Overview and Evaluation of Public Health Program:

Children's Resilience Initiative (CRI)

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Author Note

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Abstract

The Children's Resilience Initiative (CRI) is less of a Public Health program than a process to encourage social change based in the public health functions of assessment, policy development, and assurance on a community-wide basis. CRI's primary messages are: identifying basic information about ACEs, brain research, and resilience/child development research; human health and behavior issues that were showing up in Walla Walla, Washington due to ACEs influence; and the primary goal of creating "a community conversant in ACEs and resilience (Barila & Brown, 2013, p. 11)". As time went on, a second goal, that worked to expand the CRI into the community was, "embed the principles of ACEs and Resilience into key constituent groups (p.24)."

Keywords: Adverse Childhood Experiences, ACEs, Children's Resilience Initiative, Resilience Trumps ACEs ™, Walla Walla, Washington, public health, brain research, hope, neurodevelopment, resilience, parents.

Overview and Evaluation of Public Health Program:

Children's Resilience Initiative (CRI)

The Children's Resilience Initiative (CRI) is a community response to Adverse Childhood Experiences (ACE) (Frequently Asked Questions, 2015). CRI is less of a Public Health program than a process to encourage social change based in the public health functions of assessment, policy development, and assurance on a community-wide basis. It presents similar to a program in that it started with the passion of one person and involved teams of people; training; grant writing, receiving, and administration; communication; and policy development. The ultimate goal is not self-sustainability as a stand-along "program," though. The goal is to have everyone in the community identify and address the fact that acute stress disrupts neurodevelopment and explains behavior. By looking at people through this lens and changing/shifting "business as usual" activities to integrate this thinking, society changes.

The story of the CRI starts with the Adverse Childhood Experiences (ACE) Study that took place in the 1990s in California (Brown & Barila, 2012, slide 15). It was a joint venture between the Centers for Disease Control and Prevention (CDC) and Kaiser Permanente. The study involved over 17,000 adults and it tracked health outcomes and risk behaviors against childhood ACEs. In this landmark study, 10 ACEs were particularly studied: physical, sexual, and emotional abuse; emotional and physical neglect; and several family dysfunction ACEs of: witnessing domestic violence against the mother; living with someone in the family with mental illness, depression, or suicidal tendencies; having someone in the household that was chemically dependent; incarcerated family members; or loss of parent due to death, divorce, or abandonment (slide 16).

What was learned through the ACE Study was that ACEs impact health throughout a lifetime due to disrupted neurodevelopment, followed by social, emotional, and cognitive impairments, adoption of risky health behaviors, resulting in disease, disability, and social problems, and ending in early death (slide 17). The researchers found that the number of different ACE categories impacts a person more than a high intensity or frequency of one category and without intervention, ACEs tend to increase from one generation to the next (slide 22). Most importantly, the researchers found a dose response, or causal relationship between the number of ACEs and health problems and risky behavior (slide 24). The higher the number of ACEs the more likely a person is to have alcoholism, chronic obstructive pulmonary disease, heart disease, depression, liver disease, obesity, sexually transmitted infections, as well as a propensity for high risk sexual activity, illicit drug use, involvement in intimate partner violence, smoking, or suicide attempts (slide 25).

In October 2007, Teri Barila, the Walla Walla County Community Network Coordinator of the Washington State Family Policy Council, attended a conference at which, Dr. Rob Anda, CDC Epidemiologist and co-investigator of the ACE Study, spoke about ACE data. After presenting the data, Dr. Anda offered a personal challenge to all attendees to go back to their respective communities and start a discussion about ACEs and raise community awareness about the data he had just presented. That was what was needed to light the passion inside Ms. Barila (Barila & Brown, 2013, p. 9). In January 2008, Ms. Barila met Dr. Mark Brown, the new Executive Director of Friends of Children of Walla Walla, and the glint-of-new-things-to-be, the Children's Resilience Initiative, was seen (p. 10).

