in October 2007, when Teri Barila, Walla Walla County Community Network coordinator, heard Dr. Robert Anda, co-investigator of the CDC's Adverse Childhood Experiences Study, speak at a Washington State Family Policy Council (FPC) event.

The Family Policy Council was the umbrella organization for 42 community networks across the state that were addressing local issues such as youth substance abuse, school drop-out rates and teen pregnancy. Anda implored the coordinators to "get something started" in their own communities because he was getting little traction on a national level.

KEY INGREDIENTS:

- A written plan outlining the Children's Resilience Initiative's (CRI) goals, visions and responsibilities; the document provided members with a navigation chart and an "elevator speech" on ACEs and resilience
- Media exposure (article about Lincoln High School's trauma-sensitive policies on ACEsTooHigh.com) that brought a surge of national interest
- Development of the Resilience Trumps ACEs Manual as a record of CRI's evolution and a guide to other communities

Barila returned to Walla Walla fired up. The city, with a population of 32,000, has three colleges, a robust agricultural community, including a newly flourishing wine industry, and a revitalized downtown. But one out of four of its children live in poverty, 65% of its residents

have not attended college, and gangs and drugs are common. Barila was determined to educate the community about the dire and costly consequences of ACEs and the "clear impact of stress on the developing brain of a child." She organized a community meeting in early 2008 and brought Anda in for a two-and-a-half-hour seminar; 165 people showed up.

At the end of Anda's presentation, a parent named Annett Ridenour walked to the front of the room, and, with tears streaming down her face, took the microphone out of Anda's hand. "I have 10 ACEs," she said, "and now I understand my life."

"This made me believe in the liberating effects of ACEs," writes Barila in the "Getting Started" chapter of the the Resilience Trumps ACEs Manual. It was also the unofficial start of the Children's Resilience Initiative.

The first order of business was to find a partner. With her ten years as community network coordinator, Barila had plenty of experience mobilizing and developing capacity in communities. She needed someone with a background in mental health. She found that person in Mark Brown, the new executive director of Friends of Children of Walla Walla, a local mentoring program.

The second order of business was, as Barila and Brown write in the manual, to "plow the field." In other words, identify critical community leaders and organizations, explain the research and the goal of creating "a community conversant in ACEs and resilience," and answer their questions and concerns.

Brown and Barila compiled a list that included people from the school district, city government, mental health, social service agencies, the local offices of the state Department of Health and Human Services, law enforcement, juvenile justice, public health, local media, business leaders and parents. After more than 40 conversations with individuals and small groups of people, they were ready to hold the first team meeting.

Reflection Question # 1 – In your community, which groups, agencies or individuals have already been exposed to the ACE study and the concepts of toxic stress and resilience?

In 2009, a local foundation, the Donald & Virginia Sherwood Trust, provided $40,000 in start-up funds. The Bill and Melinda Gates Foundation heard about the project and offered a three-year, $130,000 grant. This was enough to support Barila's work and 25% of Brown's salary, to bring in expert speakers, to organize meetings, to do a city-wide ACEs survey and to launch ResilienceTrumpsACEs.org .

THE CHILDREN'S RESILIENCE INITIATIVE GETS UNDERWAY

The Children's Resilience Initiative (CRI) officially launched in February 2010. Its members developed a plan that helped identify the goals, vision and responsibilities of the 25-member team and its facilitators, Barila and Brown. The goals: to raise awareness of ACEs and brain development, foster resilience, and embed the principles in the community. Barila recalls that "a tremendous amount of effort" went into the document; it turned out to be an extremely useful navigation chart for the organization and its members, providing the "elevator speech" and the confidence to speak to CRI's goals.

The Children's Resilience Initative of Walla Walla developed tools friendly to parents and providers that help guide ways to build be sensitive to ACEs and build resilience

Brown also knew that, as the initiative matured, it was likely to develop other goals. One that emerged was the need for the members to integrate the principles of ACEs awareness and resilience into their own organizations. This raised the ante on members to report progress, or lack of it, at each meeting. It also expanded the leadership, notes Barila, as people developed their own approaches to working with others in the community.

