THE HIGH COST OF ADVERSE CHILDHOOD EXPERIENCES
Today’s workshop will:
Present emerging research so new & powerful that, when understood, it transforms mental models

So that
You create transformative conversations

So that
Leaders throughout the state act most effectively to support thriving families
UNDERSTANDING
SCIENTIFIC DISCOVERIES
SOMETIMES REQUIRES
UNLEARNING
WHAT WE ONCE BELIEVED TO BE TRUE
To ensure the best match between the individual & the conditions he/she will face, the brain adapts to experience. Adaptation is fundamental to the brain’s design.
ADVERSE CHILDHOOD EXPERIENCE

FOUNDATIONS OF HEALTHY DEVELOPMENT

Adapted from Shonkoff, J.P., Building a New Biodevelopmental Framework to guide the Future of Public Policy, Child Development, Jan./Feb. 2010
ADVERSE CHILDHOOD EXPERIENCE

EXPERIENCE DRIVES DEVELOPMENT

Genetic Predispositions

Heritable Traits

Structure & Developmental Sequence of Brain; Baseline Intelligence

Determines function & specialty of cells exposed to certain hormones.

Activate systems & makes them more or less sensitive to future stressors.

Regulates myelination—the coating of nerves with fat.

Regulates the development of receptor cells—the decoder rings of the brain.

Determines how brain cells network with each other, shaping mass & function of the brain at maturity.

Stress-related chemicals kill off baby brain cells so they can’t develop in early adulthood

Experience
ADVERSE CHILDHOOD EXPERIENCE

BRAIN RESEARCH


EPIDEMIOLOGICAL RESEARCH


For a full list of publications, see http://www.cdc.gov/nccdphp/ace/publications.htm

RESILIENCY RESEARCH


Brain Research Findings

- Maltreatment, trauma & Adverse Childhood Experiences
  - Predictable adaptation during brain development cause cognitive, social, & behavioral traits

Cognitive, social, behavioral & health outcomes
(Brain Research & Epidemiological Findings)

Epidemiology Findings

- Poor health & excessive use of healthcare systems
- Early Death
BRAIN RESEARCH:
THE NEUROBIOLOGY OF MALTREATMENT


BRAIN DEVELOPMENT PATTERNS
Adapted from the research of Martin Teicher, MD, Ph.D

**BRAIN**
Hormones, chemicals & cellular systems prepare for a tough life in an evil world

**INDIVIDUAL**
- Edgy
- Hot temper
- Impulsive
- Hyper vigilant
- “Brawn over brains”

**OUTCOME**
Individual & species survive the worst conditions.

**TRAUMATIC STRESS**

**BRAIN**
Hormones, chemicals & cellular systems prepare for life in a benevolent world

**INDIVIDUAL**
- Laid back
- Relationship-oriented
- Thinks things through
- “Process over power”

**OUTCOME**
Individual & species live peacefully in good times; vulnerable in poor conditions.

Dissonance between biological expectations & social reality fuels psychiatric disorders
→ In your experience, how do our major social services, health, justice, education and/or mental health systems respond to young people who act on “brawn over brains”?

→ How do these systems’ responses work for children and families?

→ What are some of the more successful system responses you have seen?
KEY VARIABLES IN BRAIN OUTCOMES

CRITICAL TIME: AGE OF MALTREATMENT
The brain develops over time. The effects of maltreatment correspond to the region and/or function that is developing at the time of maltreatment.

TYPE OF ABUSE
Different types of maltreatment activate different processes that shape the brain, such as chemicals & hormones, electrical activity, cell growth, & specialization of cells.

GENDER
Although both boys & girls are affected by maltreatment the effects of sexual abuse are more profound in girls while the effects of neglect are more profound in boys.
HIPPOCAMPUS
The center for:
• Controlling emotional reactions
• Constructing verbal memory
• Constructing spatial memory

VULNERABLE TO:
All forms of maltreatment in the first 2-3 years of life.
CORPUS CALLOSUM

Integrates hemispheres & facilitates:
• Language development
• Proficiency in math
• Processing of social cues, such as facial expression

VULNERABLE TO:
Neglect in infancy.
Sexual abuse in the elementary school years.
RIGHT TEMPORAL GYRUS

Center for spoken language.

