TRAUMA AND RESILIENCY: A SYSTEMS CHANGE APPROACH

Executive Summary of Year 1 and Year 2 Final Reports for
Los Angeles County's **Trauma and Resiliency-Informed Systems Change Initiative**

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Over the past two years, the Center for Collective Wisdom (C4CW) has worked with a group of funders and a broad group of stakeholders to explore the potential for nurturing and deepening systems change efforts in Los Angeles County focused on trauma and resiliency.

During this time, we researched relevant systems change efforts from across the country, analyzed a wide range of resources related to trauma and resiliency, and engaged in conversations with senior leaders and others from systems across the county to gauge resonance and readiness for systems-level change to address trauma and promote resiliency.

This document summarizes the two reports we have developed for the Los Angeles County Trauma and Resiliency-Informed Systems Change initiative (LAC TRISC) to date, briefly reviewing the results of our dialogues and research, including lessons learned, a developmental framework to guide systems change efforts, and potential strategies for advancing this movement across the county.

WHY THIS MATTERS

Among the many historical influences that have given rise to a movement focused on trauma and resiliency, the 1998 Adverse Childhood Experiences (ACEs) study[1] has been particularly significant in building a broader conversation about trauma and the need to more systematically address its negative effects. This study examined the impact on health and wellbeing across a person's life from childhood abuse, neglect, and other adverse experiences, including: physical, sexual, or emotional abuse; physical or emotional neglect; a family member who is: depressed or diagnosed with other mental illness, addicted to alcohol or another substance, or in prison; witnessing a mother being abused; and losing a parent to separation, divorce, or other reason.

The import of this study was not simply the high prevalence of ACEs documented among the 17,000 predominantly white, older, college educated participants, all of whom had health insurance and had received physical exams. The study unexpectedly revealed a significant correlation: the higher the number of ACEs, the higher the risk for a wide range of negative health outcomes.

The original ACEs study, and many subsequent studies since, have documented the strong relationship between ACEs and the development of risk factors for negative health outcomes throughout a person's life. A 2009 study, for example, found that the life expectancy of a person with six or more ACEs is **20 years shorter** than a person with no ACEs.[2]

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1 Felitti, Vincent J., Robert F. Anda, Dale Nordenberg, David F. Williamson, Alison M. Spitz, Valerie Edwards, Mary P. Koss, and James S. Marks. "Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults." American Journal of Preventive Medicine Volume 14. Issue 4 (May, 1998): pp. 245-258. See also the description of the ACEs study by the Centers for Disease Control and Prevention: <https://www.cdc.gov/violenceprevention/acestudy/index.html>.

2 Brown, David, Robert Anda, Henning Tiemeier, Vincent Felitti, Valerie Edwards, Janet Croft, and Wayne Giles. "Adverse Childhood Experiences and the Risk of Premature Mortality." *American Journal of Preventive Medicine*, 37.5 (2009): pp. 389-396.

A more recent report by the Center for Youth Wellness applied the ACEs framework to California residents,[3] and compared the negative health outcomes for people with 4 or more ACEs to people with zero ACEs. The report found that, compared to adults with zero ACEs, Californian adults with 4 or more ACEs are:

- 12.2 times as likely to attempt suicide;
- 10.3 times as likely to use injection drugs;
- 7.4 times as likely to be an alcoholic;
- 2.2 times as likely to have ischemic heart disease;
- 1.9 times as likely to have cancer; and
- Almost 2 times as likely to report one or more days of poor physical or mental health in the past 30 days.[4]

The report authors observe:

> There is a hidden danger lurking in communities across California. Adverse Childhood Experiences, or ACEs, affect people from all backgrounds, regardless of race, income, education, or geography. Occurring in childhood, exposure to chronic adversity during the most formative years of a person's development has the potential to reap a lifetime of challenges, including poor health and even early death.[5]

As compelling as the ACEs research is, however, it actually *understates* the impact of trauma on the health and wellbeing of individuals, families, and communities. The reason is straightforward: there are far more sources of trauma, for children and adults, than the ten ACEs, including, for example:

- Physical, psychological, and sexual abuse experienced after childhood;
- Community violence;
- Homelessness;
- Natural disasters;
- Refugee and war zone trauma;
- Terrorism;
- Oppression, including structural oppression; and
- Multi-generational or historical trauma.

