

Buncombe County: One Path Toward a Resilient Community

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There is an increasing national awareness that improving the health of the nation will need to involve addressing social determinants of health, including adverse childhood experiences. Advances in translational science and the science of social change have created new opportunities to address this refractory problem. This paper will describe a cross-sector collaborative effort in Western North Carolina that has produced unexpected fruit since its start in 2010, discuss themes that supported success, and identify future essential work.

There has been increasing national recognition that solving major public health problems such as health disparities, substance abuse, and rising costs will involve addressing what has been termed social determinants of health, including adverse childhood experiences (ACEs). Many factors have delayed meeting the challenge posed by the ACE Study, published in 1998. The apparent delay can be attributed to lag time inherent in translational science [1], but there seems to be more to it: inertia of large systems, disproportionate funding of health care in America, and the “siloeed” nature of systems in the face of need for cooperative effort. Dr. Nadine Burke Harris has hinted there may be an element of denial [2]. ACEs may affect disadvantaged populations disproportionately, but as Burke Harris points out, they affect all of us [2].

Recent advances in implementation science and heightened public awareness seem to be changing the tide. Strong evidence for this assertion is the October publication of the Special Supplement of *Academic Pediatrics* devoted to ACEs. Part of a call for a “national agenda to address ACEs” [3], the Supplement features 28 articles examining the problem from multiple perspectives. Most importantly, many of the articles discuss strategies that have already produced results. Dr. Christina Bethell concludes her call for a national agenda on a positive note: “The accumulated research and action to date have cultivated a palpable hope for prevention, mitigation, and healing of individual, intergenerational, and community trauma associated with ACEs exposure” [3]. It is a call to action.

Tools for Change

Worth highlighting are 4 ideas/tools for change pub-

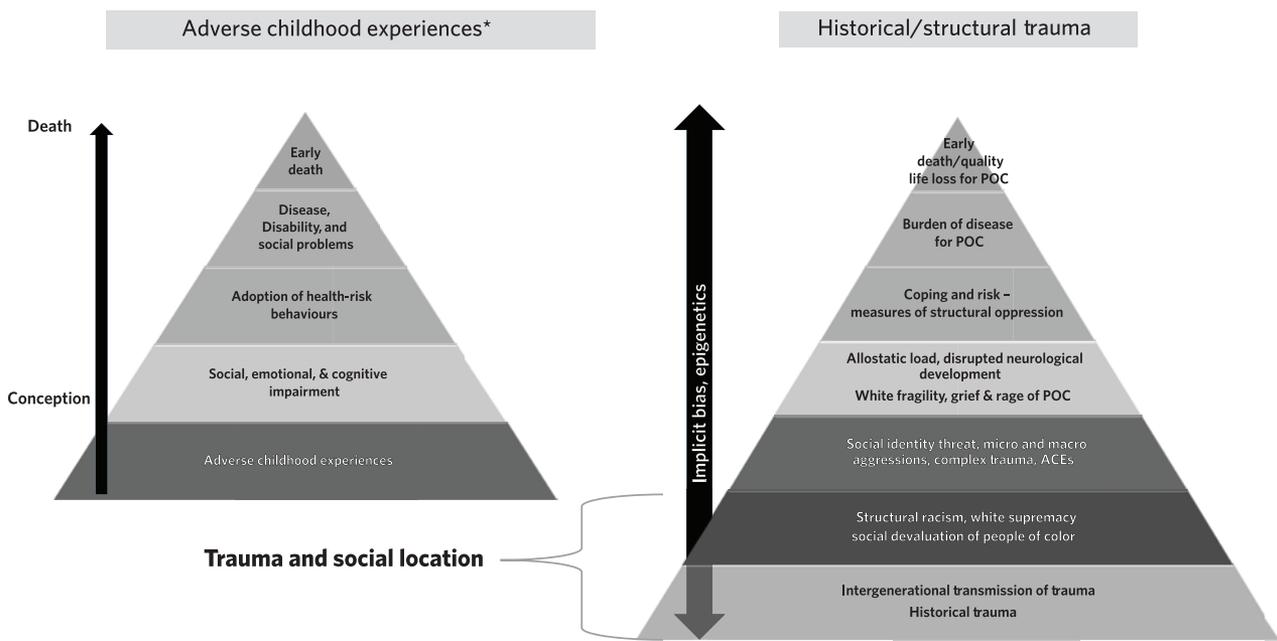
lished since the ACE Study: 1) The “ACEs Pyramid,” illustrating the connection between ACEs and early morbidity and mortality, has been modified as an “Extended ACEs Pyramid.” Two additional levels address the importance of historical trauma and social issues like discrimination and poverty (see Figure 1). There is strong documentation of the increased incidence of ACEs in vulnerable populations [4]. Yet to be demonstrated, but highly probable, is the assertion that piling ACEs on top of other disadvantages is particularly traumatic in its effects. 2) Epidemiology has emphasized that population problems demand population solutions. Sandro Galea points out that if the population experience of trauma is expressed as a bell curve, treatment can trim the curve on the right, but would miss the full spectrum of biology and context. “If our goal is to make populations healthier, we must intercept trauma before it strikes,” he said [5]. 3) The Collective Impact Model, published in 2011, has proved to be a useful road map in promoting broad cross-sector collaboration to produce meaningful change [6]; and 4) less known, is a useful modification of the evidence-based process called the Adaptome [7]. The authors of this model propose that implementation should involve choosing methods with high plausibility for success, working in partnership with community stakeholders, and allowing program drift when circumstances dictate. The Adaptome authors encourage “adaptation within the context of implementation” rather than the one-size-fits-all “approach to evidence-based practice delivery” [7]. They also assert that once a particular program has been adapted to local resources and needs, there is then a rich opportunity to rigorously and scientifically measure outcomes and to discover what works best in varied situations. Research on outcomes should then continue to examine what is effective in varied settings [7]. Efforts to address ACEs in Buncombe County are beginning to bear fruit and illustrate the power of the above 4 ideas. Much has been accomplished, but there is a shared sense that much has yet to be done.

