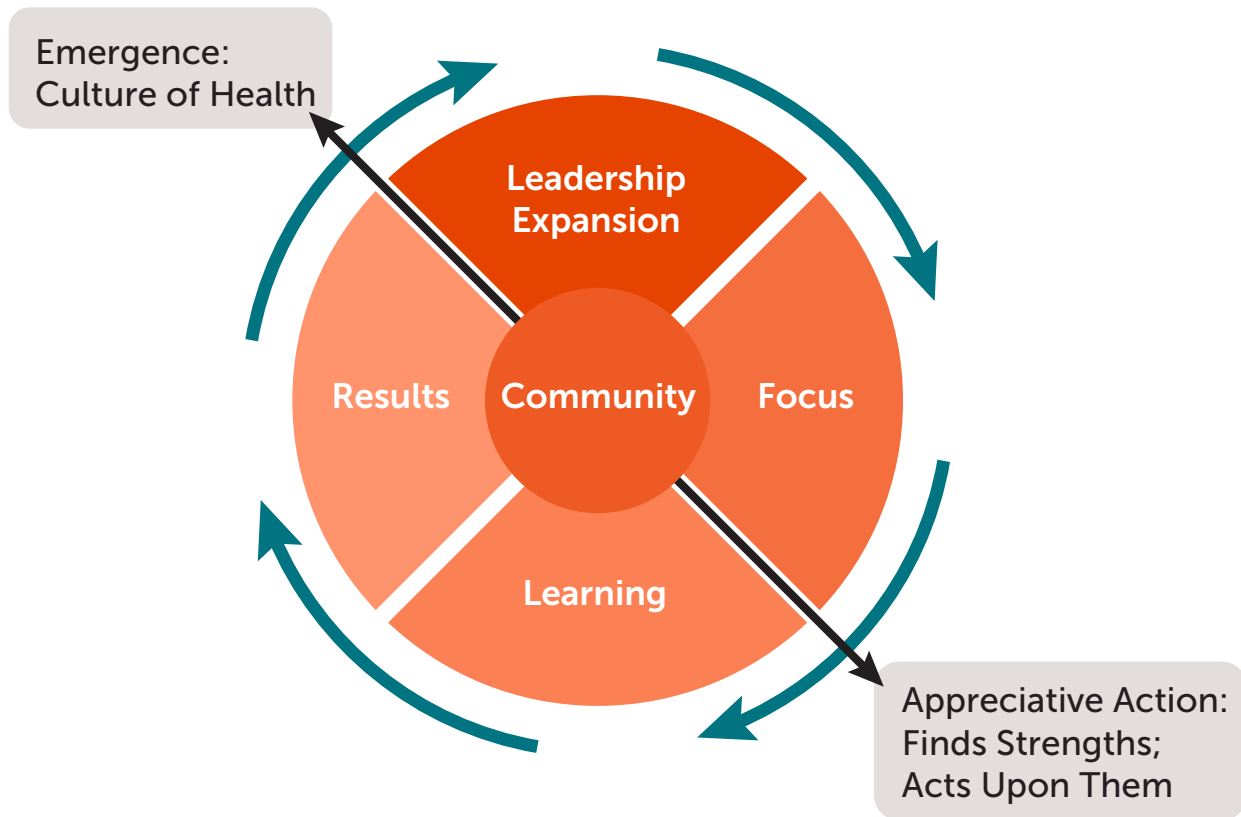


Self-Healing Communities

A Transformational Process Model for Improving Intergenerational Health



Commissioned by the Robert Wood Johnson Foundation

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In the 1980s, when the timber and fishing industries declined, and in 2003, when the aluminum reduction manufacturing plant went bankrupt, Cowlitz County residents lost more than jobs—they lost their ways of life. Compounding problems, the region was also devastated by the volcanic eruption of Mount St. Helens in 1980 and the second largest urban landslide in U.S. history in 1998. Through the 1980s and 1990s the county experienced chronic underemployment (over 15 percent), and many health and social problems—infant mortality, births to mothers ages 10 to 17, violence against self and others, chronic disease, youth hospitalizations for suicide attempts, and dropping out of school, for example—were occurring at rates in the worst quartile of county rates throughout the state. In less than two decades, though, this community has achieved stunning child safety and school completion results for a small investment (see Table 1).

The turning point occurred when their theory of change shifted from solely adding or enhancing direct service programs to incorporating layers of strategy that supported parents as agents of culture change. They began working to “improve parent skills so they can give sound advice and be good mentors to their children, and, in turn [parents] will gain skills and relationships to give sound advice to the community—and that advice will make a better system of help for them and for other families” (Cowlitz Network Report, 2007). They held education events to learn about the science of adversity, hosted networking cafés, organized neighborhood residents and linked service strengths across disciplines; for example, court-appointed special advocates were deployed in schools to ensure that children served by the child welfare system had appropriate education plans that supported their academic progress. The work was strategic, personal and trauma-informed.

Cowlitz County’s story demonstrates what is possible when a community turns from a culture of illness, conflict and despair to a culture of self-healing. When 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 a learning organization characterized by a rhythm of engagement that invites flourishing: continuous, steady, strong growing into well-being.

Creating this kind of change is the goal of the Self-Healing Communities Model (SHCM), a process model with demonstrated success in improving the rates of many interrelated and intergenerational health and social problems.

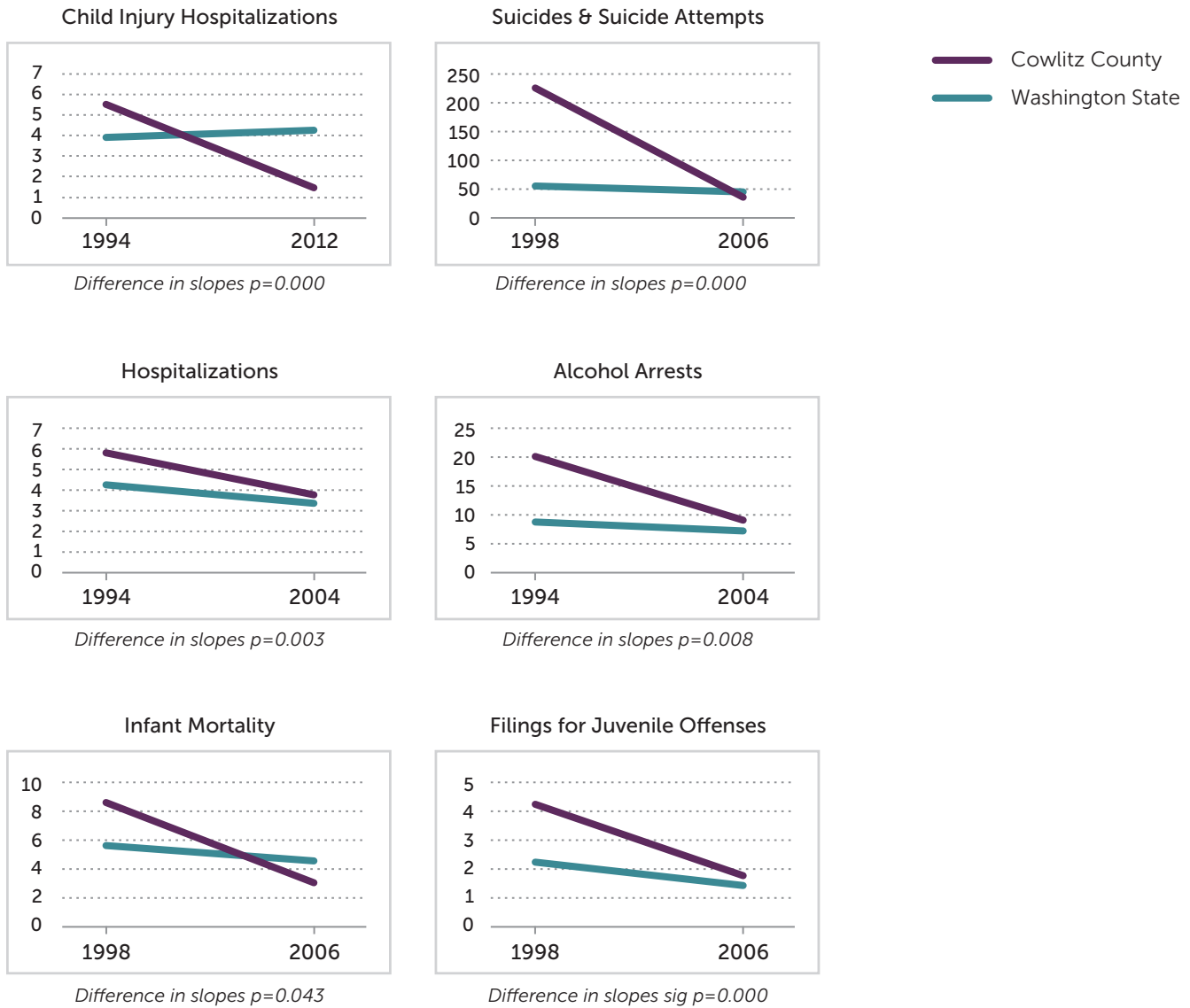
The SHCM builds the capacity of communities to define and solve problems most relevant to them and generates new cultural norms that mirror the values and aspirations that community members have for their children. It requires investment in the processes of healthy community and family life: engagement, learning, innovation and reflection. Uncommon partners across disciplines, systems and cultures must be invited to share resources, high expectations, respect, and a commitment to a new sense of shared identity—one of hope, optimism, efficacy, curiosity and welcoming.

