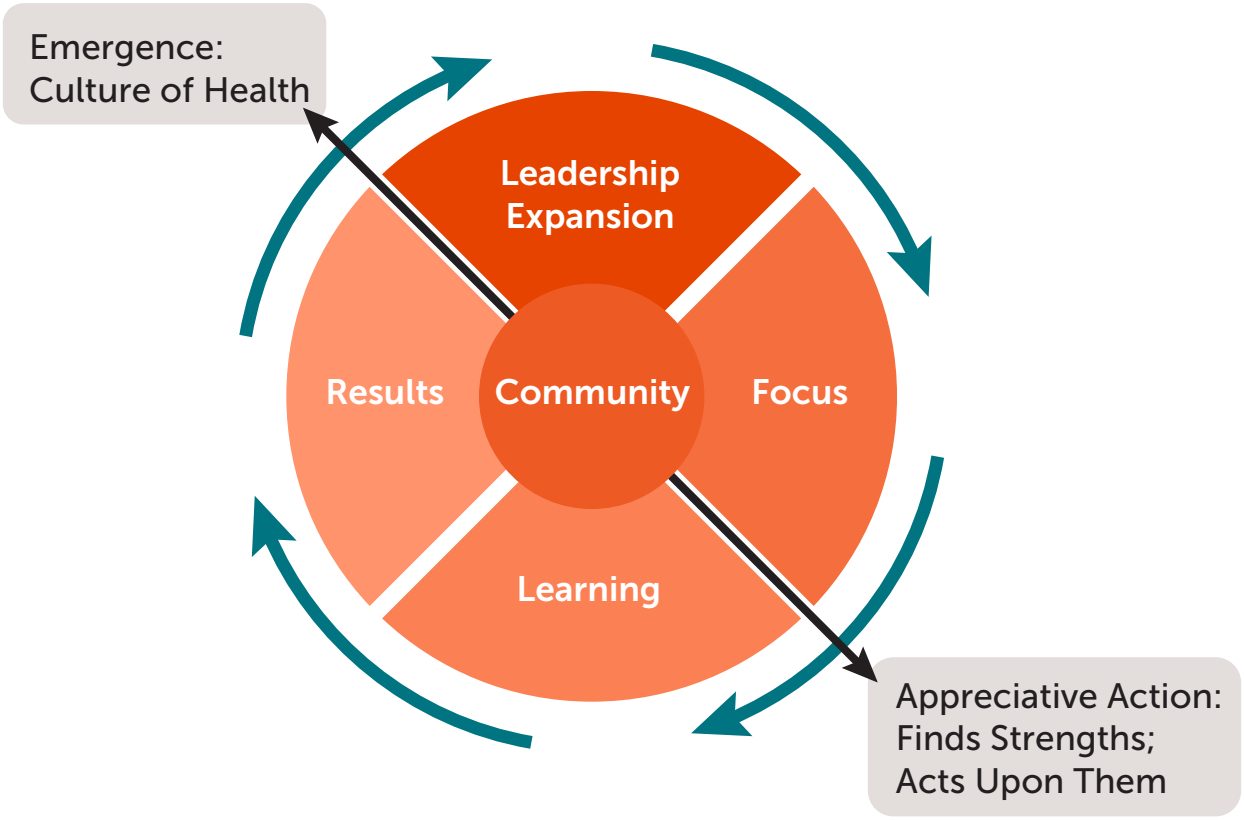
Robert Wood Johnson Foundation

Self-Healing Communities

A Transformational Process Model for Improving Intergenerational Health

Executive Summary



Commissioned by the Robert Wood Johnson Foundation

Laura Porter
Kimberly Martin, PhD
Robert Anda, MD, MS

June 2016

Self-Healing Communities

A Transformational Process Model for Improving Intergenerational Health

EXECUTIVE SUMMARY

This article presents a model with demonstrated success in improving rates of many interrelated and intergenerational health and social problems by investing in the people most at risk and reducing and preventing the root cause of these problems: Adverse Childhood Experiences (ACEs).The Self-Healing Communities Model (SHCM) builds the capacity of communities to intentionally generate new cultural norms and thereby improve health, safety and productivity for current and future generations.

The SHCM brings together recent scientific discoveries into a single framework. In less than three decades, scientific discoveries in epidemiology, neuroscience, epigenetics, and network and systems theory have changed our understanding of the origins and dynamics of social and health problems. The landmark Adverse Childhood Experiences Study established that accumulation of adversity during child development, including abuse, neglect and household dysfunction, is the most powerful determinant of the public's health. We have also learned about the power of networks to carry information, connect like-minded people, and provide a flexible yet durable infrastructure for social movements. The scientific framework for solving problems in our world has been also transformed by chaos, quantum and relativity theories. When combined together, these recent discoveries call for new modes of thinking and action that transcend traditional linear and categorical thinking about prevention of our nation's most troublesome health and social problems.