VULNERABLE TO:
Emotional abuse, especially between ages 7 and 9.
CEREBELLAR VERMIS

Center for:
• Regulating mental health
• Regulating movement through the physical environment
• Reacting to peripheral details in the world around us

VULNERABLE TO:
High levels of cortisol prior to puberty.
CORTEX

Center for:
• Thinking & judgment
• Executive function
• Long term memory
• Vision

VULNERABLE TO:
Trauma in the first several years of life affecting pre-frontal cortex.
Witnessing domestic violence in the elementary school years affecting visual cortex.
Sexual abuse at 15-16 affecting executive function.
# BRAIN EFFECTS BY CRITICAL PERIODS

<table>
<thead>
<tr>
<th>CRITICAL TIME</th>
<th>BRAIN REGION</th>
<th>FUNCTION</th>
<th>AFFECTED BY</th>
</tr>
</thead>
<tbody>
<tr>
<td>First 3 yrs</td>
<td>HIPPOCAMPUS</td>
<td>Emotional regulation, Verbal memory, Spatial memory, With the AMYGDALA,</td>
<td>All maltreatment</td>
</tr>
<tr>
<td>Ages 3-5</td>
<td></td>
<td>Manages fear, panic, emotional understanding, Regulates emotionally-appropriate responses, Puts the brakes on outbursts &amp; tantrums</td>
<td>Sexual abuse</td>
</tr>
<tr>
<td>Infancy</td>
<td>CORPUS CALLOSUM</td>
<td>Cross-brain function, Language &amp; math proficiency, Social cues</td>
<td>Neglect</td>
</tr>
<tr>
<td>Age 8-10</td>
<td></td>
<td></td>
<td>Sexual abuse</td>
</tr>
<tr>
<td>Age 7-9</td>
<td>RT TEMPORAL GYRUS</td>
<td>Spoken language</td>
<td>Emotional abuse</td>
</tr>
<tr>
<td>Prior to puberty</td>
<td>CEREBELLAR VERMIS</td>
<td>Center for mental health, Navigation through space, Track periphery</td>
<td>All maltreatment</td>
</tr>
<tr>
<td>First 2-3 yrs</td>
<td>CORTEX</td>
<td>Thinking and judgment, Vision, Executive function, Long-term memory</td>
<td>All maltreatment Witnessing Family Violence Sexual abuse</td>
</tr>
</tbody>
</table>
CONSEQUENCES OF BIOLOGICAL OUTCOMES

**COGNITIVE**
- Slowed language development
- Attention problems (ADD/ADHD)
- Speech delay
- Poor verbal memory/recall
- Loss of brain matter/IQ

**SOCIAL**
- Aggression & violent outbursts
- Poor self-control of emotion
- Can’t modify behavior in response to social cues
- Social isolation—can’t navigate friendship

**MENTAL HEALTH**
- Poor social/emotional development
- Alcohol, tobacco & other drug abuse—vulnerable to early initiation
- Adolescent & adult mental health disorders—especially depression, suicide, dissociative disorder, borderline personality disorder, PTSD
HALF FULL OR HALF EMPTY?

- How might we systematically build on the strengths of children affected by early maltreatment?
- What academic supports might we reasonably provide?
- How might we support pathways to vocational success?
- What do we know about mitigating the effects? How might we learn more?
ADVERSE CHILDHOOD EXPERIENCES
STUDY
INTEGRATING BRAIN & EPIDEMIOLOGICAL RESEARCH

- Adverse Childhood Experiences
  - Conception
  - Whole Life Perspective
  - Early Death
    - Disease, Disability, and Social Problems
    - Adoption of Health-risk Behaviors
    - Social, Emotional, & Cognitive Impairment
    - Death

Scientific Gaps
WHAT ARE THE ADVERSE CHILDHOOD EXPERIENCES (ACEs)?

1. Child physical abuse
2. Child sexual abuse
3. Child emotional abuse
4. Neglect
5. Mentally ill, depressed or suicidal person in the home
6. Drug addicted or alcoholic family member
7. Witnessing domestic violence against the mother
8. Loss of a parent to death or abandonment, including abandonment by divorce
9. Incarceration of any family member
ACES ARE HIGHLY INTERRELATED, SELF PERPETUATING, & HAVE A CUMULATIVE STRESSOR EFFECT

The number of different categories of ACEs (ACE score) was found to determine health outcomes, not the intensity or frequency of a single category.

The evidence suggests that ACEs are a causal agent for many health challenges, as the study findings meet all nine of Sir Bradford Hill’s criterion for causal inference in epidemiology.