Despite the seemingly depressing and overwhelming results of the ACE Study, when paired with new and continuing brain research, the outcomes are filled with hope because the

brain can change. The disrupted neurodevelopment resulting from ACEs can be buffered with resilience. Brain research has been able to identify what parts of the brain are impacted by time of maltreatment, type of maltreatment, and the different response due to gender (Brown & Barila, 2012, slide 18 & 19). Resilience can potentially counter the logic model that starts with ACEs and ultimately leads to premature death (slide 20). CRI utilized this data, created materials and conversation guidance around ACEs and corresponding resilience activities, and inspired hope and change within their community.

The power behind the birth of CRI was relationships and community partnerships. Both of these co-facilitators of the CRI had long standing relationships within the community and they were known for community capacity building and community mobilization. During the time of January 2008 and December 2009, Ms. Barila and Dr. Brown held over 40 face-to-face conversations with community members who they felt would have an interest in moving this concept of social change forward in Walla Walla. They met with and presented to persons from schools, city government, mental health professionals, social service agencies, law enforcement, juvenile justice, public health, local media, business leaders, and interested parents (Barila & Brown, 2013, p. 11). When it was clear there was solid community support, the first CRI Policy Team was convened in February 2010. Over time, the original policy team morphed into a more broad-reaching community-based, grassroots team that worked in collaboration with a Parent Team. Parents are the focus of this work and the Parent Team's input and involvement was essential and priceless (p. 11).

The vision of CRI (2015) is "All young people thrive and parents raise their children with consistency and nurturance to develop lasting resilience in the community as a whole." The mission is "Mobilizing the community through dialogue to radically reduce the number of

adverse childhood experiences while building resilience and a more effective service delivery system." In the beginning, the primary messages were: identifying basic information about ACEs, brain research, and resilience/child development research; human health and behavior issues that were showing up in Walla Walla due to ACEs influence; and the primary goal of creating "a community conversant in ACEs and resilience (Barila & Brown, 2013, p. 11)". As time went on, a second goal, that worked to expand the CRI into the community was, "embed the principles of ACEs and Resilience into key constituent groups (p.24)."

CRI has shown some great effectiveness, not only in community data, but also by the fact that others are asking for information and writing about it in newspapers, online blogs, videos, and a documentary – as well as ongoing requests for Ms. Barila and Dr. Brown to speak for groups and conferences (p. 24). One particular area of effectiveness is the *Resilience Trumps ACEs* ™ store. They have 16 ready-made products as resources for parents and other community advocates to assist in discussing ACEs and Resilience. These 16 products focus around the 10 ACEs and 42 Resilience strategies that Ms. Barila culled from copious amounts of reading of the vast works in resilience in the field. Much of the final resilience products stem from the work of Dr. Robert Brooks and Sam Goldstein. One of the products particularly addresses "upstream" work; it is a handout for expecting parents with tips and suggestions. The Walla Walla medical community has been using the product and it is well received by the parents (p. 21). For community education, they talk about the iceberg effect to include the tip being all the work we see being done from day to day, yet what is under the water is what has lead up to this day to day work. The attempt is to get the community partners, through embedding of the ACEs and Resilience principles into practice, to treat clients differently because they are seeing them through a different lens, a more comprehensive lens. Over the course of five years, the initiative

was able to reach the following community systems: high school, school-based health center, parenting support/head start/family support center, a neighborhood outreach entity, law enforcement, a shelter serving men experiencing homelessness, and individual parents (p. 24). Finally, the discipline transformation at the high school demonstrated unprecedented effectiveness. While accountability was maintained and perhaps even increased, the following changes took place: out of school suspensions went from 798 per year to 135. Discipline referrals and expulsions each saw a 50% decrease. Police reports dropped from 48 to 17 (Brown & Barila, 2012, slide 42). This type of change allowed for a welcome breathing space within the system, from the student base to Administration.

The CRI movement is going on its eighth year of existence. To assess if a community is conversant in ACEs and resilience would take at least three generations to determine in ACE scores are going down. There has already been progress in key constituent groups changing the way they are doing things as they consider principles of ACEs and Resilience. Another way to look at or evaluate an initiative is to conduct a SWOT analysis. With eight years of community work behind them, CRI has many strengths (S). Primarily, the work is based in relationships and partner communication. Since the primary target of the work is parents, it speaks volumes for their work that they have a parent voice as a large part of the process. They have taken the time to document their process and lessons learned in a *Resilience Trumps ACEs ™ Manual*. They are taking the long-term approach and they made the long-term commitment from the beginning (p. 23 & 24). Different learning styles have been taken into account and educational materials are developed to accommodate those differences (p. 13 & 22); they also called on each other's talents and used therapy principles, humor, and music (p. 17). When experts were needed they called in content or information technology experts (p. 13 & 19).