A series of turning points began in April 2010, when the school district sent a group to the "From Hope to Resilience" conference in Spokane, whose education community was undergoing its own transition to learning about and integrating trauma-informed practices.

Jim Sporleder, principal of Lincoln High School, an "alternative" school attended by students who couldn't make it at Walla Walla High School, was among that group. He heard Dr. John Medina, a developmental molecular biologist, speak about ACEs and the effects of toxic stress on children's developing brains. Sporleder realized that he'd been approaching discipline all wrong. He returned to Walla Walla determined to integrate trauma-informed practices in his school.

One year later, CRI sponsored a community event, the Children's Forum, and brought Medina in to speak. The school board closed schools for half a day so that all teachers, administrators and staff could learn about ACEs research.

Lincoln High School website links to this orientation video on "Civility." The video uses humorous approach in which students role-model examples of "Inclusive" or Social & Civil actions versus "Antisocial" or Exclusive.

Reflection Question #9 – What kinds of education, training, supervision or mentorship could help your community become more trauma-informed?

"Looking around the packed 1,200-seat auditorium that day," Brown noted in the manual, "we knew that we were moving from dipping water from one bucket into another and into the practice of starting fires."

Barila and Brown knew that they'd made significant progress when a survey revealed that, over two years, community awareness of the term ACEs increased five-fold.

Reflection Question #3 – What are some ways you can educate others about ACEs, toxic stress and resilience? Who can help you in this effort?

Children's Resilience Initiative developed this training card deck and manual. "Through this website you will learn how resilience can help to overcome adverse childhood experiences (ACEs). No one gets to choose the hand that they are dealt. We can all change the cards in our hands by building resilience into our daily lives.

A TRAUMA-INFORMED SCHOOL SHINES NATIONAL SPOTLIGHT ON WALLA WALLA

In April 2012, Walla Walla was catapulted into the national spotlight when the story about how Lincoln High School had dropped its suspensions by 85% over one year went viral (with more than 700,000 page views to date). Sporleder, Barila and Brown began giving presentations about their work around the country. Filmmaker James Redford started work on a documentary (scheduled for release in 2015) about the school and its trauma-infomed approach.

And then the rollercoaster came to an abrupt stop.

In June 2012, the Washington State legislature closed the Family Policy Council, which was providing basic funding for the state's community networks, including the network in Walla Walla. The Gates grant also ended.

Barila and Brown learned that with this type of major social change being driven by a perfect storm of research—the epidemiology of ACEs, the neurobiological effects of toxic stress on children's brains, the long-term biomedical and epigenetic consequences of childhood trauma, and the science of resilience—the traditional two- to three-year funding cycles can be challenging. That's because foundations tend to support an individual organization's

short-term accomplishments and not the steady, but slow, change in a community's systems. Barila and Brown had always maintained that their work was a two- to three-generation endeavor, not a two- to three-year project.

And despite the overwhelming success at Lincoln High School, the school district took no further steps to integrate trauma-informed practices in its other schools, because it wanted to wait for additional documentation on specific strategies. Brown and Barila knew that it took multiple exposures to ACEs research for people to begin to integrate the knowledge into their own lives and then to the rest of the community. This development underlined that realization.

Nevertheless, the Barila and Brown kept plugging along. In September 2012, the CRI launched ResilienceTrumpsACEs.org; it explored ACEs and resilience through a card game whose deck listed specific experiences and skills such as learning to ask for help. "I developed the deck based on parents saying: 'I know what the word resilience means, but what do you mean when you talk about the building blocks?'" says Barila. "That gave me the idea to come up with forty-two examples."

In 2013, they were able to scrape together small grants to keep the momentum going. They were hopeful for more substantial funding in 2014 and 2015. But the setbacks did not dampen their resolve.

Reflection Question #7 – What would you or your organization do to prevent ACEs and boost resilience if you had absolutely no budget? What would you do if funds were unlimited?