Without interruption, ACEs escalate across generations
A SIGNIFICANT PORTION OF DISEASE ACROSS THE POPULATION IS ATTRIBUTABLE TO ACES

54% of depression,
58% of suicide attempts
39% of ever smoking,
26% of current smoking
65% of alcoholism,
50% of drug abuse
78% of IV drug use is attributable to ACEs
48% of promiscuity (having more than 50 sexual partners)

...are attributable to ACEs
A CLASSIC CAUSAL RELATIONSHIP
MORE ACEs = MORE HEALTH PROBLEMS

Dose-response is a direct measure of cause & effect.

The “response”—in this case the occurrence of the health condition—is caused directly by the size of the “dose”—in this case, the number of ACEs.
DOSE RESPONSE RELATIONSHIP
MORE GAS = MORE MILES

Number of Miles You Can Drive (Response Gets Bigger)

Gallons of Gas (Dose of Gas Gets Bigger)
ADVERSE CHILDHOOD EXPERIENCE

LIFE LONG PHYSICAL, MENTAL & BEHAVIORAL OUTCOMES OF ACEs

→ Alcoholism & alcohol abuse
→ Chronic obstructive pulmonary disease & ischemic heart disease
→ Depression
→ Fetal death
→ High risk sexual activity
→ Illicit drug use
→ Intimate partner violence
→ Liver disease

→ Obesity
→ Sexually transmitted disease
→ Smoking
→ Suicide attempts
→ Unintended pregnancy

The higher the ACE Score, the greater the incidence of co-occurring conditions from this list.
ACE STUDY DOSE-RESPONSE FINDINGS

**Adult Alcoholism**

- **% Reporting Alcoholism** vs. **ACE Score**
- Graph shows a positive correlation between ACE score and the percentage of people reporting alcoholism.

**Women & Teen Pregnancy**

- **% Ever Experiencing Teen Pregnancy** vs. **ACE Score**
- Graph shows a positive correlation between ACE score and the percentage of women experiencing teen pregnancy.

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ADVERSE CHILDHOOD EXPERIENCE  
DRAFT
ACE STUDY DOSE RESPONSE FINDINGS

Intravenous Drug Use

- % Reporting IV Drug Use
  - ACE Score 1: 1
  - ACE Score 2: 2
  - ACE Score 3: 3
  - ACE Score 4: 4

Attempted Suicide

- % Ever Attempting Suicide
  - ACE Score 1: 1
  - ACE Score 2: 2
  - ACE Score 3: 3
  - ACE Score 4: 4
PROBABILITY OF SAMPLE OUTCOMES GIVEN 100 AMERICAN ADULTS

33 Report No ACEs
WITH 0 ACEs
1 in 16 smokes
1 in 69 are alcoholic
1 in 480 uses IV drugs
1 in 14 has heart disease
1 in 96 attempts suicide

51 Report 1-3 ACES
WITH 3 ACEs
1 in 9 smokes
1 in 9 are alcoholic
1 in 43 uses IV drugs
1 in 7 has heart disease
1 in 10 attempts suicide

16 Report 4-8 ACES
WITH 7+ ACEs
1 in 6 smokes
1 in 6 are alcoholic
1 in 30 use IV drugs
1 in 6 has heart disease
1 in 5 attempts suicide
High Public Cost of ACEs

The public costs of smoking, substance abuse and chronic illness are well documented.

The study found disproportionate use of prescription pharmaceuticals, particularly those used to treat mental health issues, by the group with the highest ACE Scores.

The study also measured the effects of ACEs on employment stability, productivity and absenteeism. ACEs have negative effects on these business measures, suggesting significant, detrimental effects on tax revenue.