When strictly talking about process, a huge strength was the creation of a Charter Plan. This plan identified roles and responsibilities and the standard elevator speech (p. 15). Additionally, they took the time and energy up front to identify the mission and goals and even despite changes, due to quality improvement procedures, they stood unwavering on their mission and goals. The strength of their process shone through in their willingness to address impact and change their strategy when they found something that wasn't working as they expected. This openness to change actually allowed one of their tipping point events to happen: to regularly discuss team member work toward integration of ACE/Resilience principles into their organization (p. 15) CRI also stands firmly on the passion, resourcefulness, and dedication of their co-facilitators Ms. Barila and Dr. Brown.

As with any program, CRI has its weaknesses (W). Barila & Brown self-identify that identifying outcome measures, baseline data, and data targets from the beginning was not the strong suit in their initiative (p. 18). Surprisingly, in the first five years, even though the ACE Study originated in the medical community, it was difficult to engage the Walla Walla medical groups. One of their lessons learned involved finding a champion within the medical groups to advocate for the CRI work and internal training. The value of internal champions is immeasurable (p. 22). It has also been a challenge to engage the business community, although with the increase in worksite wellness research and literature, this may increase in the future. As mentioned earlier, CRI is not necessarily a program, yet there was and continues to be a need to identify funding to continue dissemination of information. There have been generous donors through the years, but it is difficult to maintain forward progress through grant funds. The sustainability goal is for community partners to incorporate the ACE/Resilience principles in

their regular, daily work and then it becomes normal practice and does not require additional funding streams (p. 23 & 20).

The opportunities (O) for CRI seem to be large in number and broad in nature. The initiative is based in foundational public health work: the data behind the assessment of need is completely solid, sustainability is based in the concept of policy development, and the mission is community-based assurance. This type of effort could potentially be used in countless areas. A brief literature review for resilience research identified supporting documentation on CRI opportunities. A study by Fouri, Tzavidis, and Kallis (2010) found a relationship between numbers of adverse childhood experience categories and increased adverse health. Additionally, they identified that successful resilience interventions may negate the original disrupted neurodevelopment when utilizing in-home, cognition work such as some of the CRI tools. Focht-Birkerts & Beardslee (2000) describe success in working with teenagers utilizing the resilience strategy of expressing his or her feelings about their parent with Affective Disorder to mend family relationships. Just imagine if those children were given the opportunity to add in the other 41 strategies utilized by CRI. Finkelstein et al. (2013) look at additional ACEs of depression, chemical use, and incarceration. Their study involved an intervention model for the adult along with implementation issues. Several of the implementation issues revolved around identifying a way for the parents to successfully communicate with their children. The CRI materials are a perfect way for parents to communicate with their children about ACEs, but more importantly about resilience and hope. The tools have been created; they only need to be learned about and utilized. Brewer-Smyth & Koenig (2014) conducted a literature review to identify if spirituality and religion could promote stress resilience in adults who had ACEs. Their conclusion was a statement that there is evidence that religious communities can offer forgiveness, social support,

and a place to express emotions, yet conversely they can be a community that inspires shame and guilt. CRI has presented to faith-based communities, there has been limited known utilization, but it is an area of great opportunity. Lay Ministers, such as those in the Christian-based Stephen Ministry, could benefit greatly from the CRI tools for communicating about ACEs and Resilience. Toche-Manley et al. (2013) presents a hypothetical case for utilizing outcome management for improving the child welfare system by tracking ongoing resiliency scores for children and youth in out-of-home placements. CRI has a concrete, existing system to explore their hypothesis. The CRI thinking/principles could be instituted within child welfare agencies and the CRI tools could be utilized as a curriculum by social workers. As an alternative, a community agency could become proficient in the use of CRI tools and child welfare workers could refer to the that agency. Using a standard resilience assessment tool, progress could be tracked using an electronic system that could graph progress.