Importantly, in this same time period we have experienced and describe herein a fast-paced journey that transitioned from knowledge acquisition and management by experts, to distributed knowledge that is managed and shared by the population as a whole. Knowledge is changing so fast that detailed plans and programs can become obsolete before they can be implemented; therefore, system-innovation processes must be integrated into health improvement strategies and policies. The SHCM promotes emergence of new ways of fostering a Culture of Health in communities that incorporates low-cost, locally promoted, sustainable solutions on a scale that can match the magnitude of health and social problems.

In this new paradigm, it is becoming increasingly clear that direct-service interventions are necessary but not sufficient to produce transformative health improvements, generate population-based change, or catalyze the social movement necessary to address the scope of the problems generated by ACEs. Direct services reach only a small portion of the people affected, and the cost of direct services prohibits their use as a primary strategy for preventing ACEs, their intergenerational transmission, and the wide array of serious health and social problems they cause. Moreover, these services are often limited in their effectiveness and generally not designed to address complex and comorbid health and social problems concurrently, even though co-occurring problems are common among children and adults with high ACE scores. And challenges associated with the maze of eligibility and application processes, silos of programming, and limited service availability in communities that are most in need do nothing to slow the escalation of adversity across the life course that leads to a vicious cycle of ever-increasing demand on service systems.

Investments in static or structural solutions will not solve dynamic problems. Rather than restructuring decision-making groups, programs, service locations or evaluation dashboards, we need to engage the public, inspire innovation, support peer helping, ease the daily stress burden of parents and promote change in all of the systems that serve them so that together communities can better protect and nurture the next generation. ACEs are common in every socioeconomic group in our nation. We have to change the way we think about social problems and solutions to generate change that is affordable, scalable, and designed to produce exponential improvements in population health.

The SHCM is based on 15 years of promoting community capacity and culture change in communities across Washington State, where health outcomes were dramatically improved as a result. In the SHCM, as communities develop the capacity to shift typical cultural patterns, individuals within the community gain new knowledge and skills, and the community as a whole becomes proficient at critically evaluating all of the underlying assumptions that shaped previous action. Residents and professionals co-create practice-improvement cycles that produce stunning results. Investments in culture change processes are vital for this success.

CULTURE AND COMMUNITY CAPACITY

Strategies that increase the capacity of a community to reduce adversity can be incorporated as new and customary ways of being with self and others. These new ways change how people experience and deal with the world: their culture. Culture comprises the abstract, learned, shared rules/standards/patterns used to interpret experience and shape behavior (Martin, 1997). We are not consciously aware of most of our culture; instead, culture becomes our autopilot. We unconsciously follow cultural norms, but we also have the ability to consciously take control of our perceptions, thoughts and behaviors. In order to improve generational health and equity, we need to empower communities to recognize their own ability to make change, engender hope that what they do will make a difference, and challenge unexamined patterns that prevent realization of the community's aspirations. The processes communities use to improve hope and efficacy, examine patterns, and make cultural changes are general community capacity-building processes.

General community capacity (GCC) refers to the ability of a geographically based group of people to come together, build authentic relationships and reflect honestly about things that matter, share democratic leadership, and take collective actions that assure social and health equity for all residents (Morgan, 2015). Increasing the GCC of a community is a holistic, long-range culture-change strategy that includes connecting people so that they can provide support and assistance for each other and generate solutions for locally prioritized issues. Better adapted, more resilient communities with high community capacity have extensive, community-wide networks of relationships through which reciprocity can flow and foster collaboration.

The SHCM has the power to decrease ACE prevalence and intensity from one generation to the next, thereby concurrently reducing many mental, physical, behavioral and economic/productivity problems. Solutions are durable because they are born from culture change—change that becomes a part of the autopilot for people's ways of being with one another. Improvements are sustainable because they originate from solving problems, rather than treating symptoms, and they emerge from within the often-unexplored pool of creativity, resources and resilience in communities that change from their traditional "autopilot" to a culture that creates health.

THE SELF-HEALING COMMUNITIES MODEL

From 1994 to 2012, Washington State supported use of the SHCM in 42 communities. Community capacity was assessed using an index containing indicators of effective use of the four process phases of the SHCM: leadership expansion, focus, learning and results. Communities using the SHCM for eight or more years reduced the rates of seven major social problems: child abuse and neglect, family violence, youth violence, youth substance abuse, dropping out of school, teen pregnancy and youth suicide. Communities with consistently high index scores improved five or more separate problem rates concurrently. Per-year avoided caseload costs in child welfare, juvenile justice and public medical costs associated with births to teen mothers were calculated to be over $601 million, an average of $120 million per year, for a public investment of $3.4 million per year (Scheuler et al., 2009).

The SHCM has three properties, each of which is essential to the process by which change occurs.

I. Partners

Funders, subject matter experts, service providers and community members are partners who work in concert to support culture change. Partners each work in their own sphere of influence as meta-leaders, and together their insights and abilities link and leverage efforts, transcending the limitations of existing silos and services to generate connectivity and achieve unity of purpose. Direct services provide financial, transportation, and other resources in times of crisis, and they can develop individuals' capabilities necessary for participation in community life. In Self-Healing Communities, these same services are delivered in ways that also build community and social networks that will remain in the lives of clients after formal services have ended.