The website tools offer: "Help your kids bounce back – ACEs can be devastating" and "Parenting is the hardest job you will ever have. There is no training manual and you may feel lost trying to raise your child.

Road to Protective Factors
Here's hope and help! Be sure to look for the 5 ROAD SIGNS on the resilience road map where you'll find a WEALTH of information for you. On this site all roads lead to resilience! "

Over the last year and a half, CRI's education and outreach efforts have continued. The parents' initiative is going strong. A workshop for the business community drew 130 people. They've done training for staff at a state penitentiary in Walla Walla and "just about every agency, service provider and entity that will have us in," says Barila. "We stopped counting, but we've given over 500 presentations in the valley, including adjacent communities like Dayton, and out of state, too."

And, as part of a small community grant from the Gates Foundation – the Lincoln High School ACEs and Resilience Program — a member of the Walla Walla community spoke to the health class at Lincoln High during the 2013-2014 school year to tell her or his own story of trauma and resilience. Another part of the program for pregnant and parenting teens offered a daily class in resilience, basic parenting, and child development. Transportation and child care insured that teens were able to attend the classes.

The CRI team continues to receive an increasing number of requests from the community: from Head Start, the local community college, and a call-in project for gang-affected parents and kids to learn about alternatives to gang violence and sex trafficking. Those alternatives were based on a framework of ACEs and included vocational training, education, counseling and housing.

Barila and Brown persevere, one conversation at a time, to deepen the understanding of what ACE-informed changes mean. For example, says Barila, the sheriff is extremely supportive, but he always raises the question law enforcement must respond to: "What do you expect us to do? We still have to arrest them." To begin to change the mindset—from abusing and further traumatizing already traumatized people to treating everyone with respect—CRI facilitators give him examples.

One story Barila tells comes from a nearby sheriff who understood how police actions may trigger certain behaviors in people who are traumatized. Rather than arresting a person suspected of methamphetamine use with a barrage of lights, noise and agitation, certain to trigger a fight-or-flight response, officers kept the room dark, used quiet voices and talked calmly to the person, who offered no resistance.

At a strategic planning session in November 2013, the CRI team was "recharged," says Barila, for the next two to three years. Policy, measurement and increased outreach in the business and faith-based communities rose to the top of their to-do list.

RECHARGED, AND MOVING FORWARD INTO POLICY CHANGES

Lincoln High School webpage features a link to bullying prevention

Policy changes need to happen at many different levels, notes Barila. In September 2013, the Walla Walla City Council issued a proclamation, in response to a memorandum of understanding developed by the CRI team, that recognized the CRI's efforts to make Walla Walla a trauma-informed community. That led to a declaration that October 2013 was Children's Resilience Month in Walla Walla. At a community festival that month, with speakers, music and food, families played 10 resilience games developed by Lincoln High School students taking a course in ACEs, brain development and resilience.

> Reflection Question #10 – When you envision a resilient community, what do you see? How would it be different from what currently exists? How will you get from here to there?

Barila pointed to the education system as another sector in need of policy change—for instance, a school board resolution directing the school district to move toward becoming trauma-informed. Such a policy would require the district to train its teachers, administrators and staff. Teachers and schools would be evaluated on their use of trauma-informed practices, and data-gathering would determine whether those changes were working.

Establishing common measurements and standards is also a vital next step, so that CRI can learn whether its work is making a difference. In the works is a standardized survey for service providers to use with parents and children to "measure gains in parental resilience and in social-emotional competency as a result of our work," says Barila. The 25 members of the CRI are doing a self-evaluation to measure changes in awareness, understanding and integration of resilience into daily practice. In February, Lincoln High School deployed a resilience-focused survey that evaluated interventions according to academic data and ACE scores. The survey, published in July, found that student resilience improved, and students with higher resilience scores earned higher grades, irrespective of their ACE scores, thus providing support that changes in school practices in which teachers and administrators were sensitive to students' ACEs, made a positive difference.

Reflection Question # 4 – What kinds of data and research would help you understand the impact of ACEs in your community? Does any such data already exist? If not, how could you gather it?