Defining Trauma and Resiliency

In our research, we discovered numerous definitions of trauma. Building on the work of the Substance Abuse and Mental Health Services Administration (SAMHSA)[6] and incorporating reflections and feedback from workgroup participants, we ultimately defined trauma as follows:

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[3] Center for Youth Wellness. *A Hidden Crisis: Findings on Adverse Childhood Experiences in California*. San Francisco, CA: 2014, p. 6. <https://app.box.com/s/nf7lw36bjjr5kdfx4ct9>. Note: The data in this report on California residents was collected through the Behavioral Risk Factor Surveillance System, an annual, state-based, random-digit-dial telephone survey. The summary is a cumulative analysis of all four years of ACEs data (sample size = 27,745).

[4] Ibid., pp. 2, 11.

[5] Ibid., p. 1.

[6] Substance Abuse and Mental Health Services Administration. *SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach*. HHS Publication No. (SMA) 14-4884. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014. <http://store.samhsa.gov/shin/content/SMA14-4884/SMA14-4884.pdf>

> The term *trauma* refers to the effects of a single event, a series of events, and/or ongoing circumstances that are experienced or perceived as physically or emotionally harmful and/or life threatening.
>
> Trauma can affect individuals, families, and communities immediately and over time, even generations. The adverse effects of trauma can be profound and long-lasting, resulting in diminished functioning and wellbeing, including mental, physical, social, emotional, and/or spiritual wellbeing.

Regardless of the precise definition of trauma, however, the research and work on ACEs, complex trauma, toxic stress, and community trauma invite a profound shift in perspective and behavior in organizations and systems dedicated to promoting wellbeing among children, adults, families, and communities. This shift begins with a renewed commitment to curiosity and empathy for another person's life experiences. Instead of seeing a person's behavior as the root problem, we are invited instead to see behavior both as symptom and communication. Rather than asking 'What's *wrong* with you?' we ask 'What *happened* to you?'[7]

And yet, as impactful as this research has been, a potential unintended consequence is that it can reinforce a (mis)perception that nothing can be done once someone has experienced adverse childhood experiences or other experiences leading to severe trauma. This is why any conversation about trauma should be linked to a conversation about resiliency, which we defined as follows:

> The term *resiliency* refers to the capacity of individuals, families, and communities to heal from trauma, and to strengthen their wellbeing and adaptability in ways that can mitigate or prevent future trauma.

As organizations and systems become more adept at assessing for, recognizing the symptoms of, and addressing trauma, they must become equally adept at helping individuals, families, and communities strengthen their resiliency. This call to promote resiliency is not merely rhetorical, nor is this work a substitute for the work to understand and address the root causes of trauma. Working to strengthen the capacity of individuals, families, and communities to heal and adapt in the face of profound adverse circumstances requires discipline and persistence, as does the equally challenging and essential work of reducing and, where possible, eradicating sources of trauma.

Our call, therefore, is for a commitment within organizations and systems to help individuals, families, and communities both heal from trauma and strengthen their resiliency, to become trauma *and* resiliency-informed.

YEAR 1 LESSONS LEARNED

The commitment of funders and stakeholders in this process has been to move beyond particular assessments, treatments, and practices related to trauma-informed care, exploring instead how to

[7] See, e.g., ACEs Connection. <http://www.acesconnection.com/blog/the-origins-of-a-paradigm-shift-from-what-s-wrong-with-you-to-what-happened-to-you>

foster systems change efforts across Los Angeles County. The language we use to describe this level of change is *trauma and resiliency-informed systems change*, defined as follows:

> The phrase *trauma and resiliency-informed systems change* refers to an ongoing process to strengthen an organization, department, or larger system's impact by integrating into its programs, structures, and culture a comprehensive commitment to address trauma and promote resiliency.

Such a process "is not a program model that can be implemented and then simply monitored by a fidelity checklist. Rather, it is a profound paradigm shift in knowledge, perspective, attitudes, and skills that continues to deepen and unfold over time."[8]

Through this process, we distilled a number of lessons learned about how to create and sustain successful systems change efforts focused on trauma and resiliency. These lessons included:

- An abiding *why* tied to results;
- A sustained focus on long-term culture change;
- An ongoing *yes* to participatory engagement;
- Cultivating a learning culture; and
- The complexity of community.