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Table 1

Change in Rates of Selected Youth & Family Problems Cowlitz County versus Washington State Rates

Note: Please refer to Appendix 1 on page 16 for the complete data labels for each graph.



Source: Washington State Department of Social and Health Services Research and Data Analysis Division, 2015

SELF-HEALING AND SHARED LEADERSHIP

Cowlitz County is just one of dozens of communities that implemented SHCM strategies over 15 years to achieve profound change. A key strategy from the SHCM is the expansion of leadership: empowering community members to participate in decision-making and problem-solving. In 2005, Cowlitz County employed this approach in order to address problems in a neighborhood that was documented to have the highest emergency call rates. A project coordinator sat on the hood of her car in the neighborhood, day after day, even though residents came out of their houses to say that she should not be sitting there because the neighborhood wasn't safe. She knocked on doors and talked with individuals at the thresholds of their homes asking how she could help. Residents warned her that it was dangerous to hang out on the streets in their neighborhood, especially at night, because of a pack of feral dogs.

The coordinator knew the *prevailing view* about why it was so dark in that neighborhood at night—*people like the dark because it covers up criminal activity*. She questioned that assumption and asked the people who lived there: "Why is it so dark here at night?" When she heard the answer, she thought, "Shame on us that we didn't know: It's dark in this neighborhood because people can't afford lightbulbs."

There were three problems that affected the neighborhood: (1) darkness and danger; (2) people feeling powerless over their own safety; and (3) wrong assumptions that created a barrier to real improvements in the quality of people's lives. Seeing these dynamics inspired creative and powerful solutions.

Notes were delivered to all the houses letting people know that volunteers (recruited from civic clubs) would be coming to each house to count the number of outdoor light fixtures missing lightbulbs. The note invited every person to participate in a free barbecue and community lighting ceremony—with bulbs supplied by a hardware store owner who was invited to help. A date was set for a celebration that neighborhood residents called *Take Back the Light*. Lightbulbs were distributed to people who could install them, and they waited for the time when everyone would turn on the lights at the same moment. When the lights came on, the celebration began: free food, music, conversations among people who had feared one another, and hope.

People began to think about what else they could do to make their neighborhood even better. The *Take Back the Light* initiative provided a simple solution to a problem that residents cared deeply about and became a symbol of the kinds of small changes with big impact that could be accomplished when people take time to truly

understand one another. Because the action addressed a problem that was important to those living with it and the solution involved everyone in the area, success belonged to the neighborhood, and everyone had the satisfaction of being a part of the change. People who were not considered leaders in the past became leaders of the future, and the capacity of the community to solve problems flourished.

NEW APPROACH PRODUCES PROFOUND RESULTS AND COST SAVINGS

In 1994, 10 elected and appointed state officials working as the Washington Family Policy Council oversaw formation of a statewide system of local coalitions called Community Public Health and Safety Networks (Networks). Networks were required by the state to prioritize and select three of seven¹ social problems for improvement and were provided small grants and technical assistance from the Council. At that time, the Council and Networks used a standard approach to prevention: monitoring risk and protective factors for each social problem, targeting factors for change, analyzing service gaps related to the factors, and selecting programs to fill those gaps. Assistance for communities was intended to help community coalition members to make decisions about prevention program selection in order to achieve desired participant outcomes.

Community decision-making was informed by cross-sectional data (e.g., monthly number of out-of-home placements of children; annual arrests for violent crime). These data document what is occurring, but do not illuminate why. Use of this type of data typically invites debate about which problems are worse than others, which, in turn, becomes a barrier to creating collaborative solutions.

In 1999, Council staff made an intentional change in the way they worked with communities. The Council brought together two scientific frameworks, each of which offered new paradigms of thought that were relevant to generating health and social improvements: living systems theory and Adverse Childhood Experience (ACE) Study concepts. At that time, living systems theory, incorporating relativity, chaos, quantum and network theories, had not been widely applied in the social sphere. The ACE Study findings revealed childhood adversity—such as abuse or neglect—to be the common origin for the social problems of concern to Washingtonians. Washington State was among the first of the states to apply these findings in order to reduce all

1 Networks selected three of the following: child abuse and neglect; family violence; youth violence; youth substance abuse; dropping out of school; teen pregnancy; or youth suicide.

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ACE-attributable problems concurrently. Taken together, systems theory and ACE concepts became a new unifying framework for improving the lives of children, families and communities.

As community residents and professionals became more familiar with using systems-thinking knowledge and tools, they also became more hopeful, engaged and motivated to co-create positive change in their communities. State staff compiled and distributed trend-over-time data for each community in order to support local dialogue and insight about drivers of social patterns. Conversation among Network and Council members shifted from a focus on answers, to examination of past assumptions and future possibilities.

Communities are complex, dynamic systems; concurrently, individuals affect community, and community affects the lives of individuals. Council staff understood that making improvements within complex, dynamic systems is not a deterministic process. There is no silver bullet. Therefore, the Council urged communities to continuously learn, manage and improve their strategies, focus on preventing the origins of health and social problems, and develop redundancies and habits of working that would enable rapid response and course correction when unintended consequences occurred.

Changes that Council staff made in orientation and activities included the following:

1. Learning directly from leading researchers in the fields of neuroscience, epigenetics, ACEs, and resilience (NEAR Science), as well as complexity theory. Social networks were used to disseminate scientific findings with fidelity via a train-the-trainer program. Quarterly education events were designed to develop a knowledge ecology that was welcoming, challenging and celebratory (Goldstine-Cole, 2009).
2. Organizing decision-making around two core values: fundamental respect for the wisdom in every human being and transformational change, and employing a few basic principles in their work, namely, inclusive leadership, NEAR-informed engagement, emergent capabilities, right-fit solutions, and hope and efficacy. These principles informed a coaching model for technical assistance.
3. Changing contracts to require course correction when outcomes were not favorable. The contracts controlled for learning and application of learning, thus turning away from traditional contracting forms that control for activities or outcomes. Both the state and local parties to the contract agreed to learn, manage and improve their own roles in the dynamics that were generating child and family outcomes.
4. Using findings from communities as a springboard to introduce new questions into state policy deliberation. For example, social problem rates were not randomly distributed among communities in Washington. Some communities had none of these problems occurring at high rates; other communities had all of these problems occurring at high rates. The Council asked: Does the state need to be a different kind of partner in places where many problems occur at high rates?
5. Reducing the frequency of required reporting in order to support deeper reflection and meaning-making at the local level.
6. Measuring the development of community capacity for solving interrelated social problems using an index developed for this purpose. At the same time, the Council monitored the correlation between community capacity index scores and changes in the rates of seven social problems in communities using the SHCM. Comparison counties were not using the model. Monitoring revealed profound results: Rates of multiple problems were reduced concurrently in communities using the SHCM consistently for eight or more years (see Tables 2 and 3).