II. Principles

Six principles create the integrity of the SHCM: (1) inclusive leadership; (2) learning communities; (3) emergent capabilities; (4) engagement informed by neuroscience, epigenetics, adverse childhood experience and resilience research (NEAR); (5) right-fit solutions; and (6) hope and efficacy. The use of these principles requires a fundamental understanding of meta-leadership and a commitment to consider everyone who wants to help as a leader of culture change. In order to fully infuse these principles into community capacity-building work, community members participate in learning, skill-building, as well as design and implementation of new strategies for improving health. They participate in regular reflective dialogue about the degree to which all aspects of community strategy and activities are consistent with the principles.

III. Process

The SHCM process consists of four phases of community engagement: leadership expansion, focus, learning and results. Use of the process provides increasing opportunity for community members to overcome or reduce stress and adversity and the life challenges they generate by developing and expanding healthy social and cultural networks and practices. The rhythm of the SHCM four-phase process allows time for reflection and emergence of new perspectives, leaders and opportunities, and for active inquiry and intentional changes to policies, formal services, and the day-to-day interactions of community members. The phases of this process are powerful because success in each phase naturally invites the next, forming what systems-thinking experts call a virtuous self-reinforcing cycle that mirrors the emerging understanding of healthy living systems.

IMPLICATIONS

The health and social problems we are facing in many communities are highly complex. They are interrelated and intergenerational. To the extent that existing interventions can address problems, they tend to focus on narrow sets of outcomes and are hard to adapt to real-world conditions. Interventions tend to be expensive, and yet we have very limited fiscal resources. If we have any chance of turning things around, we need right-fit solutions that address the complexity of problems and will inspire emergent change in different community environments at a modest cost. Building the community capacity to create a Culture of Health for neighborhoods and families offers us the best hope for doing that in our time.

References

Martin K. Diversity orientations: Culture, ethnicity and race. In *Cultural Diversity in the United States*, Naylor L (ed). Westport, CT: Bergin & Garvey, 1997.

Morgan GB. "Building Community Capacity: A Qualitative Study." Unpublished doctoral dissertation, Seattle University, 2015.

Scheuler V, Goldstine-Cole K and Longhi D. *Projected Cost Savings Due to Caseloads Avoided: Technical Notes*. WA: Washington State Family Policy Council, 2009.

About the Authors

Laura Porter is co-founder of ACE Interface, LLC. Ms. Porter supports leaders in over 25 states, providing education, facilitation and empowerment strategies for building flourishing communities. Ms. Porter concurrently serves as the senior director of The Learning Institute at the Foundation for Healthy Generations, a Seattle-based nonprofit. She is an award-winning public servant who is best known for her work directing systemic improvements to the child and family serving system in Washington State. Working with elected and appointed state officials from the legislature and seven state agencies, and leaders of community-based collaborative organizations, Ms. Porter and colleagues developed a unique model for improving the capacity of communities to deliver stunning results for a small investment. Ms. Porter holds a BA degree from The Evergreen State College.

Dr. Kimberly Martin is a professor of anthropology at the University of La Verne and president of the Southwestern Anthropological Association. Dr. Martin's areas of specialization include cognitive and psychological anthropology, gender, sustainable culture, culture change, ethnic identity and group affiliation in the United States, Europe, Mesoamerica and the Pacific. Her current interests involve culture change theory as it applies to identity, affiliation, and sustainability in a globalizing world. Dr. Martin teaches a variety of anthropology and student research courses at the University of La Verne. She has also served as a multicultural consultant, leading workshops for educational, government and professional organizations. Dr. Martin earned a BA in Psychology from Stanford University, an MA in Anthropology from the University of Hawaii and a PhD in Anthropology from the University of California, Riverside.

Dr. Robert Anda is co-principal investigator of the Adverse Childhood Experience Study (ACE) and co-founder of ACE Interface, LLC. For more than a decade, Dr. Anda served as a senior scientist at the Centers for Disease Control and Prevention conducting research in disease surveillance, behavioral health, mental health and disease, cardiovascular disease, psychosocial origins of health-risk behaviors, and childhood determinants of health. Dr. Anda is the author of more than 200 publications, including numerous government publications and book chapters, and has received many awards and recognition for scientific achievements. The ACE Study is being replicated in numerous countries by the World Health Organization (WHO), and is in use to assess the childhood origins of health and social problems in more than 25 U.S. states. Dr. Anda provides education and consultation about the ACE Study and its application throughout the country, and throughout the state of Washington. Dr. Anda holds an MD from Rush Medical College with board certification in internal medicine, and an MS degree in Epidemiology from the University of Wisconsin.

ACKNOWLEDGMENTS

The generous support of the Robert Wood Johnson Foundation made the formalized description of this model possible. The authors extend their appreciation for the Foundation's innovative approach and commitment to health equity and an intergenerational Culture of Health.

We acknowledge important contributors to this article, including Erin A. Cusick for copyediting, Kevin Kowalewski of Cryan Design for graphic arts, Joseph Cabrera for statistical methods consultation, and all of the members of Self-Healing Communities throughout the state of Washington.