A first lesson is about what will help organizations and systems commit to this work, and to dedicate the resources, time, and energy necessary for success. The most compelling reason is that staff and their partners recognize that addressing trauma and promoting resiliency are *essential* to achieving the results the system is committed to effect. This is why the ACEs, toxic stress, complex trauma, and other research is so impactful: it helps multiple systems begin to recognize unresolved trauma as a root cause of many of the issues that are impeding progress toward positive results.

A second lesson, closely related to the first, is reflected in our understanding of trauma and resiliency-informed systems change as an *ongoing* process. Any systems change effort will of course include myriad short-term actions and steps—e.g., trainings, testing different assessment protocols, and short-term experiments funded with one-time dollars. All of these time-limited interventions, however, should ultimately emerge in support of a long-term effort to address trauma and promote resiliency across all dimensions of an organization until this orientation permeates and helps define the organization's culture.

The third lesson is about the ongoing need for participatory engagement. We have labeled this lesson an ongoing *yes* to make clear that such processes cannot be shallow, one-off experiences of token engagement, either for people served by the organization or for staff. For staff in particular, the level of energy and vulnerability required to embody a commitment to address trauma and promote resiliency, both with other staff and the people they serve, is substantial. Their *yes* must be routinely invited and regularly reinforced by senior leaders, including through their modeling of the same level of vulnerability and engagement being asked of staff.

The need to cultivate a learning culture within systems committed to becoming trauma and resiliency-informed is the fourth lesson learned. In particular, organizations committed to successful

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[8] *Missouri Model: A Developmental Framework for Trauma Informed,* Missouri Department of Mental Health and Partners (2014), p. 1. <https://dmh.mo.gov/trauma/MO%20Model%20Working%20Document%20february%202015.pdf>.

long-term change efforts must cultivate their capacity to promote safety for staff, partners, and the people they serve, and strengthen their capacity to stay with complexity when it (inevitably) arises.

We summarized the final lesson discovered through the first year of this work as the complexity of community. Any systems change effort focused on trauma and resiliency ultimately must address fundamental questions about community that begin to reveal some of the inherent complexity of trauma and resiliency-informed systems change efforts. These questions include:

- What is our definition of community?
- What is the role of community in healing trauma and promoting resiliency?

Many efforts that focus on trauma and resiliency consider cities, counties, or states to be communities. From this understanding of *community*, becoming trauma-informed means implementing a wide range of strategies—e.g., broad public awareness campaigns; and multi-organization and cross-system efforts to improve collaboration among public systems and community-based service providers.

For others, *community* is used to describe people who share a common dimension of personal identity, culture, and/or historical experience—e.g., the Native American community, the African American community, the Hispanic and/or Latino communities, and the LGBTQ+ community. The importance of the use of the term *community* in this context is that it can help focus attention on ways that different groups of people may be similarly vulnerable to experiences of trauma, both presently and historically, and may share access to common sources of strength and resiliency.

In our work helping education, health, and human services systems strengthen their strategies for community capacity-building,[9] we introduce an additional definition of *community* that is equally vital for any discussion of trauma and resiliency: namely, groups of people who provide tangible support to each other and can act together.

Why is this additional understanding of community important? Because each of these different definitions of *community* suggests a different locus of action. Systems change efforts to improve the effectiveness of services are different from efforts to improve communities' capacity to address the individual or collective trauma of their members, or to strengthen their resiliency, *independent of services*. Both are needed. Systems leaders and others, however, need to understand the differences and unique requirements of each.

This distinction becomes even more crucial when we remember that trauma can be experienced both individually *and* collectively. While much of the research to date has focused on the effects and potential responses to individual trauma, a growing body of work is beginning to map the terrain of community trauma.

Community change efforts to address historical trauma and/or to promote resiliency and other dimensions of community wellbeing require different forms of leadership, process designs, and engagement strategies than do systems efforts.

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[9] See, e.g., Ott, John, and Rose Pinard. *California Institute For Mental Health Community Capacity-Building Learning Collaborative: Final Report.* Manhattan Beach, CA: 2011. <http://c4cw.org/wp-content/uploads/2017/06/CIMH-Community-Capacity-Building-Lessons-2011.pdf>.

A Developmental Framework

A dominant theme from the research and our many conversations with workgroup participants and others was the wide variation in understanding about what it means to be a trauma and resiliency-informed system. Some organizations describe themselves as trauma-informed after offering a one-time training to staff. Other organizations interpret the phrase to mean the integration of evidence-based treatments for trauma into particular programs, regardless of whether this work is embedded in a broader culture change effort.