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FIGURE 1.
Racing ACEs: Ensuring Racial Justice Is A Central Tenet of Trauma-informed Care



Source: RYSE Center; 2016.

The Buncombe County Experience: “Do Something”

Asheville, county seat of Buncombe County and a regional center for Western North Carolina, became acquainted with the ACE Study in 2012. Two years earlier Buncombe County had been awarded a state Innovative Approaches (IA) grant for Children and Youth with Special Healthcare Needs. A Steering Committee was formed, including representatives of many public and nonprofit agencies dealing with the welfare of children. Recognizing that children who had suffered trauma constitute a population at risk, the IA Steering Committee began to focus on ACEs in a community based effort.

There was no road map to provide form and purpose. The Committee initially groped to find concrete actions that might have impact and eventually decided to concentrate on spreading awareness of ACEs and their importance. A website was planned and a speakers’ bureau formed. “Collective Impact” had just been described at the start of the IA project, and the Steering Committee chose to follow the core principles of this model. Buncombe County Department of Health and Human Services (BCDHHS), working in concert with Community Care of Western North Carolina (CCWNC), served not only as the convener of relevant agencies, but also as the “backbone organization” that managed collaboration and maintained communication. Funding for IA ended in 2016, but momentum around ACEs had been generated and enthusiasm sparked. The ACEs Subcommittee of IA reinvented itself as the ACEs Learning Collaborative, which has continued to serve as the backbone component. In the

process, the purpose of the project has evolved beyond the aim of increasing awareness to taking effective action, as the member agencies have found productive projects, each in their own spheres.

The initial project to increase awareness had both direct and indirect results. Direct results included an interactive website (buncombeACEs.org), the speakers’ bureau, and 2 regional/national conferences. The speakers’ bureau addressed multiple venues, including health and mental health, justice and the legal system, and faith communities. Meanwhile, indirectly, local participants in the Collaborative were discovering positive actions they could take, and reported back to the group, generating more ideas and energy. This article will focus on just a few of these agencies as illustrations of what has and can be done.

Buncombe County: Individual Projects

Members of the ACEs Collaborative progressively shaped the work they were doing in their particular sectors by meeting regularly to share ideas and discoveries. Schools became compassionate; the justice system created a one-stop center for victims of domestic violence; and family medicine residents became trauma-informed, bent on fostering resilience and preventing ACEs. While recognizing the magnitude of the task remaining, members of the Collaborative shared the sense that they were witnessing the beginning of community transformation.

Buncombe County Schools

The Buncombe County Schools system has been a central participant in the ACEs Collaborative. Through the

Collaborative, the Student Services Division became aware of the Washington State Compassionate Schools model. Based on this model, in 2014, Buncombe County Schools received a \$1.2 million grant from the US Department of Education focused on increasing the mental health and emotional supports for students, improving student discipline and achievement, and emphasizing teacher self-care. While there was a consistent overall strategy, each school established its own implementation plans; different classrooms within the same school could follow different paths. To varying degrees, the 23 elementary and intermediate schools in the county system have become trauma-aware, nurturing environments. Since the public schools touch the majority of children in Buncombe County, school transformation is proving to be a true population strategy for improving health. Outcome measures indicate early results. Some qualitative studies have been dramatic and readily noticeable. Disruptive schools have become positive places for teachers and students. Quantitative measures are also showing initial improvement. After the first year of implementation and introducing a social-emotional skills curriculum district-wide, Buncombe County Schools noted a statistically significant improvement as measured by the DESSA (Devereux Student Strength Assessment), a standardized, norm referenced behavior rating scale that assesses social-emotional competencies of children in kindergarten through 5th grade (Deborah Luckett, Buncombe County school counselor, e-mail communication, January 2018). As one teacher commented about a mindfulness session in her kindergarten class, "If I do this for 20 minutes on the front end, I can teach!"