Just as having strong, dedicated co-facilitators is a strength, that type of set up could be a threat (T) to the process in that CRI is sometimes viewed as Ms. Barila and Dr. Brown (Barila & Brown, 2013, p. 16). It takes ongoing, concerted effort by Ms. Barila and Dr. Brown to acknowledge that viewpoint and counter by passing on the praise of the good work that is being done by all the community partners. Another threat to CRI is simply the long-term nature of social change. In the instant-gratification society of today, the long-term efforts can get lost in the short-term blazing fires of the day. By engaging community partners and supporting and encouraging them to embed the ACEs and Resilience principles into their daily practices will help CRI prevail and be sustainable in the long-run.

CRI is an effort that was implemented in the community of Walla Walla, Washington.

Walla Walla is a rural, agriculturally based, conservative community. The county population is 59,000, comprised of 92% White, 2% Black or African American, 1.5% Native American, 1.7% Asian, 0.3% Pacific Islander, 2.4% Two or More Races, as well as 21% Hispanic/Latino. The city itself is approximately 32,000 people. There are three higher education institutions although 65% of the population maintains a high school degree or less. The city is also the home of the Washington State Penitentiary. Barila and Brown attribute much of the success of CRI to the geographic size of the community. Since it is smaller, the co-facilitators were familiar with or knew pretty much all of the people (2013, p. 12). The question is: Is CRI scalable to larger communities? It is the opinion of this researcher that it is, particularly because of its basic premise in concepts and making social change.

The Keller Influence Indicator (2016) has a short article about scalability, which indicates a business needs to consider the following factors prior to scaling or growing: know what you love to do, make connections, don't waver, crunch the numbers, and establish procedures. This article is specific to businesses, but can be applied to the Children's Resilience Initiative. Most of these factors were included in the strengths of CRI. There is also the matter of defining "community." There may be a city of 500,000, but the persons or agencies interested in implementing CRI in their area may involve a population of similar size to Walla Walla or smaller. Keller hits the nail on the head when they listed "love what you do" and "don't waver" on their list. Both Ms. Barila and Dr. Brown certainly had passion for CRI and it is most likely that the initiative would not have survived or would have existed in a smaller sense if it were not for their dedication and stick-to-it-iveness. CRI, as a social-change initiative, is not something that any group or city can enter into and see the change they are looking for in a 12-month period

of time. If there is a person, or preferably a small group of people, who have a passion for the goals and messages of CRI, long term passion will be key to its success in a new community.

"Make connections" is another essential ingredient to CRI. Barila and Brown (2013) also indicate that CRI is about relationships (p. 12). If a community has a passionate person who has connections and relationships in the community, they are that much closer to a successful venture. Or, even if a community/agency brought in a new organizer, it would be essential that they provided that new person with a list of important people with which they connected with as soon as possible. Sometimes it isn't necessarily who you know as long as you know the person who knows the person.

The great part of CRI is that Barila and Brown (2013) have created the *Resilience Trumps ACEs ™ Manual*, so the "establish procedures" is already partially complete for the next interested community or agency. They have provided their narrative on the path they traveled and lessons they have learned. There is also a section on Building a Work Plan with sample forms and documents.

Finally, the "crunch the numbers" aspect may be the most difficult part for expanding this process to another community. Starting a new process always involves at least some staff time. The creation of the products has already been complete and they are broad enough that any community or agency could pick them up and work with them. There is a cost, but limited need for development. If the entire process would start off as an in-depth grass-roots process, there may be agencies within the community that are willing to provide staff time, office space, etc., for the CRI. The interested person or persons would need to identify reasons why any agency or foundation would benefit from funding the community CRI. Ms. Barila, Dr. Brown, and the Walla Walla team have provided some very compelling data. If similarities can be drawn

between the two communities, the data is ready. If an agency isn't able to step up and sponsor the community CRI process, ideally, a long term grant could be identified to demonstrate community-specific traction. The principles would get embedded into partnering agencies and the work would continue as an ongoing community discussion, woven into the natural workings of the community.

The work that has been done and continues to be done by CRI in Walla Walla is exciting and inspiring. It has demonstrated effectiveness and has improved people's lives. The strengths and opportunities far outweigh the weaknesses and threats. Scalability to additional communities looks promising. This researcher evaluates this public health "program" as an A.

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