When combined with the most recent brain research, the ACE Study reveals heightened risk for three pathways resulting in life-long poverty.
Significant risk of early use/abuse of:
- Alcohol, tobacco, illicit & prescription drugs
- Slowed language & reading
- Lateralization
- Diminished IQ
- Poor decision making skills
- Attention problems
- ADD
- ADHD
- Aggressive behavior
- Social isolation among peers
- Poor understanding of social cues = conflict

Significant risk of early use/abuse of: Alcohol, tobacco, illicit & prescription drugs
- Special education
- School failure
- Dropping out

Predictable patterns of brain development, traits & behaviors

- Low-wage jobs
- Unemployment
- Public Assistance
- Prison
- Chronic health problems
- Debilitating mental health

EARLY TRAUMA & STRESS

INTEGRATING SCIENTIFIC FINDINGS:
THE FAST TRACK TO POVERTY
DISCUSSION

→ In what ways does this study affirm or challenge your professional understanding and experience of mental, behavioral & physical health outcomes?
ACEs IN WASHINGTON

1. ACEs in Young Children & Academic, Behavioral and Health Challenges
2. ACEs in High School Sophomores and Seniors
3. ACEs in Adjudicated Youth - Pierce County Juvenile Court Improvement Project
4. ACEs in Adults – ACEs and Lifelong Health
“Understanding Adverse Childhood Experiences isn’t to know one’s life path. It is to open doors for the future you would like for yourself and for future generations.”

Dr. Ronald Voorhees, MD, PhD
Chief Office of Epidemiology & Biostatistics
Allegheny County Health Department
ACEs AND ELEMENTARY SCHOOL CHILDREN

• 2101 children, ages 5 to 12, from 9 schools; randomly selected; 50% of student population

• Four of the schools are non-Title-One schools, five are Title-One schools

• Adverse Events include: referral to child protective services, family violence, exposures to community violence, and residential instability (using a McKinney Vento definition)

FINDINGS:
1. Adverse Events are the greatest single predictor for health, attendance, and behavior
2. Adverse Events are the second strongest predictor, after special education status, for academic failure
3. The relationship between academic achievement and health status appears much less related to income than to AEs
ACEs and High School Sophomores and Seniors

Washington School Classroom (30 Students)
Adverse Childhood Experiences (ACEs)

6 students with no ACE
5 students with 1 ACE
6 students with 2 ACEs
3 students with 3 ACEs
7 students with 4 or 5 ACEs
3 students with 6 or more ACEs

58% (17) students with no exposure to physical abuse or adult to adult violence
29% (9) of students exposed to physical abuse or adult to adult violence
13% (4) of students exposed to physical abuse and adult to adult violence

Population Average

0
0
0
0
0
0

1
1
1
1
1
2

2
2
2
2
2
3

3
3
4
4
4

4
5
5
6
6
8
ACE DATA IN CONTEXT & ACTION:

Pierce County Juvenile Court Improvement Project
PREVALENCE of ACEs
COURT INVOLVED YOUTH vs. ADULTS IN ACE STUDY

<table>
<thead>
<tr>
<th>Type of ACEs</th>
<th>Juveniles</th>
<th>Adults</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-1 ACEs</td>
<td>17%</td>
<td>58%</td>
</tr>
<tr>
<td>2-3 ACEs</td>
<td>33%</td>
<td>25%</td>
</tr>
<tr>
<td>4+ ACEs</td>
<td>33%</td>
<td>16%</td>
</tr>
</tbody>
</table>

0% 10% 20% 30% 40% 50% 60% 70%
DISTRIBUTION OF ACEs AMONG JUVENILE OFFENDERS IN PIERCE COUNTY, WASHINGTON

17 OFFENDERS Report 0-1 ACEs
OFFENDERS WITH 1 ACE REPORT:
• Loss of a parent

50 OFFENDERS Report 2-3 ACES
OFFENDERS WITH 3 ACEs REPORT:
• Loss of a parent
• Incarcerated family member
• Threats/intimidation (Emotional abuse)

33 OFFENDERS Report 4+ ACEs
OFFENDERS WITH 5 ACEs REPORT:
• Loss of a parent
• Threats/intimidation
• Incarcerated family member
• Substance abuse in the home
• Physically Abused
JUVENILE OFFENDERS:
ACES & SCHOOL EXPERIENCE

- **Special Education**
  - 0-1 ACEs: 33%
  - 2-3 ACEs: 41%
  - 4+ ACEs: 51%

- **Below 2.0 GPA**
  - 0-1 ACEs: 58%
  - 2-3 ACEs: 69%
  - 4+ ACEs: 74%
FELONY RE-OFFENSE BY ACE CATEGORY (Males)

- 0-1 ACEs: 11% (1 Yr Re-offense), 13% (2 Yr Re-offense)
- 2-3 ACEs: 18% (1 Yr Re-offense), 29% (2 Yr Re-offense)
- 4+ ACEs: 20% (1 Yr Re-offense), 33% (2 Yr Re-offense)
ADVERSE CHILDHOOD EXPERIENCE DATA
from
WASHINGTON STATE
BEHAVIORAL RISK FACTOR SURVEILANCE SURVEY

Will Help Us:
Understand the Dynamics of Health Challenges
Invest More Wisely
Achieve Greater Impacts
WHAT IS THE BEHAVIORAL RISK FACTOR SURVEILLANCE SYSTEM (BRFSS)?