Buncombe County Department of Health and Human Services

Both the Health Services Division and the Social Services Division have been connected with the ACEs Collaborative in some measure over the years. The BCDHHS was the backbone organization for the Collaborative in its first incarnation. The Health Services Division has remained an active member of the Collaborative. Both divisions have many community projects that connect with the work of the Collaborative, involve other members of the Collaborative (agencies and individuals), and impact families and communities exposed to trauma. For example, through the Mobilizing Action for Resilient Communities program, local community groups were given financial and logistical support for projects that promoted resiliency. Within DSS, Buncombe County piloted Project Broadcast, which disseminated trauma-informed practices to children in the state welfare system. This led to the introduction of neutral facilitators and visitation coaches (provided by the SPARC Foundation) with ACEs knowledge.

Community Care of Western North Carolina

CCWNC supports primary care providers in meeting the health care needs of vulnerable consumers through care management, clinical pharmacy, innovations in behav-

ioral health provision, and quality improvement. Inspired by the local ACE Collaborative work, CCWNC designated a Resiliency Educator to implement workforce resiliency strategies, beginning with its own staff. CCWNC is now taking resiliency training to its community partners, including primary care providers and their practice staff in Buncombe County and some rural communities. As with the schools, self-care is planned as a basis for improved, compassionate care of patients.

Family Justice Center

In its first year, the IA ACEs speakers' bureau engaged the local bar association, magistrates, and law enforcement officials who appreciated the significance of this information. Trauma awareness played a part in establishing Buncombe's client-centered Family Justice Center (FJC) in 2014, a best-practice model to address domestic violence. Through the FJC, clients have a one-stop-shop safe place to find support, counseling, legal advice, medical care, and access to law enforcement. Initial surveys have shown reduced fear and anxiety after receiving integrated services.

Mountain Area Health Education Center

Three items will illustrate some of the work done at Mountain Area Health Education Center (MAHEC). First, ACEs awareness and strategies to promote resilience have become core parts of the behavioral training of family medicine residents. Second, MAHEC has promoted a public health resiliency education curriculum throughout the region in school systems, hospitals, clinics, churches, and jails, and to early childhood educators, Division of Social Services (DSS) workers, biopsychosocial case managers, law enforcement officers, first responders, and nurse home visitors, among many others. Third, MAHEC's Division of Regional Services sponsored successful ACEs Southeastern Regional Summits in 2015 and 2017. These 2 conferences attracted 350-400 participants each and featured such national authorities as Drs. Vincent Felitti, Robert Anda, and Christina Bethell.

Discussion

Much has been accomplished in Buncombe County, but much is yet to be done to claim an identity as a trauma-informed community. Serendipity played a large role, but it was necessary to notice and seize available opportunities. Relationships were key. The nature of the Collaborative has been to hear the voices of members at the table with equal authority; this paradigm has allowed new perspectives to form and led to unexpected positive outcomes. Yet, another theme has been action: "Do something," as Michael Marmot admonishes [8].

The Collaborative has many goals as it approaches its second 5 years. First, involvement of community members was singularly productive but needs to be expanded. Culture change and ACEs awareness in the general community have been under discussion for some time, but not yet achieved.

Second, there are organizations involved with ACEs work that can be more fully connected to the ACEs Collaborative. These include grassroots community organizations, Mission Hospital (the largest county health organization), and—as aforementioned—BCDHHS. Third, outcome measures (both short and long term) need to be developed to assess progress. Fourth, partnering with surrounding rural counties is also in its beginning stages. Finally, the health care sector needs to step to the plate, as Dr. Bethell has challenged it to live up to its potential to address the preventive agenda with its full power.

“What is a trauma-informed community?” There is no clear answer to this question, and there will likely never be a single answer. It is clear that too many children are growing up in toxic environments. Beyond adverse experiences, how many communities, families, and public institutions fall short of being as fully nurturing as they could be in this, the most affluent human society that has ever existed? The Buncombe experience would seem to point not to specific programs, but to examining community assets and getting down to work. In the process of doing, avenues for positive change become visible and possible. Tools for change seem to be in our hands. The question is whether we can find common direction and the social will to achieve our goals. **NCMJ**

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