Meanwhile, CRI's leaders continue to search for community leaders and members who can take on the goals of the initiative. "The key is finding champions in the right places," says Barila.

For example, the former school resource officer at Lincoln High School—who had served during its transition to becoming trauma-informed—was promoted to sergeant. He invited Barila and Brown to join him in leading a workshop for the Walla Walla Police Department. He helped them gain entry to the sheriff's department, too, and conducted a workshop with them.

Recently, a school board member encouraged the superintendent to start figuring out how to integrate trauma-informed practices in Walla Walla's other schools. As a result, they are expanding trauma-informed practices into Head Start and three elementary schools..

Finally, Walla Walla is probably the only trauma-informed, resilience-building community

that has its own song, an anthem to the healing power of community. It was written by Brown:

So, I was dealt a bad hand
But that ain't gonna stop me
A fistful of ACEs I can rise above
I've people around me
They'll lift me up – won't drop me
They see me – help heal me
I know now I deserve love

Broken cups, broken dishes
Broken bones, family torn apart
I lost my childhood – my dreams and childish wishes
But I will never lose my heart

I've got the power to bounce back
I've got the heart to succeed
I've got the people around me
I've got the grit that I need

So if you come upon some kids
With their eyes hurt and staring
You could be a life raft, help them rise above
Put away your judgment, yes, and cover them with caring
In spite of their sad stories
They can bounce back, and they deserve love

WALLA WALLA TIMELINE

1998

Fall: First multi-disciplinary forum on the health of families and children.

2004

Exposure to ACE Study and brain development research through Family Policy Council.

2007

Rob Anda visits; his message is "go home and create a grassroots movement".

2008

Spring: Anda visits again; Barila and Brown create framework for CRI.

2009

Start-up funding of $40,000, followed by Gates Foundation three-year, $130,000 grant. Groundwork on CRI begins.

2010

February: CRI's official launch; monthly meetings begin.

April: Walla Walla School District sends staff to Spokane "Hurt to Hope" conference.

Fall: Lincoln High School begins shift to trauma-informed practices.

2011

April: John Medina, a developmental molecular biologist who studies how the brain organizes information, keynotes Children's Forum; Walla Walla school board closes schools so every employee can attend.

2012

March: Vincent Felitti visits, engages medical community.

April: Article about Lincoln High School on ACEsTooHigh goes viral; prompts major response to community initiative.

June: Family Policy Council closes.

National interest in Walla Walla develops, with invitations to conferences around the U.S.; James Redford begins work on documentary about Lincoln High.

September: ResilienceTrumpsACEs.org launched.

2013

February: CDC's ACE Learning Lab for local businesses draws 130 participants and creates major buzz.

June: ACEs Public Private Initiative selects five sites in Washington State, including Walla Walla, for evaluation of ACE integration at community level.

September: Walla Walla City Council recognizes CRI for its work in creating a trauma-informed and resilient community.

September: Lincoln High School ACEs and Resilience Program -- a Gates Foundation grant – reaches pregnant and parenting teens, and general student population to increase understanding of resilience and ACEs.

November: CRI "visioning" session for community sets goals and objectives.

2014

February: Lincoln High School deploys resilience-focused survey.

July: Survey finds that student resilience improved; students with higher resilience scores earn higher grades, irrespective of their ACE scores. Survey supports trauma-informed/resilience-building program.

ESSENTIAL INGREDIENTS

Take one suffering community, season with passionate leadership, a few "aha moments" and a scoop of flexible philanthropy. Stir in training by experts in the field. Whisk together a robust communication strategy and cross-sector collaboration. Sprinkle with compelling local data. Sample frequently; share results generously. Simmer on the front burner. See change happen.

If only there were a single, simple formula for integrating practices based on adverse childhood experiences research. But the five cities and four states highlighted in this cookbook—just a small sampling of the dozens nationwide that are using ACEs research to grow healthier—demonstrate that the process varies widely from place to place.

Will your effort be grass-roots or top-down? Will it be backed by a local foundation or bolstered by government support? Propelled by social workers, pediatricians, school principals or parents? Your recipe for resilience will vary depending on where you live (small town or large city), the scope of your target area (neighborhood, city, county, state, region), the individuals involved and the resources at hand.