For still others, becoming trauma and resiliency-informed implies a commitment to a comprehensive transformation that includes both increased access to effective treatment for unaddressed trauma and a broader culture change to prevent re-traumatization and better ensure that all supports, including for staff and community partners, are responsive and nurturing.

Given this wide variation in understanding, we constructed a developmental framework to serve at least three purposes: demonstrate the scope of the change we are inviting; help organizations become more systematic in their internal change efforts to address trauma and promote resiliency; and help facilitate cross-system learning and collaboration.

This framework builds upon several others, including the Missouri Model,[10] the Philadelphia Framework,[11] and SAMHSA's framework for a Trauma-Informed Approach.[12]

Six principles are at the heart of the SAMHSA framework and have been widely embraced by change efforts across the country. Based on workgroup participants' feedback, we evolved the labels and definitions of these principles to be more relevant for efforts within Los Angeles County. These principles are: safety; trust and transparency; peer support; collaboration and mutuality; voice, choice, and self-agency; and culturally, historically, and gender-identity appropriate. These principles, when fully embodied, define the essence of a trauma and resiliency-informed system.

In addition to the six principles, SAMHSA has identified ten implementation domains that systems should address as they progress toward becoming trauma and resiliency-informed. As with the guiding principles, we refined the labels and descriptions of these domains to reflect lessons learned from our research and workgroup feedback. The ten implementation domains include: leadership and governance; training and workforce development; screening, assessment, and services; progress and results monitoring; engagement and involvement; physical environment; cross-system collaboration; media and marketing; policies and procedures; and financing.

The developmental framework—summarized in the diagram below—is intended to help systems in their work to embody the guiding principles across all implementation domains.

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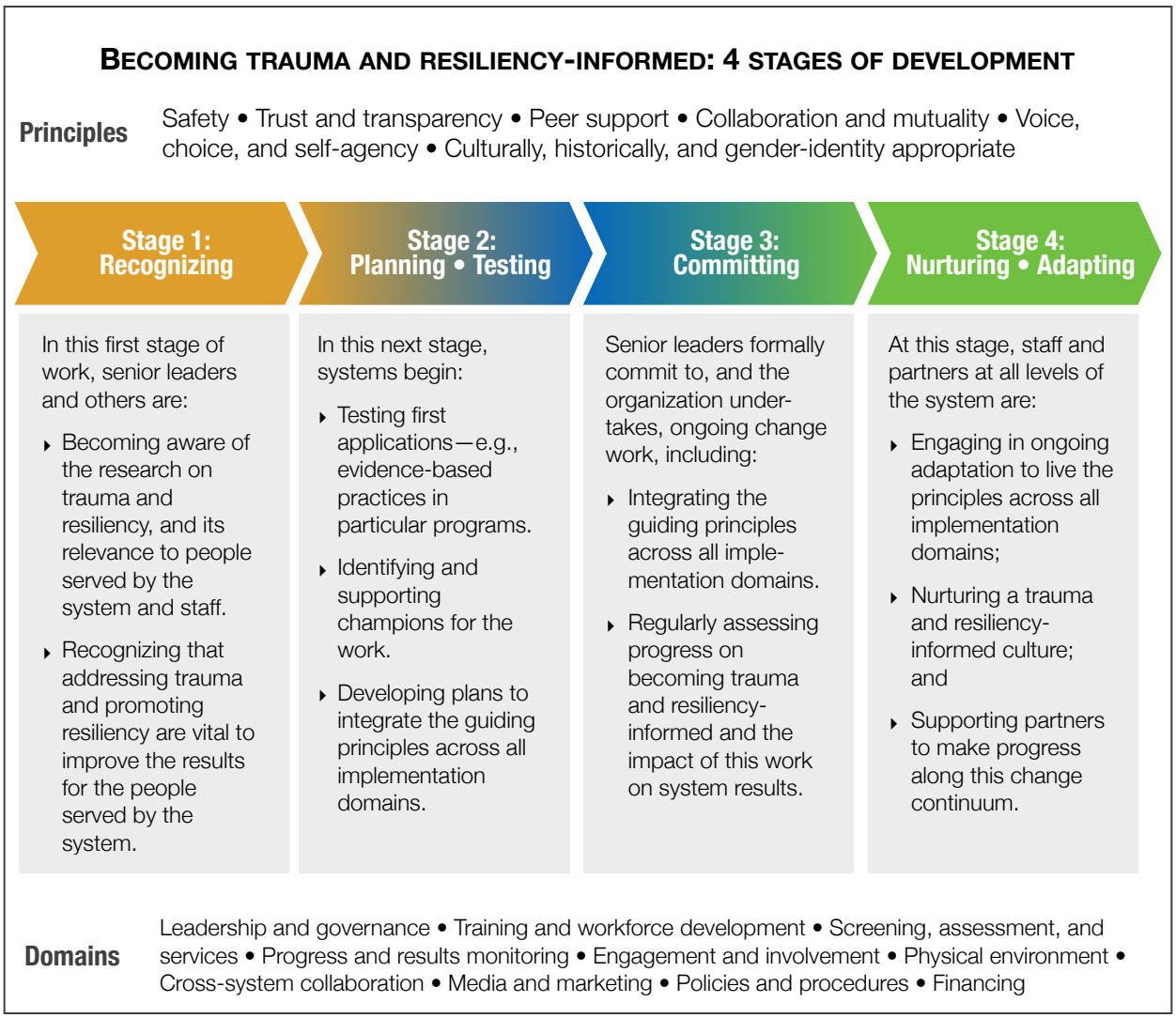
[10] Ibid.