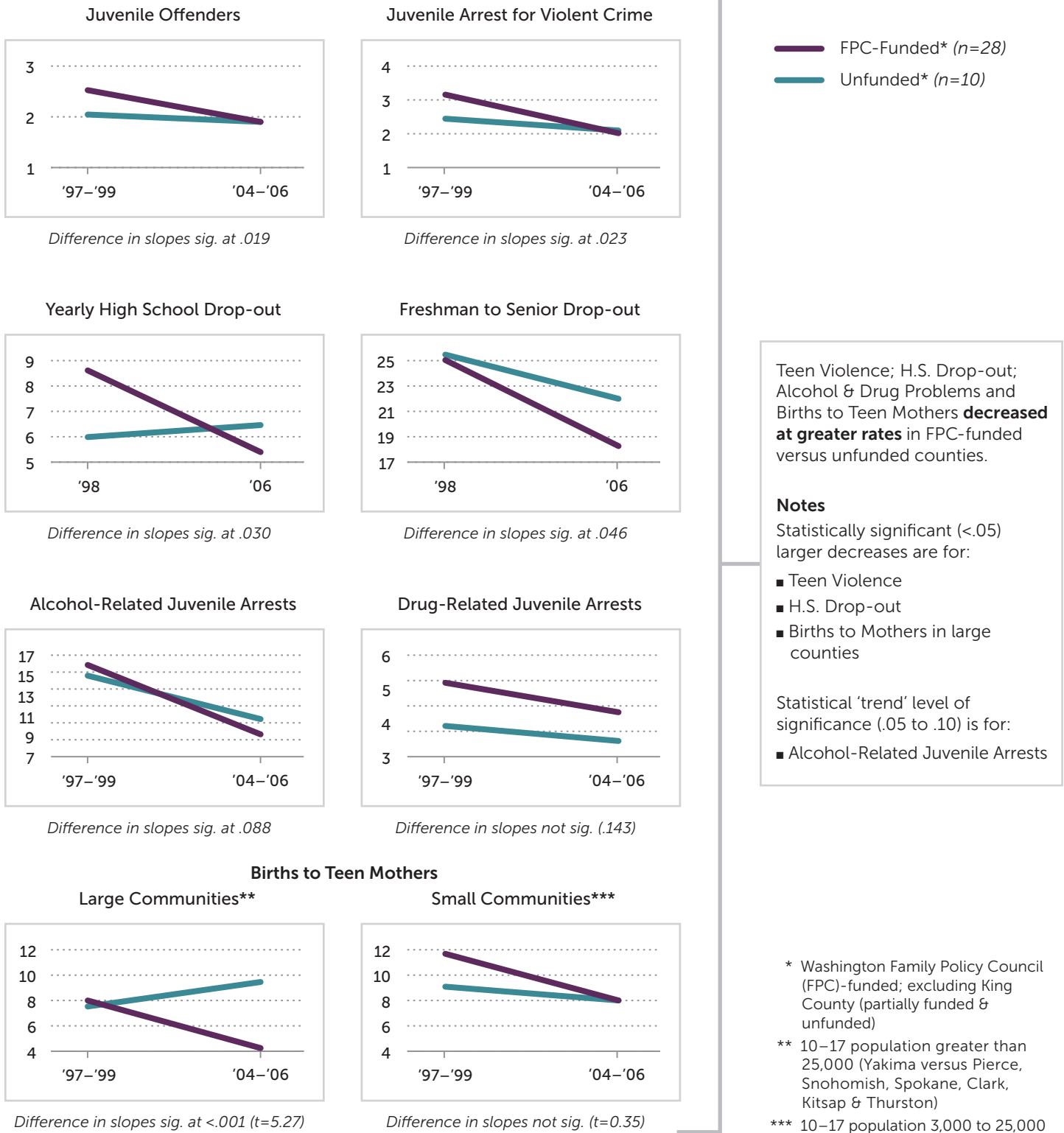
The SHCM mirrors how living systems retain identity and health under changing conditions. Yet this model is not simply about sustaining change. It is also about change that is focused on common origins of many high-cost health, social and productivity problems. It is about working with a whole new point of view regarding where problems come from.

The ACE Study concepts, including NEAR research findings, provide a framework for transformational change. Because ACEs are common across all socioeconomic and ethnic groups, diverse people relate personally to this science. When people learn about ACEs, many experience increased compassion for self and others and an 'aha' insight about how our efforts can fundamentally transform the health of future generations.

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Table 2
Change in Rates of Youth & Family Problems Among Teens
FPC-Funded Counties versus Unfunded Counties

Note: Please refer to Appendix 1 on page 16 for the complete data labels for each graph.

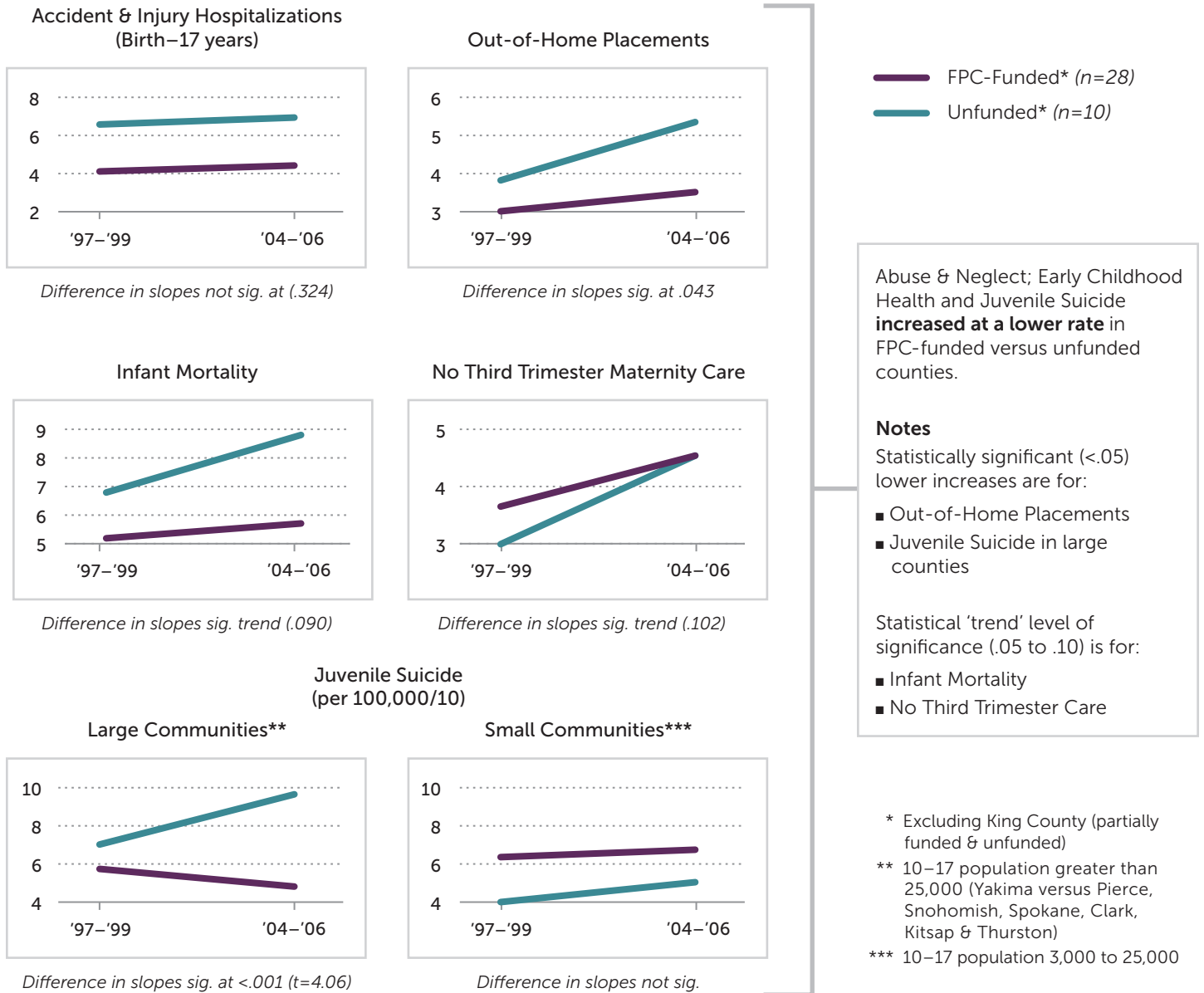


Source: Longhi et al., 2009

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Table 3
Change in Rates of Children & Family Health & Safety Issues
FPC-Funded Counties versus Unfunded Counties

Note: Please refer to Appendix 1 on page 16 for the complete data labels for each graph.