Still, just as a savvy home cook stocks pantry staples like canned tomatoes and olive oil, certain "key ingredients" emerge from these communities' stories:

LEADERSHIP AND COLLABORATION

- Anyone—a community advocate, a local priest, an artist, a group of pediatricians—can catalyze the beginning of a community's resilience-building efforts. It can start as an informal exploration or discussion over coffee and grow from there. What's important is that the individual or group understand the foundational concepts and science of ACEs and be committed to integrating them into all parts of the community. That individual or group may go on to lead, or someone else may be the leader.
- The individual or group identifies and educates a small group (30-50 people) of community leaders about ACES, trauma and resilience. Aim for cross-sector representation (local or state government, education, law enforcement, human services, public health, civic groups).

- The most responsive and enthusiastic members of this group form a "think tank" or steering committee that drives the initial effort. That might be just a handful of people.
- This group can be housed in or hosted by a backbone organization that will provide a stablizing force and provide coordination for the movement.
- Schedule regular public meetings of the steering committee, and make them open to anyone in the community.
- Identify all sectors in the community—and their leaders—that need education about ACEs research and trauma-informed/resilience-building practices.
- Set a goal for all members of your coalition to "walk the talk" of trauma-informed practice in their own agencies and departments; at meetings, leave time for these members to share challenges, questions and triumphs.
- Learn about and develop a "collective impact" model in which multiple groups or agencies share an agenda and goals but approach those goals in different ways.
- Develop a mission statement, goals and a plan of action that your group will review and update every two years.

COMMUNITY EDUCATION

- Individuals and "think tanks" or steering committees educate themselves through research, networking and attending conferences that often provide "aha moments" about ACEs and their impact.
- Use a train-the-trainer model, developing a cadre of people who can give presentations to a variety of groups, customizing the information for different audiences—physicians, for instance, or parents of young children.
- Educate all identified sectors in the community—police departments, juvenile court judges, childcare workers—that need knowledge about ACEs by arranging presentations and/or inviting them to cross-disciplinary trainings. You're likely to have to present to the same groups more than once.
- Identify experts in adverse childhood experiences research, as well as experts from communities and sectors that are implementing trauma-informed and resilience-building practices. Invite them to speak to local or regional groups and/or attend conferences at which they are presenting.

- Plan ongoing education opportunities—from monthly "learning circles" to annual ACE Summits—to deepen understanding from "ACEs 101" to more complex ideas about impact and implementation.

RESOURCES

- Assess your resources—local funding, meeting space, in-kind support, expertise and enthusiasm.
- Apply to local or regional foundations for initial funding; a small philanthropy may be more flexible than a larger foundation or a government agency.
- Increase your reach by tapping the connections and resources of members of your "think tank" or steering committee. In Arizona, for instance, the ACE Consortium operates without a budget; members donate speaker fees, meeting space, copying and other necessities.
- Seek input from coalition members when allocating the funds you have; in Maine, for example, leaders of the state's Resilience Building Network (MRBN) decided to use funds for collective projects rather than seeding twenty different local sites.
- As the effort develops, consider the pros and cons of seeking large-scale funding from places such as the Gates Foundation (see Walla Walla story) or the Robert Wood Johnson Foundation (Philadelphia).

COMMUNICATION

- Consider a one-line slogan or tagline for your effort. The Alberta Family Wellness Initiative sought to "bridge the gap between what we know and what we do," while the Arizona ACE Consortium chose "Strong Communities Raise Strong Kids" as its motto.
- Create tools (PowerPoint presentation, web site, Facebook page, brochures, video to post on YouTube) to share research about ACEs and resilience, inform leaders and the public and provide ways for people to get involved.
- Draft a memorandum of understanding (see Tarpon Springs story) and have local government provide official recognition of its standing as a trauma-informed, resilience-building community.
- Conduct media outreach at every step through traditional news outlets (radio, television, newspapers, magazines), digital media (blogs, online toolkits) and social media.