A state-based system of health surveys that generates information about health risk behaviors, clinical preventive practices, and health care access and use primarily related to chronic diseases and injury.

A cross-sectional telephone survey conducted by state health departments with technical and methodological assistance provided by the CDC.
PREVIEW OF ACE FINDINGS FOR WASHINGTON ADULTS

ACEs are common in Washington

1.62% of adults have at least one ACE

2.17% of adults report physical abuse during childhood

3.17% of women and 7% of men report sexual abuse during childhood

4. One in four adults report parental separation or divorce during childhood

5. A third of adults grew up with substance abuse in the household
ACES ADD UP—MORE IS WORSE
(As captured by the ACE Score)

One in four adults report three or more ACEs

5% of adults have six or more ACEs
ACES TEND TO CO-OCCUR / CLUSTER
In the lives of Washingtonians

Among adults exposed to physical abuse, 84% reported at least 2 additional ACEs.

Among adults exposed to sexual abuse, 72% reported at least 2 additional ACEs.
Compared to adults without exposure to ACEs, the risk of smoking – a risk factor for many chronic diseases – was increased:

1.2 times for those with 1 ACE, * 1.5 times with 2 ACEs, * 1.9 times with 3 ACEs, * 2.8 times with 4 or 5 ACEs, * 4.6 times with 6 or more ACEs
AS THE ACE SCORE INCREASES
RISK OF NUMEROUS HEALTH AND SOCIAL PROBLEMS INCREASE DRAMATICALLY

LIFE DISSATISFACTION

Age-adjusted prevalence and multivariable-adjusted relative odds of low life satisfaction by ACE score

ACTIVITY LIMITATION

Age-adjusted prevalence and multivariable-adjusted relative odds of activity limitation due to health problems by ACE score

The likelihood of life dissatisfaction – a risk factor for suicide – increased with increasing ACE score. Adults with 6 or more ACEs 9 times more likely to report life dissatisfaction compared to those with an ACE score of zero.
# ACEs in Washington

Health and Social Problems Shown to Have a Graded Relationship to the ACE Score in the 2009 Washington BRFSS

<table>
<thead>
<tr>
<th>Type of Problem Experience</th>
<th>Outcome Associated with Adverse Childhood Experience</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prevalent Diseases</td>
<td>Cardiovascular disease, cancer, asthma</td>
</tr>
<tr>
<td>Risk Factors for Common Diseases/Poor Health</td>
<td>Smoking, heavy drinking, binge drinking, obesity, high perceived risk of AIDS, taking painkillers to get high, marijuana use</td>
</tr>
<tr>
<td>Poor Mental Health</td>
<td>Sleep disturbances, frequent mental distress, nervousness, mental health or emotional problem requiring medication, emotional problems that restrict activities</td>
</tr>
<tr>
<td>General Health and Social Problems</td>
<td>Fair or poor health, life dissatisfaction, health-related quality of life</td>
</tr>
</tbody>
</table>
| Risk for Intergenerational Transmission | **Mental Illness**: depression, anxiety, emotional problems that restrict activities, medication for mental health conditions  
**Drugs and Alcohol**: Use of painkillers to get high, use of marijuana, smoking, heavy drinking, binge drinking  
**Loss of a Parent**: Divorced-widowed-separated |
ACEs CREATE INTERGENERATIONAL RISK

- INCREASED RISK FOR INTERGENERATIONAL TRANSMISSION
- EXPERIENCING ACE
- TRAITS & BEHAVIORS = RISK FACTORS

\[ R \]
POSITIVE ADAPTATION

Shifting from Deficit Oriented Models
to
Strengths, Health, & Thriving.

RESILIENCE
WHAT IS RESILIENCE?

“Resilience refers to a class of phenomena characterized by good outcomes in spite of serious threats to adaptation or development.”

-Ann Masten, Ordinary Magic: Resilience Processes in Development

“Resilience is the result not only of biologically given traits, but also of people’s embeddedness in complex and dynamic social contexts, contexts that are themselves more or less vulnerable to harm, more or less amenable to change, and apt focal points for intervention.”