Source: Longhi et al., 2009

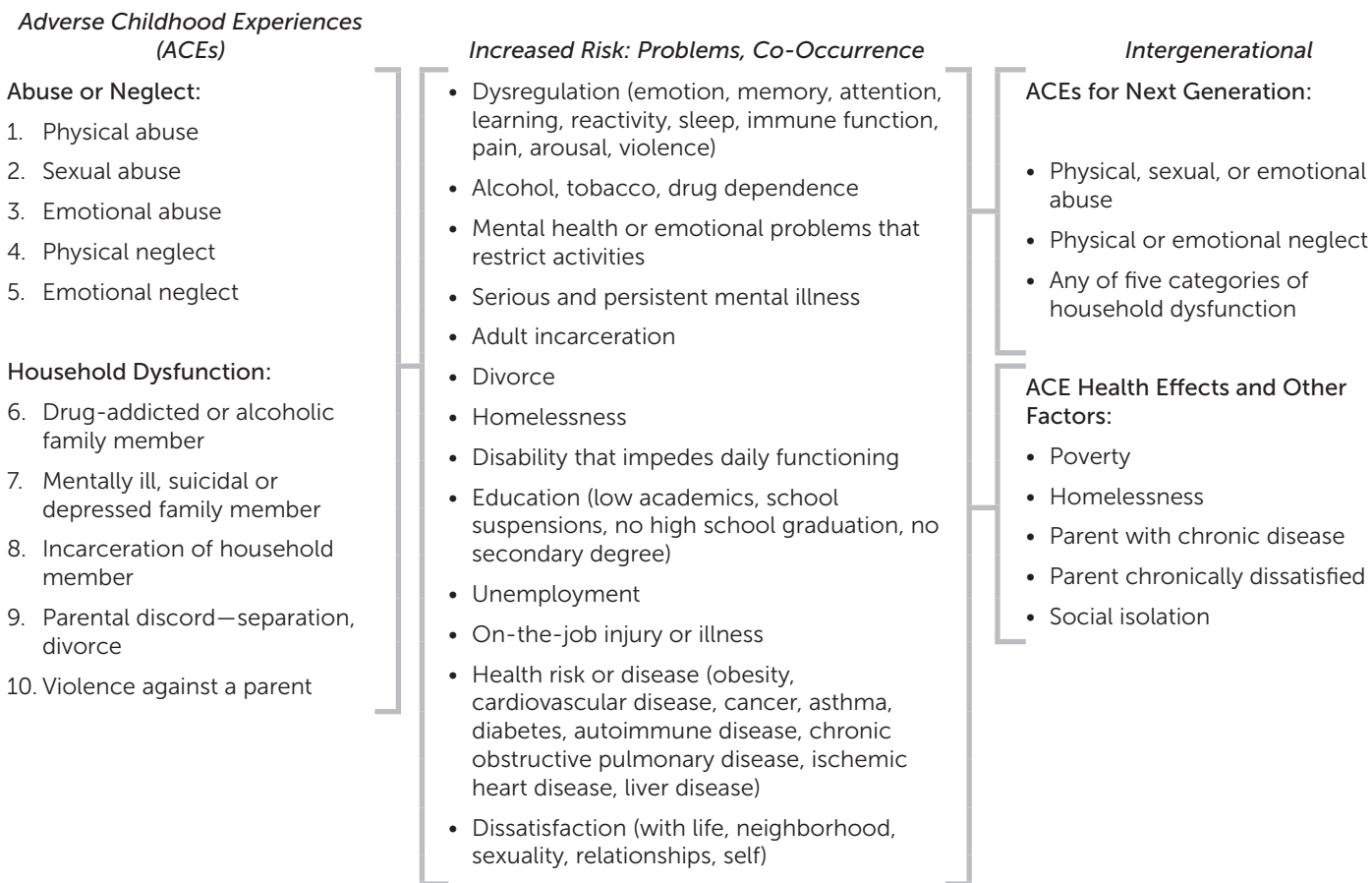
The Washington experience produced stunning results for a small investment. The budget for the Community Network partnership using the SHCM was, on average, \$3.4 million per year between 1994 and 2011. Per-year avoided caseload costs in child welfare, juvenile justice and public medical costs associated with births to teen mothers were calculated to be \$27.9 million, based on prevented cases between 2002 and 2006 (Scheuler et al., 2009). Because of the progressive nature of adversity and associated costs for public services throughout the life course, plus lost tax revenue from productivity loss, the taxpayer savings from Network-improved rates from 2002 to 2006 were conservatively estimated at an average of \$120 million per year (Scheuler et al., 2009). The cost/benefit ratio for this investment is impressive: for every dollar spent, 35 dollars were saved (Scheuler et al., 2009).

UNDERSTANDING HEALTH AND SOCIAL PROBLEMS

Our understanding of the origins and dynamics of child, family and community problems changed rapidly during the period of time when the Council and Networks were developing methods and strategies for improving child and family life. Those changes were integrated into the work. In 1998, the first peer-reviewed publications from a landmark study [Adverse Childhood Experiences (ACEs)] revealed the most powerful determinant of the public's health. The study revealed that nearly 67 percent of adults had experienced one or more categories of significant abuse, neglect and/or dysfunctional family issues before age 18, and 27 percent had experienced three or more categories (Felitti et al., 1998). Later publications showed that ACEs are clustered (Dong et al., 2004), compounded by societal responses, and escalate over the life course and across generations (see Dube et al., 2003 and 2006). In addition, neuroscientists and epigeneticists established the biological and genetic mechanisms that explain why ACEs increase risk for disease, disability, early death (Anda et al., 2006), and intergenerational transmission of ACEs (see Table 4).

The accumulation of childhood adversity combined with ACE-attributable adult problems, such as incarceration, workplace injury or homelessness, has a profound effect on risk for lost daily functioning, a loss that affects families, communities and the U.S. economy. For example, among adults in Washington State with an ACE score of three or more who also experienced three or more adult adversities, 56 percent report not being able to do usual activities in half to all of a given 30-day period (Reeves et al., 2012).

Table 4
ACEs, ACE-Attributable Problems, Intergenerational Escalation



Source: Foundation for Healthy Generations, 2014

THE CONTEXT FOR SUSTAINABLE SOLUTIONS

Health and social problems occur in the context of family, community and culture. In the past three decades, our understanding of the ways that we can or cannot work together to solve health and social problems has changed (Ostrom, 2002). We have 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, 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 incorporate low-cost, locally promoted, sustainable solutions on a scale that can match the magnitude of health and social problems.

FOCUS ON COMMUNITY TO ENHANCE PREVENTION, HEALING AND RESILIENCE

Service-system silos of programming, mazes of eligibility and application processes, and limited availability in many of the communities most in need allow escalation of adversity across the life course and lead to an ever-increasing demand for services. The cost of these services prohibits their use as a primary strategy for

addressing common problems of adversity, trauma and their sequelae. Services are generally not designed to address four or five co-occurring major health and social problems concurrently, even though co-occurring problems are common among adults with high ACE scores. Although direct services are necessary and important, they are insufficient in the face of a chronic public health disaster.