- Form a local group on ACEsConnection.com.
- Document your efforts (see Walla Walla story) so others can learn from your community's experience.
- Celebrate progress and successes.

DATA/RESEARCH

- Identify any trauma-informed or resilience-building efforts already underway in your area, and connect with the leaders of those efforts.
- Do an ACE survey (see Arizona, Iowa, Maine and Philadelphia stories) to set a baseline against which to measure change and to gauge the impact of ACEs in your area. Do a survey to assess providers' understanding of ACEs/resilience.
- Develop common measures of success and ways to gather feedback—ranging from evaluation sheets at workshops to longitudinal research on changing attitudes and practices (see Alberta story)

MINDSET

- Recognize that deep-rooted attitudes—for example, a belief in individual responsibility and self-sufficiency—may present barriers to understanding ACEs and resilience, and that such attitudes take time to change.
- "Follow the interest" in ACEs education and trauma-informed practices (see Arizonastory); be open to "uncommon partners" in the work.
- Let local conditions—high violence rates in Camden, the level of child poverty inMaine—create a sense of urgency and fuel your education efforts.
- Remember that becoming trauma-informed is a long-term process, and that not everyone will "come on board" right away.
- Recognize how past trauma—for instance, a natural disaster, racial or ethnic conflict or the job losses that accompanied the closing of a major employer—affects your community now. Be willing to address these issues in a sensitive and inclusive way.
- "Work small and think big"—that is, to put trauma-informed practices in place in your own coalition and day-to-day work while building alliances and momentum for larger-scale change.

- Focus on hope, resilience and change without losing sight of the deep and long-term impact of childhood adversity. Remember that ACEs are not destiny; if the brain can be hurt, it can also be healed.
- Seek community; nourish yourselves; remember that you are not alone in wishing to create a more just, compassionate and healthy world.

RECIPE FOR RESILIENCE

Here is one recipe that includes the essential ingredients gathered from 9 Tastes of Success from 9 different communities. The recipe is presented in the infographic, followed by a text description to more fully explain each step. Your community may follow this recipe as a guide, or as you take stock of your strengths and resources and find that you want to put together these ingredients in a different order, or using a slightly different set. You can print this infographic and the text, and share with your own community to start your plan. You can share your Recipe, as you put it together, or your "Questions for the Cooks" in the comments section below.

1. Someone starts. Anyone—a community advocate, a local priest, an artist, a group of pediatricians—starts the conversation and catalyzes, the community's trauma-informed, resilience-building efforts. That person may lead, or someone else may lead from there.

What's important is that the individual or group understand the science of ACEs and be committed to integrating them into all parts of the community.

2. Local efforts. Identify any trauma-informed, resilience-building efforts under way locally and engage the leaders of those efforts.
3. Engage local leaders. The individual or group identifies a small group (30-50 people) of community leaders from different sectors—education, human services, juvenile justice, mental health—and educates them one-on-one about ACES, trauma and resilience.
4. Steering committee and Backbone organization. The most enthusiastic members of this group form a steering committee that drives the initial effort, and become the backbone organization or the committee may be housed by one of the member's organizations.
5. ACEsConnection group. Form a local group on ACEsConnection.com.
6. Make history. Document your efforts so others can learn from your community's experience.
7. Collective impact. Develop a "collective impact" model in which multiple groups or agencies share a mission and develop a collaborative approach to carry out that mission.
8. Local resources. Assess your resources—local funding, meeting space, in-kind support, etc.

9. Mission, goals, action. Develop a mission statement, goals and a plan of action; review and update every two years.
10. Slogan. Develop a one-line slogan or tagline.
11. Local data, local urgency. Use local data to create a sense of urgency.

Focus on hope, resilience and change without losing sight of the deep and long-term impact of childhood adversity. ACEs are not destiny; if the brain can be hurt, it can also be healed.

12. Communication tools (Develop PowerPoint presentation, web site, Facebook page, brochures, video).
13. Public meetings. Schedule regular public meetings of the steering committee and make them open to anyone in the community.

