A New Framework for Addressing Adverse Childhood and Community Experiences: The Building Community Resilience Model

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ABSTRACT

OBJECTIVE: We propose a transformative approach to foster collaboration across child health, public health, and community-based agencies to address the root causes of toxic stress and childhood adversity and to build community resilience.

METHODS: Physicians, members of social service agencies, and experts in toxic stress and adverse childhood experiences (ACEs) were interviewed to inform development of the Building Community Resilience (BCR) model. Through a series of key informant interviews and focus groups, we sought to understand the role of BCR for child health systems and their partners to reduce toxic stress and build community resilience to improve child health outcomes.

RESULTS: Key informants indicated the intentional approach to ACEs and toxic stress through continuous quality improvement (data-driven decisions and program development, partners testing and adapting to changes to their needs, and iterative development and testing) which provides a mechanism by which social determinants or a population health approach could be introduced to physicians and community partners as part of a larger effort to build community resilience. Structured interviews also reveal a need for a framework that provides guidance, structure, and support for child health systems and community partners to develop collective goals, shared work plans, and a means for data-sharing to reinforce the components that will contribute to community resilience.

CONCLUSIONS: Key informant interviews and focus group dialogues revealed a deep understanding of the factors related to toxic stress and ACEs. Respondents endorsed the BCR approach as a means to explore capacity issues, reduce fragmented health care delivery, and facilitate integrated systems across partners in efforts to build community resilience. Current financing models are seen as a potential barrier, because they often do not support restructured roles, partnership development, and the work to sustain upstream efforts to address toxic stress and community resilience.

KEYWORDS: adverse childhood experiences; child health services; community resilience; integrated clinical and community care; toxic stress

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THE BUILDING COMMUNITY Resilience (BCR) model is an innovative, transformative approach that will foster collaboration across child health systems, community-based agencies, and cross-sector partners to address the root causes of toxic stress and childhood adversity, and build community resilience. A growing body of science connects the exposure of young children to toxic stress with the emergence of serious emotional and behavioral disorders in childhood and the development of chronic disease across the life course.[1] Persistent exposure to adversity in childhood without adequate family and other social supports results in toxic stress.[2] A graded relationship between adverse childhood experiences (ACEs) and subsequent health problems in adults has been established—the more stresses endured in childhood, the greater likelihood of heart disease, obesity, depression, and other chronic conditions later in life.[3–5] Adverse childhood events vary in severity and are often chronic occurrences in a child's family or social environment that cause harm or distress and disrupt a child's physical or psychological health and development.[6] With this evidence in mind, it is imperative that clinicians extend their focus and reach beyond the clinical environment to address social determinants that lead to adverse childhood and community experiences that affect early childhood development.

STATEMENT OF THE PROBLEM

Recent data from the National Survey of Children's Health indicate that nearly 50% of all American children have experienced at least 1 ACE, with children of color at highest risk. ACEs are distributed across a relatively steep social gradient. Children in the poorest families and

communities show the greatest risk, but children at all levels of the income ladder experience exceptionally high levels of stress and trauma. Compounding their risk of exposure to ACEs, African American, American Indian, and Hispanic children are also more likely to live in high-poverty areas (30%, 28%, and 23%, respectively).[7] Poverty and household stressors, like unemployment, housing instability, and food insecurity combine to create an environment in which a child's home, school, and community are sources of stress.[8] A higher prevalence of poverty, unemployment, and food insecurity indicate higher levels of social vulnerability and lower levels of community resilience.[9] When families live in communities in which food insecurity, domestic violence, challenges to parenting, unemployment, inadequate educational systems, crime, and social justice issues are common, the result is an environment in which ACEs abound, needed social supports are scarce, and toxic stress results.

These data point to the need for child health systems to take a life course, transgenerational approach that coordinates care for children in the context of their family and community.[10,11] By joining with parents, families, and community partners to create strategically coordinated supports and services, child health systems can play a critical role in improving the long-term health and well-being of the communities they serve.

We define community resilience as the capacity to anticipate risk, limit effects, and recover rapidly through survival, adaptability, evolution, and growth in the face of turbulent change and stress.[12] In effect, resiliency is the capability to endure and thrive despite adversity. Although we cannot prevent all adverse exposures, we can reinforce social supports for vulnerable children, families, and communities so that together they may thrive. Community resilience is a measurable quality that is increasingly recognized as an important ingredient in preventing childhood adversity and building stronger communities to support child health and well-being.[13] Building community resilience is a crucial task that merges a need for disaster preparedness with population health promotion. Community resilience is based on 4 sets of adaptive capacities—the ability to sustain economic development within the community, the degree to which residents possess social capital (social networks and supports that include family and other community members), the effective bidirectional transfer of information and communication between residents and the social services agencies that serve them, and the community competence to support civic engagement (eg, voting and advocacy), self-management (health and social needs) and collective empowerment for community advocacy and engagement. Ultimately, children can become resilient when the communities in which they live are home to resilient adults.

A FRAMEWORK FOR ACTION

The BCR approach aims to provide a seamless continuum of cross-sector cooperation and services to build the 'social scaffolding' that will support children and families and contribute to community resilience. BCR will create an integrated network of partners across several sectors to engage community members in a collaborative effort to promote health, create stronger community and organizational linkages, and increase social supports for families and individuals. BCR is framed within the Collective Impact model, which includes development of a common agenda, mutually reinforcing activities across a diverse set of partners, continuous communication across stakeholder groups, leveraging a backbone organization, and creation of a shared measurement system.[14]

Child health providers have largely operated within the clinical domain, but the BCR approach recognizes the importance of putting health care at the table with agency and community partners to work strategically in addressing the root causes of toxic stress. This collective and deliberate approach will build a framework for resilience. Building this framework requires the merger of diverse disciplines to create stronger community linkages between clinicians, providers, health systems, community members, social services, and government organizations. However, currently there exists no systematic process to provide guidance on how to create networked systems of cross-sectors partners. As one pediatrician we interviewed noted, "[Despite] what know we about ACEs, we still don't know what to do with them or who to call for help. We need partners." The process described in this report is innovative in its explicit aim to address the root causes of toxic stress and ACEs and build community resilience through a community-integrated approach.

The BCR approach aims to address gaps and strengthen assets in child health and community systems (including clinical, public health, social welfare, education, human services, juvenile justice, public safety, etc) through a phased strategic readiness and implementation process that will enable clinicians, providers, social service, and community-based partners to align services and resources to coordinate efforts aimed at addressing the health, emotional, and social needs of children and their families (Fig). Collectively these partners will work to inform a community-based plan to reduce and prevent trauma and toxic stress, improve mental and physical health, and build capacities that influence resilience in the near as well as long term.

The components of the model are applied as a continuous quality improvement (CQI) model to help child health systems and their community partners create a shared understanding of childhood adversity, assess system readiness to respond and build supports, develop a cross-sector community-based network and engage parents, families, and community residents. The BCR approach is guided by central components of CQI, including systematic data-guided activities, design with local conditions in mind, and iterative development and testing (Plan, Do, Study, Act cycles) as programs are implemented and new partners join the local effort.[15] In phase 1 the components are used to focus on enabling child health systems and their partners to assess readiness and strategically operationalize