Policies and programs that were intended to improve health and safety often fail among specific populations due in part to community variation in ACE prevalence and associated escalation of ACE-attributable problems over time. Diverse groups are situated differently relative to the institutions and resources of society, but funders often operate as if sameness equals fairness. This way of thinking has a down side: “Universal programs are very likely to exacerbate inequality rather than reduce it” (Powell et al., 2009).

In fact, many people do not seek healing or recovery through formal services. We prefer to turn to one another and/or to culture-specific home- and community-healing practices, such as movement, mindful/prayer practices, relationship and ritual. We rely on a circle of trustworthy people for help and support. The size, availability and effectiveness of that circle of support depends on the health, functionality and capacity of the community. New sources of support may be added by bridging cultural differences and through culture change, powerful strategies for improving recovery and resilience for individuals and families.

We now have new information about how social problems are linked together through childhood adversity. We know that ACEs are common in every socioeconomic group in our nation. We have evidence that these problems are so widespread that we cannot use direct services to address them. Investments in structural solutions will not solve these 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, and ease the daily stress burden of parents so they can better protect and nurture the next generation. This means that we have to change the way we think about social problems and solutions.

Promoting Culture Change

SHCM strategies aim to increase the capacity of a community to reduce adversity. Community members learn to incorporate new customary ways of being with self and others that change how people experience and deal with the world: their culture. Understanding how this happens requires recognizing what culture is and how it can change.

Culture comprises the abstract, learned, shared rules/standards/patterns used to interpret experience and to shape behavior (Martin, 1997). It is a fluid phenomenon, co-created every day by the interactions of the individual members of the group for which it organizes the world. The fundamental role of culture as it functions in the everyday lives of individuals, regardless of nationality, ethnic background, geographical location or ancestry, is to help us to interpret the world around us and adapt to our environments.

Developmental (childhood) experience shapes biology, epigenetics and culture. Usually people cannot purposefully change their biological or genetic traits. But they can intentionally change their culture; and cultural changes can impact not only their own health and well-being, but also that of their children and others in their community. And we now know that changes in culture have the potential to shape biology, epigenetics and culture for future generations.

We acquire our cultures as we grow up, experiencing the world through interactions with and observations of others. The shared quality of culture is what makes the behaviors and beliefs of one individual intelligible to others in his or her group. When we recognize patterns of experience, behavior and interaction, we can relax and respond appropriately without having to think about every response. In this way, culture acts as a kind of autopilot: we unconsciously follow cultural norms, but we also have the ability to take ourselves off autopilot and consciously take control of our perceptions, thoughts and behaviors. Doing so can lead to profound and positive change.

Culture is an emergent property resulting from the interaction of individuals living in a group. Individuals experiment with new rules or patterns, and these innovations either spread because others find them useful and superior to the old ways, or they are rejected as disruptive to the system and soon die out. In this way, culture is fluid, as each individual in the group is constantly balancing conservation of patterns that have served well in the past with trials of innovative new strategies that may or may not work better in new circumstances. Culture change is not about incidents of change; it is an ongoing characteristic of shared rules/standards/patterns that can be harnessed to create self-healing communities.

Social problems frequently arise from cultural patterns that have developed in one group over time, often as adaptations to adverse circumstances over which these people had little control. These cultures (or subcultures) emerge literally as a response to adversity, and they may appear deviant to mainstream individuals. When our

autopilot leads us to judge others by our own standards rather than trying to understand why they do things differently, it creates huge barriers for cooperation across different cultures, whether they be national, religious, ethnic, socioeconomic, generational, community, neighborhood or trauma-impacted cultures. In order to overcome misunderstandings, we must be willing to bring our own culture into consciousness and to consider carefully how it relates to the cultures of others.

For example, in her 1974 book *All Our Kin: Strategies for Survival in a Black Community*, Carol Stack describes the culture of reciprocity, or “swapping,” that existed in a Black ghetto in a Midwestern city in the late 1960s. Government agencies and mainstream society condemned the family structures, employment patterns and ways of life of those living in “The Flats,” because they violated many mainstream cultural norms. Most notably, residents of “The Flats” made no attempt to save money to raise themselves out of poverty, but instead frequently gave away what they had.

Stack shows the efficiency of the system of swapping as the central economic strategy for this group of Blacks who experienced systematic discrimination in a community where there were very few low-level jobs, and the ones that did exist were generally temporary and very low paying. The culture that emerged reflects patterns of belief, meaning and behavior that were more effective under the circumstances with which they had to live.

Individuals and groups have the power to influence what others do by changing their own behavior and attitudes, that is, by changing their culture. But change requires hope, optimism and efficacy. In order to improve generational health and equity, we need to encourage communities to recognize their ability to make change, engender hope that what they do will make a difference, and encourage them to drill down into their autopilot cultures to challenge unexamined patterns that prevent realization of the community’s aspirations. The processes communities use to increase efficacy, examining patterns and making cultural changes, are general community capacity-building processes.

Developing General Community Capacity

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). Scholars distinguish this type of community capacity, which focuses on enhancing the infrastructure, skills, motivation and norms of a community, from the kind of

community capacity that is used to implement programs, which focuses on implementing proven model activities and evaluation protocols with fidelity (Flaspohler et al., 2008). High levels of GCC help communities to meet all kinds of challenges, from reducing interrelated and chronic problems (Hall, 2012) to recovery after a natural disaster (FEMA, 2011), without significant loss of the community’s common purposes and shared identity.

GCC depends on whether the culture of the community allows and supports its members to work together under pressure. 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. Strategies and programs become better aligned with the hope-filled actions of residents and professionals. Better adapted, more resilient communities with high community capacity have extensive, community-wide networks of relationships through which reciprocity can flow and by which collaboration can occur. People in many, if not most neighborhoods and communities in the United States lack the kind of relationship networks that optimize community capacity and resilience.

Communities can improve the relational experience of everyday life by changing the patterns and purposes of social interaction among residents. At the heart of GCC is the connection between the number and kinds of relationships people develop and their ability to successfully address their problems. As neighborhoods are able to make changes, even small ones, there is an infusion of self- and collective-efficacy, optimism and excitement fueled by hope. As demonstrated in the Cowlitz County story, people begin to talk with one another, sharing their problems and ideas and forming relationships among themselves and, eventually, with individuals and organizations outside their neighborhoods. Individual relationships grow into networks of connection that allow each part of the community to know the needs of all the other parts and offer help and support to meet those needs.

As culture change and GCC development improve the context of community life, people’s social-emotional needs are better met and social bridging increases within and between social networks, neighborhoods and across communities. Population-based surveys demonstrate that adults who report having two or more people they can rely on for practical help when needed are 65 percent less likely to go hungry because they don’t have enough money for food; 53 percent less likely to have insulin-dependent diabetes; 94 percent less likely to report being depressed all or most of the past month; 62 percent less likely to experience symptoms of serious

and persistent mental illness as indicated by scores using the Kessler 6 Scale (Kessler et al., 2010); and 59 percent less likely to report poor health for more than half of a month (Foundation for Healthy Generations, 2014). The health of the entire community is improved, and adults are likely better able to protect the next generation from ACE accumulation.

THE THREE PROPERTIES OF THE SELF-HEALING COMMUNITIES MODEL (SHCM)

The Self-Healing Communities Model is based on more than 15 years of experience with the successes that emerged from a new approach to solving health and wellness issues in communities across Washington State. From 1994 to 2012, Washington State supported use of the SHCM in 42 communities. They assessed community capacity to gauge effective use of the four-process phases of the SHCM: leadership, focus, learning and results. High GCC scores were associated with reduced rates of multiple interrelated social problems and lower ACE scores for youth aging into adulthood (Hall, 2012). Higher scoring communities improved five or more separate problem rates concurrently. In these communities, high GCC proved to be a significant contributor that positively improved youth academic, physical and mental health through increased reciprocity and social bridging and changes in peer and school social norms (Longhi et al., 2009).