Be open to "uncommon partners" in the work.

14. Local funding? Apply to local or regional foundations for initial funding, but don't stop if you don't get funding.
15. Walk the talk. Set a goal for all members of your coalition to "walk the talk" of trauma-informed practice in their own agencies and departments.

"Work small and think big"—that is, put trauma-informed practices in place in your own coalition and day-to-day work while building alliances and momentum for larger-scale change.

16. Presenters. Develop and train a cadre of people who can give presentations to different sectors—nurses, probation officers, pediatricians, Rotary Club, teachers—in the community.
17. Educate. Present. Educate. Repeat. Do presentations about ACEs and resilience for all identified sectors in the community—police departments, juvenile court judges, child-care workers. Present to the same groups multiple times; it takes repeated exposures for new information to take hold.
18. Local ACE survey. Develop measures of success: an ACE survey and a "comprehension" survey to assess understanding of ACEs and resilience.
19. Feedback. Develop ways to gather feedback (e.g., evaluation sheets at workshops).

Recognize that deep-rooted attitudes—for example, a belief in individual responsibility and self-sufficiency—may present barriers to understanding

ACEs and resilience, and that such attitudes take time to change.

Remember that becoming trauma-informed is a long-term process, and that not everyone will "come on board" right away.

20. Summits, learning circles. Plan public education meetings—monthly "learning circles," annual ACE Summits. Start with "ACEs 101" and move to more complex trainings on impact and implementation.

Recognize how past trauma—whether economic, environmental or political—affects your community now. Be willing to address these issues in a sensitive and inclusive way.

21. Media. Conduct media outreach at every step through local news, including traditional (newspapers, magazines), digital and social media.

Celebrate progress and successes.

22. Official recognition. Develop an MOU—memorandum of understanding—for local government to provide official endorsement and support of your organization and its goal of creating a trauma-informed, resilience-building community.
23. Large-scale funding? Decide whether to seek large-scale funding to support the steering committee and its work.

Ask your "Questions for the Cooks" in the comments section below or click here to comment at ACEsConnection.com

REFLECTION QUESTIONS

These Reflection Questions are designed to help you think through where the strengths are in your community and how you can design your path forward.

- In your community, which groups, agencies or individuals have already been exposed to the ACE study and the concepts of toxic stress and resilience?
- In your community, who has yet to learn about this information?
- What are some ways you can educate others about ACEs, toxic stress and resilience? Who can help you in this effort?
- What kinds of data and research would help you understand the impact of ACEs in your community? Does any such data already exist? If not, how could you gather it?
- In addition to the ACEs counted in the 1998 Kaiser study, are there other sources of adversity particular to your community, such as neighborhood violence, racial/ethnic discrimination or the trauma caused by a natural disaster like flood or fire?
- Who can be your partners in the work of preventing childhood adversity and building resilience among individuals and families? Think about obvious partners and uncommon/unlikely allies and collaborators.
- What would you or your organization do to prevent ACEs and boost resilience if you had absolutely no budget? What would you do if funds were unlimited?
- What are the skills, assets and resources in your community that might be tapped in the work of preventing childhood adversity and building resilience? What skills, assets and resources do you need?
- What kinds of education, training, supervision or mentorship could help your community become more trauma-informed?
- When you envision a resilient community, what do you see? How would it be different from what currently exists? How will you get from here to there?

Please share comments or additional reflection questions that may help others advance the work on ACEs and resilience.

RESOURCES

For more information on each community featured in "Tastes of Success" sign up on ACEsConnection.com to connect with these and other people

Alberta, Canada Contacts: Michelle Gagnon and Sheryl Fricke

Arizona Contact: Marcia Stanton

Camden, New Jersey Contact: Father Jeff Putthoff

The Dalles Contact: Trudy Townsend

Iowa Contact: Suzanne Mineck

Maine Contact: Sue Mackey Andrews

Philadelphia, Pennsylvania Contact: Leslie Lieberman

Tarpon Springs, Florida Contact: Robin Saenger

Walla Walla Contact: Teri Barila