-Mary Harvey, Towards an Ecological Understanding of Resilience in Trauma Survivors
WHAT IS RESILIENCE?

The natural human capacity to navigate life well.

(HeavyRunner & Marshall, 2003)

The capacity to absorb disturbance and re-organize while undergoing change, yet still retain essentially the same function, structure, identity, feedbacks.

(Walker et al., 2002)

The ability of an individual, system or organization to meet challenges, survive, and do well despite adversity.

(Kirmayer 2009)
**Contextual** – Why ages, stages, personal and family history, community context matter for promotion of resilience.

**Integrative** – Encompasses rapid advances in the study of genes, developmental neurobiology, neural plasticity, and the conditions, contexts, and processes that affect positive adaptation throughout the lifespan.

“Resilience rests, fundamentally, on relationships”.

RESILIENCE AS A DEVELOPMENTAL PROCESS

• We develop competencies & characteristics that prepare us to be effective in the world we’re growing into.

• We develop the capacity to adapt in the face of challenges.

• None of us is perfect—we’ll all have moments when we don’t appear to be very well adapted to the conditions we’re facing.

• Resilience is complex; it is possible to be resilient in one setting and pathological in another.
KEY COMPONENTS OF RESILIENCE AS A DEVELOPMENTAL PROCESS

Recent studies with diverse approaches point to a short list of global factors associated with resilience:

- Cognitive & self-regulation skills
- Positive view of self
- Motivation/ability to be effective in the environment
- Connections/attachment to competent & caring adults in family & community
- Relational experience that supports the process of finding meaning from experience; tempering mastery to fit time & place; constructing identity; building hope
- Community context and functionality
KEY COMPONENTS OF RESILIENCE

**CAPABILITY**
- Intellectual & employable skills
- Self regulation – self control, executive function, flexible thinking
- Ability to direct & control attention, emotion, behavior
- Positive self view, efficacy

**ATTACHMENT & BELONGING**
- Bonds with parents and/or caregivers
- Positive relationships with competent and nurturing adults
- Friends or romantic partners who provide a sense of security & belonging

**COMMUNITY, CULTURE, SPIRITUALITY**
- Faith, hope, sense of meaning
- Engagement with effective orgs – schools, work, pro-social groups
- Network of supports/services & opportunity to help others
- Cultures providing positive standards, expectations, rituals, relationships & supports
EXAMPLES OF PROGRAM & POLICY ACTIONS

How is your community nurturing these three systems for resilience throughout the lifespan?

CAPABILITY
- Intellectual & employable skills
- Self regulation – self control, executive function, flexible thinking
- Ability to direct & control attention, emotion, behavior
- Positive self view, efficacy

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CAUTIONS ABOUT THE RESILIENCE APPROACH

1. Expectation for Thriving Despite Oppression

2. Strength Based ≠ Solutions

3. Attending to Characteristics & Factors that Promote Resilience – Only Part of the Story
PARAMETERS FOR INTERVENTION

• Neurobiology suggests there are critical periods to pay attention to.

• Resilience is best understood as both how we engage with other people, and how we interact with our environment (contextual).

• Whether initiated at the individual, community or societal level, interventions to promote & sustain resilience must enhance the relationship between person & context.

• Attention to cultural context is important to successful intervention.

• To have lasting effects, even the most successful interventions must become embedded in & familiar to social setting/community contexts. “Attention to the possibilities for ensuring lasting impact & enduring change are important features of intervention design & conduct.”
DISCUSSION

→ In what ways do the findings regarding resilience offer you hope or possibility for the future?

→ The way we work with people, both adults and children, matters. What are some of the things you do already or could do that would help build resiliency in children and adults?
NEXT CONVERSATIONS:
NEXT STEPS
What do we value as a community?

What structures do we have in place to address adverse childhood experiences & the problems they cause?

How well do our structures reflect our values?
THANK YOU!

If you or someone you are working with has already made changes to the way you interact with others, or provide services based on ACE & resilience research,

We want to hear from you!

The Family Policy Council collects inventory of changes to practice, policy and neighborhood work that is consistent with brain science, the ACE Study, and Resilience research. You can complete a short survey online at:

http://www.fpc.wa.gov/

INVENTORY OF SERVICE CHANGE