Because reducing ACE scores offers the potential for decreasing the prevalence of many health, disability, education and employment problems, the SHCM's focus on culture change and increased GCC is likely to generate significant cost savings for government, private and public sectors (Kezelman et al., 2015; Sidmore, 2015). Communities don't have to achieve the highest GCC criteria to benefit, though. Less than a decade of work in low- and middle-scoring communities in Washington resulted in decreases in the rate of at least one social problem in each community (see Tables 2 and 3).

The SHCM has three properties, each of which is essential to the process by which change occurs: Partners; Principles; Process.

Partners

Funders, subject matter experts, and community members are partners who work in concert to support culture change. Partners each work in their own sphere of influence, and together their insights and abilities link and leverage efforts to galvanize connectivity and achieve unity of purpose and effort.

Meta-Leadership

Meta-leaders are described by the National Preparedness Leadership Institute as leaders who “think and perform differently. By taking a holistic view, they intentionally link and leverage the efforts of the whole community to galvanize a valuable connectivity that achieves unity of purpose and effort” (Marcus et al., 2013). Local leaders exercise courage, self-awareness and persistence in confronting the community's most challenging problems with honesty, humility and hope. They are willing and able to keep their own emotional reactivity in check and to work with others to reflect critically on strategies already in place and to identify high-leverage choice points and options for future strategy and activities.

Successful partners carry moral boldness into their work—and they are willing to ask anyone and everyone to give resources to the common good. They are effective because they have a genuine commitment to improving their community, a neutral and bird's-eye view of the systems and people who can generate improvements, and they enthusiastically chart a course of action, often with incomplete information, to which others want to contribute. Meta-leaders are able to “[stand] at the intersection of many constituencies [and] knit together social networks that complement hierarchical power structures. Rooted in a spirit of respect and inclusion, these complementary connections ensure that when disruption strikes, all parts of the social system are invested, linked, and can talk to one another” (Zolli et al., 2012).

Local Partners

Because lasting culture change requires the community to embrace new ways of thinking and behaving, change must be centered on the community. Diverse community members—those most affected by adversity; those committed to improving the lives of children and families; and those ready and willing to offer resources that will support small, iterative layers of change—must engage in hopeful, creative dialogue about how they want things to change, and then begin and sustain the process with small changes that will build into larger transformations.

A paid local coordinator and a core team of community members who develop a reputation for neutral facilitation are essential partners who shepherd the overall process and maintain the impetus for culture change. These people continuously watch for and act upon ideas and resources that might make a difference, keep community members engaged, and keep the shared vision and purpose of change in focus. The core team must be willing to provoke uncommon leaders to action and must be committed to the SHCM process. The core team works in partnership with the coordinator

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to stay one or two steps ahead in the process and thinks through design and invitation for the next phase.

Vital to the core team's role is the ability to use data to illuminate the gap between what is and local aspirations for what could be. The proficiencies required to achieve community support involve meta-leadership and management skills; public accountability, civics and public health practice knowledge; and content expertise related to improving child and family systems of care. Over time, or through partnerships, additional skills are needed: data analysis; meaning-making from data; evaluation of process and outcomes designed to support learning; systems thinking; and management of flexible or pooled resources with accountability to multiple political or funder interests.

Service-providing organizations also have an important role in developing general community capacity. Direct services provide financial, transportation and other resources in times of crisis, and develop individuals' capabilities necessary for participation in community life. These same services can be delivered in ways that also build community and social networks that will remain in the lives of clients after formal services have ended.

External Partners

External partners (e.g., funders, evaluators, educators from outside the community) who maintain a long-term relationship with the community have a unique perspective and view of the community as a whole, including its changes over time. These partners can be valuable participants with the local meta-leadership team when invited, and they can also contribute to leadership efforts by providing learning opportunities that can bring together people from many communities who are working with similar challenges or strategies.

Rather than providing programs for direct services, external partners provide right-fit assistance for the capacity-building processes of the community, which may include support for a paid local coordinator, seed money for culture change initiatives at the community level, and access to content experts who share knowledge about the causes and impact of adversity and evidence about the relative effectiveness of strategies for change. External partners also convene community leaders from different places with similar strengths and challenges so they can compare notes and learn from one another.

Funding partners should provide flexibility and educational supports while concurrently maintaining very high expectations. Funders can challenge communities to take on the most difficult issues, using innovation cycles, with full knowledge that success will not always follow. As true partners, the funders will invest

time and resources into adapting their own practices, including contracting, education and assistance, to align with the processes of the SHCM. Taken together, challenge and support can help communities to achieve stunning results.

Principles

Six principles create the integrity of the Self-Healing Communities Model. 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.

1. *Inclusive Leadership With Downward Accountability:* Leaders are accountable to the communities they support, and they engage and improve the lives of people most affected by adversity. When people who are directly affected by policy reforms become decision-makers about the ways to innovate, adapt and coordinate efforts, those reforms are better able to address the problems for which they were created. The ability of leaders to build trust, listen, and acknowledge their own roles in the dynamics that produce status-quo outcomes are central to the SHCM.
2. *Learning Communities:* Self-Healing Communities create and participate in iterative cycles of change that move from learning, to innovative action, to evaluating, examining and frequently changing previous assumptions based on new information. This creates a new level of learning that initiates the cycle again. Recognizing that cultural assumptions must be changed and developing the ability to drill down into cultural autopilots to make those changes are some of the great accomplishments of communities using the SHCM.
3. *Emergent Capabilities:* New lines of communication, peer support systems, self-organizing networks, and communities of practice² augment the formal service-delivery system and generate an infrastructure for change.
4. *NEAR-Informed Engagement:* Self-Healing Communities practice inclusion, compassion and

2 A community of practice is a group of people who share a concern or a passion for something they do, and learn how to do it better as they interact regularly.

appreciation for the core gifts of every person while recognizing that offering those gifts can be more difficult for people most affected by ACEs or other adversities. Choice, safety and collaboration are intentionally designed as primary features of engagement.

5. *Right-Fit Solutions Given Available Resources:* Communities using the SHCM address complex, severe and multigenerational problems by building ingenious solutions around available resources. They employ a multipronged, layered and aligned set of strategies to produce significant impact.
6. *Hope and Efficacy:* Self-Healing Communities nurture hope and efficacy by noticing, supporting and celebrating hope-filled action that transforms community identity, inspires peer helping systems, and builds the capacity of a community to generate well-being.

Process

The SHCM process consists of four phases of community engagement that provide 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 also time for active inquiry and intentional changes to practice (see Figure 1). The phases of this process are powerful because success in each phase naturally invites success in the next, forming self-reinforcing cycles that mirror processes in healthy living systems.

Figure 1



1. *Leadership Expansion:* Communities that expand the circle of people who are actively engaged in leading community improvement efforts are more likely to succeed. Coordinators invite people of different sectors, classes, neighborhoods, political affiliations and disciplines, including people most affected by ACEs, to develop and manage activities and strategy. Leadership that is characterized by reciprocity, not only by sacrifice or expert standing, is especially powerful.

Examples of activities in this phase are:

- Generative conversations with a mix of residents, service providers, local officials and resource people. Conversations may be recorded to capture preferred language for describing problems or solutions, offers of expertise, and hints about what would build hope and confidence in the community's ability to solve problems.
- Product development to illustrate the tension between people's values and beliefs and the community's current results.
- Invitation, in the form of personalized requests, for people to contribute to community-improvement activities.

2. *Focus:* Community members generate shared understanding of the values, mental models (ways of thinking) and cultural patterns that interact to generate status-quo outcomes. Neuroscience, epigenetics, ACEs, and resilience research (NEAR Science) combined with systems-thinking skills provide a particularly useful framework for developing this shared understanding.

Examples of activities in this phase are:

- A community summit, think tank or gathering for learning about issues of mutual concern that results in a shared action agenda that invites everyone to contribute.
- Distribution of summit outcomes to establish common language, illuminate shared values and generate further learning and opportunity.
- Recruitment of a local meta-leadership team to keep communication moving.
- Celebration routines to appreciate all those involved.

3. *Iterative Cycles of Learning:* Interactive and reflective processes facilitate the learning of community members and continuously transform the community as a whole. In this phase, new information or perspectives are introduced. People are invited to reconsider assumptions, changing context and the constellation of factors that generate current outcomes. People and systems organize efforts so that the strategies used in different disciplines are

complementary and mutually reinforcing. Evaluation with a focus on learning is vital to success.

Examples of activities in this phase are:

- Knowledge- and skill-building activities that are informative (e.g., professional development); motivating (e.g., marketplace for people to offer help, policy dialogue); and entertaining (e.g., family engagement activities such as the Children’s Resilience Treasure Hunt: <http://resiliencetrumpsaces.org>).
 - Celebration routines to appreciate all those involved.
 - Family or community cafés—with structured dialogue, free food, and childcare.
 - Peer-to-peer help: formal or informal systems for people to help and be helped by people outside of their immediate social circle.
 - Reflective practices that generate feedback to the system as a whole.
4. *Results*: Local participation in outcome research and reporting motivates communities to design iterative improvements to strategies and activities based on results (Schorr et al., 2011). Data is used to generate a powerful community journey story that explains success as it unfolds over time and invites deep commitment to culture change within a community.

A community that is focused on results does not get fixated on a small number of data sources as an agreed-upon metric for an initiative. Instead, they use data to build a sense of shared identity: *We are the ones who are creating a better future for our children*. That shared identity drives next-step improvements to the community’s strategy. These communities use data to tell a story about local people and attract unusual resources, such as in-kind donations of labor, space, materials and expertise. They use data to generate questions that matter enough for people to try something new, to illuminate new effective strategies and to help everyone to recognize: *We are in this together*.

Researchers have long recognized that the evaluation of community-level interventions is complicated. Randomized procedures are difficult to apply to complex, multi-causal community interventions, including embedded variables of local culture, knowledge and involvement (Trickett et al., 2011). However, over time, participatory action research and learning produce both quantitative and qualitative variables and measures for developmental evaluations that assess local effectiveness and results in ways that are meaningful to local people (Patton, 2011). The SHCM uses a developmental evaluation approach.

Examples of activities in this phase are:

- Products that show process and outcome measures from activities or strategies.
- Conversations to determine the kinds of actions people thought were promising, and why.
- New ways to monitor the success of the system as a whole in moving toward goals.
- Publications or presentations of data that offer a new framework for thinking about community dynamics and results, and challenge people to co-lead next steps.
- Community Capacity Index scores that provide feedback to the community, with awards given for strengths and progress.

IMPLICATIONS

The health and social problems we are facing in too many communities are highly complex. They are interrelated and intergenerational. To the extent that there are interventions that 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 resources. If we have any chance of turning things around, we need solutions that address the complexity of problems and can be easily and effectively replicated 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.

Think of a future in which adversity in childhood is rare, in which the healthy development of children is supported by parents with the capabilities and community supports so that each child reaches his or her full potential. Reciprocity and strong community capacity will provide the opportunity for children to develop strong cognitive and problem-solving skills, self-regulation, the ability to make good choices, and a sense of safety and efficacy. They will experience the security and connectedness that comes from having healthy relationships and being part of a strong community that reaches out to all of its members across cultural differences to care for each other, and they will have those experiences to pass on to their children. As median ACE scores are reduced across generations, we will create sustainability in our social, health, workforce-development, and other service systems that is born from reducing need. Reinvestment of avoided costs can drive iterative cycles of improvements, so communities will have the capabilities and cultural norms to continuously flourish.

APPENDIX 1. COMPLETE LABELS FOR GRAPHS

Table 1. Change in Rates of Selected Youth & Family Problems

| | |
|-------------------------------|---|
| Child Injury Hospitalizations | The child injury or accident hospitalizations as a percentage of all hospitalizations for children (age birth–17). |
| Suicides and Suicide Attempts | Number of people who committed suicide or were admitted to the hospital for suicide attempts per 100,000 population (all ages). |
| Hospitalizations | The child injury or accident hospitalizations as a percentage of all hospitalizations for children (age birth–17). |
| Alcohol Arrests | The arrests of younger adolescents (age 10-14) for alcohol and drug law violations, per 1,000 adolescents (age 10-14) |
| Infant Mortality | The deaths of infants under one year of age, per 100,000 population of infants under one year of age. |
| Filings for Juvenile Offenses | Number of juvenile offenses filed with the courts per 1,000 adolescents (age 10-17). <i>Note: Criminal and juvenile offender filings are categorized by the primary (i.e., most serious) original charge against the defendant in the following order: homicide, sex crimes, robbery, assault, theft/burglary, motor vehicle theft, controlled substances, other felony, and misdemeanors.</i> |

Table 2. Change in Rates of Youth & Family Problems Among Teens

| | |
|-----------------------------------|--|
| Juvenile Offenders | Number of adolescents convicted of a felony or misdemeanor crime per 1,000 adolescents (age 10-17). |
| Juvenile Arrest for Violent Crime | Number of arrests of adolescents (age 10-17) for violent crime per 1,000 adolescents (age 10-17). <i>Note: Violent crimes include all crimes involving criminal homicide, forcible rape, robbery, and aggravated assault.</i> |
| Yearly High School Drop-out | The proportion of students enrolled in grades 9-12 who drop out in a single year without completing high school, as a percentage of all students in grades 9 through 12 that year. |
| Freshman to Senior Drop-out | The percent of students dropping out prior to graduation. |
| Alcohol-Related Juvenile Arrests | The arrests of adolescents (age 10-17) for alcohol violations, per 1,000 adolescents (age 10-17). |
| Drug-Related Juvenile Arrests | The arrests of adolescents (age 10-17) for drug law violations, per 1,000 adolescents (age 10-17). <i>Note: Drug law violations include all crimes involving sale, manufacturing, and possession of drugs.</i> |
| Births to Teen Mothers | The live births to adolescents (age 10-17) per 1,000 females (age 10-17). |

Table 3. Change in Rates of Children & Family Health & Safety Issues

| | |
|--|---|
| Accident & Injury Hospitalizations (Birth to 17) | The child injury or accident hospitalizations as a percentage of all hospitalizations for children (age birth–17). |
| Out-of-Home Placements | Rate per 1,000 children (age birth–17) |
| Infant Mortality | The deaths, of infants under one year of age, per 100,000 population of infants under one year of age. |
| No Third Trimester Maternity Care | Percent of pregnant women not receiving maternity care in the 3rd trimester of pregnancy. |
| Juvenile Suicide | The adolescents (age 10-17) who committed suicide or were admitted to the hospital for suicide attempts, per 100,000 adolescents (age 10-17). |

References

- A Whole Community Approach to Emergency Management. 2011. Washington, D.C.: Federal Emergency Management Agency, www.fema.gov/media-library-data/20130726-1813-25045-0649/whole_community_dec2011__2_.pdf (accessed November 2015).
- Anda, R.F., Croft, J.B., Felitti, V.J., Nordenberg, D., Giles, W.H., Williamson, D.F., et al. 1999. "Adverse Childhood Experiences and Smoking During Adolescence and Adulthood." *Journal of the American Medical Association* 82:1652–1658.
- Anda, R.F., Felitti, V.J., Fleisher, V.I., Edwards, V.J., Whitfield, C.L., Dube, S.R., et al. 2004. "Childhood Abuse, Household Dysfunction and Indicators of Impaired Worker Performance in Adulthood." *The Permanente Journal* 8(1): 30–38.
- Anda, R.F., Felitti, V.J., Walker, J., Whitfield, C.L., Bremner, J.D., Perry, B.D., et al. 2006. "The Enduring Effects of Abuse and Related Adverse Experiences in Childhood: A Convergence of Evidence from Neurobiology and Epidemiology." *European Archives of Psychiatry and Clinical Neuroscience* 256(3): 174–186.
- "Risk and Protection Profile for Substance Abuse and Prevention in Cowlitz County. 2015. "Community Outcome and Risk Evaluation Information System (CORE). Olympia, WA: Washington State Department of Social and Health Services Research and Data Analysis Division, www.dshs.wa.gov/data/research/research-4.47-cowlitz.pdf (accessed August 2015).
- Covey, Stephen R. 2004. *The 7 Habits of Highly Effective People: Powerful Lessons in Personal Change*. New York: Free Press.
- Cowlitz County Community Public Health and Safety Network Report to the Washington Family Policy Council for work conducted in the 2005–2007 Biennium, October 2007, Unpublished.
- Dong, M., Anda, R.F., Felitti, V.J., et al. 2004. "The Interrelatedness of Multiple Forms of Childhood Abuse, Neglect, and Household Dysfunction." *Child Abuse and Neglect* 28(7): 771–784.
- Dube, S.R., Felitti, V.J., Dong, M., Chapman, D.P., Giles, W.H., and Anda, R.F. 2003. "Childhood Abuse, Neglect, and Household Dysfunction and the Risk of Illicit Drug Use: The Adverse Childhood Experience Study." *Pediatrics* 111(3): 564–572.
- Dube, S.R., Miller, J.W., Brown, D.W., Giles, W.H., Felitti, V.J., Dong, M., et al. 2006. "Adverse Childhood Experiences and the Association With Ever Using Alcohol and Initiating Alcohol Use During Adolescence." *Journal of Adolescent Health* 38(4):444.e1–444.e10.
- Felitti, V.J., Anda, R.F., Nordenberg, D., et al. 1998. "Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults: The Adverse Childhood Experiences (ACE) Study." *American Journal of Preventive Medicine* 14(4): 245–258.
- Flaspohler, P., Duffy, J., Wandersman, A., et al. 2008. "Unpacking Prevention Capacity: An Intersection of Research-To-Practice Models and Community-Centered Models." *American Journal of Community Psychology* 41:182–196.
- Foundation for Healthy Generations. 2014. *Health, Safety & Resilience: Foundations for Health Equity, Statewide Summary—Fall 2015/Winter 2015*. Seattle, www.healthygen.org/sites/default/files/Online%20Version_2014-2015%20Statewide_4-21-15.pdf (accessed August 2015).
- Goldstine-Cole, K. *Family Policy Council Education Plan 2009–2014*. 2009. Olympia, WA: Washington State Family Policy Council.
- Halfon, N. and Hochstein, M. 2002. "Life Course Health Development: An Integrated Framework for Developing Health, Policy, and Research." *The Millbank Quarterly* 80(3): 433–479.
- Hall, J., Porter, L., Longhi, D., Becker-Green, J., Dreyfus, S. 2012. "Reducing Adverse Childhood Experiences (ACEs) by Building Community Capacity: A Summary of Washington Family Policy Council Research Findings." *Journal of Prevention and Intervention in the Community*, P. 325–334.
- Harvey, M. 2007. "Towards an Ecological Understanding of Resilience in Trauma Survivors: Implications for Theory, Research and Practice." In *Sources and Expressions of Resiliency in Trauma Survivors: Ecological Theory, Multicultural Practice*, edited by Harvey M and Tummala-Narra P., 9–32. Binghamton, NY: Haworth Press.
- Kessler, R.C., Green, J.G., Gruber, M.J., et al. 2010. "Screening for Serious Mental Illness in the General Population with the K6 Screening Scale: Results From the WHO World Mental Health (WMH) Survey Initiative." *International Journal of Methods in Psychiatric Research* 19(S1): 4–22.
- Kezelman, C., Hossack, N., Stavropoulos, P., et al. 2015. *The Cost of Unresolved Childhood Trauma and Abuse in Adults in Australia*. Sydney: Adults Surviving Child Abuse, and Pegasus Economics.
- Longhi, D. and Porter, L. 2009. *Community Networks—Building Community Capacity, Reducing Rates of Child and Family Problems; Trends among Washington State Counties from 1998 to 2006 Executive Summary and Technical Paper*. Olympia, WA: Washington State Family Policy Council.
- Longhi, D. and Porter, L. 2010. *Effects of Higher Community Capacity Among Young Adults: Fewer Adverse Childhood Experiences (ACEs), Higher Social/Emotional Support and Better Health*. Olympia, WA: Washington State Family Policy Council.
- Longhi, D., Porter, L., Scheuler, V. and Baltz, K. 2009. *Social Normative Changes in Rural High Risk Counties with High Community Capacity that Accounted for Decreases in Youth Substance Use from 2000–2008*. Olympia, WA: Washington State Family Policy Council.
- Marcus, L., Dorn, B., Henderson, J. and McNulty, E. 2013. *Meta-leadership*. Cambridge, MA: National Preparedness Leadership Initiative, Harvard School of Public Health, <https://npli.sph.harvard.edu/meta-leadership/> (accessed November 2015).
- Martin, K. 1997. "Diversity Orientations: Culture, Ethnicity and Race." In *Cultural Diversity in the United States*, edited by Naylor L. Westport, CT: Bergin & Garvey.
- Morgan, GB. 2015. "Building Community Capacity: A Qualitative Study." Unpublished doctoral dissertation, Seattle University.
- National Prevention Council. 2011. *National Prevention Strategy*. Washington, D.C.: U.S. Department of Health and Human Services, Office of the Surgeon General.
- Ostrom, E. 2002. "Policy Analysis in the Future of Good Societies." *The Good Society*, 11(1): 42–48.
- Ostrom, E. 2014. "Collective Action and the Evolution of Social Norms." *Journal of Natural Resources Policy Research*, 6(4): 235–252.
- Oswald, K. 2011. "A Learning Approach to Monitoring and Evaluation." *Agricultural Learning and Impacts Network Working Paper*. Brighton, UK: Institute of Development Studies.

Self-Healing Communities

Patton, MQ. 2011. *Developmental Evaluation: Applying Complexity Concepts to Enhance Innovation and Use*, Guilford Press.

Powell, J., Menendian, S. and Reece, J. 2009. "The Importance of Targeted Universalism." *Poverty & Race*, (18)2.

Reeves, A. and Porter, L. (Unpublished, 2012). "Analysis of Washington Behavioral Risk Factor Surveillance System Survey Data from 2009–2011."

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

Schorr, E. and Farrow, F. 2011. *Expanding the Evidence Universe: Doing Better by Knowing More*. Washington, D.C.: Center for the Study of Social Policy.

Sidmore, P. 2015. *Economic Costs of Adverse Childhood Experiences in Alaska: The Price of Not Intervening Before Trauma Occurs*. Alaska Department of Health and Social Services. Anchorage, <http://dhss.alaska.gov/abada/ace-ak/Documents/ACEsEconomicCosts-AK.pdf> (accessed October 2015).

Snyder, CR (ed). 2000. *Handbook of Hope: Theory, Measures, and Applications*. Waltham, MA: Academic Press.

Stack, C. 1974. *All Our Kin: Strategies for Survival in a Black Community*. New York: Harper.

Trickett, E., Beehler, S., Deutch, C., Green, L., Hawe, P., McLeroy, K., et al. 2011. "Advancing the Science of Community-Level Interventions" *American Journal of Public Health* 101(8):1410–1419.

Wheatley, M. and Kellner-Rogers, M.A. 1996. *Simpler Way*. Oakland, CA: Berrett-Koehler Publishers.

Zolli, A. and Healy, A.M. 2012. *Resilience: Why Things Bounce Back*. New York: Simon and Schuster.

Zorrah, Q., Porter, L., et al. 2015. *NEAR@Home Toolkit*. Seattle: Thrive Washington, <https://thrivewa.org/work/trauma-and-resilience-4/> (accessed August 2015).

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