[11] The Philadelphia ACE Project. *Framework for Trauma-Informed.* Philadelphia, PA: 2015. <https://drive.google.com/file/d/0B3KAAoiw6Tn0NU9odzYyM1Z2MVU/view>.

[12] Substance Abuse and Mental Health Services Administration. *SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach*, *op. cit.*



The four developmental stages of the framework are: (1) recognizing, (2) planning and testing, (3) committing, and (4) nurturing and adapting. These stages are not intended to be rigidly prescriptive; instead, they are intended to be customized by each system to ensure alignment with its mission, current priorities, and unique culture. Leaders, staff, and partners can use this framework to better discern where their organization or system currently is along this continuum, and to explore if and how they want to evolve to next stages of commitment and action.

YEAR 2 CURRENT REALITY • ANIMATING QUESTIONS

Over the course of this past year, we engaged with leaders and stakeholders from numerous countywide systems and organizations. These conversations uncovered burgeoning interest in the exploration of trauma and resiliency, and yet, no senior leadership team has committed to embrace the developmental framework and evolve a large-scale systems change initiative focused on trauma and resiliency.

This reality does not, however, appear to suggest a lack of interest in deepening the work. While as yet unwilling to commit to large-scale systems change efforts, leaders and other stakeholders articulated two distinct questions when asked how they could build upon what they are already doing:

- How do we move beyond trainings to a next level of commitment to heal trauma and build resiliency?
- How do we connect systems and related community change efforts to improve our priority results?

These two questions reveal several nuances about the current reality, and point to potential opportunities for advancing trauma and resiliency-informed systems change in Los Angeles County.

That many senior leadership teams are reluctant, undecided, or puzzled about what to do beyond training could reflect a lack of commitment to this change agenda. Our assessment, however, is different: we believe that this reality reveals and reflects several shortcomings in the current articulation of the developmental framework.

We crafted the framework to help guide change efforts across multiple systems. While the four stages, and the multiple steps within each stage, may seem straightforward to an outside observer, how to make these steps and stages come alive within a given system is anything but. Every system we engaged is already deeply enmeshed in one or several large-scale change efforts mandated by legislation, lawsuits, and/or Board of Supervisor directives. Moreover, a number of systems are experiencing both significant changes in senior leadership, profound external pressures, or both. Given these complex—and system-distinct—realities, implementing the developmental framework requires a more refined approach tailored to each system, beginning with creating a more explicit link to that system's priority results.

Interestingly, however, when leaders and stakeholders we engaged during the year *were* wrestling with how to make progress toward priority results, they were not only interested in how to advance trauma and resiliency-informed systems change, but also in how to connect their systems change work to related community change efforts. That is, their response to the question of how to move beyond training included connecting community and systems change efforts in support of effecting priority results.

YEAR 2 LESSONS LEARNED

Through our work this year, we gleaned a number of additional lessons and hypotheses beyond those discovered during the first year.

A first lesson is about the challenge of scaling up from clinical theories and practices into broader commitments for the workplace. Trauma and resiliency-informed systems change efforts that we have researched have often begun by adapting into workplace contexts clinical theories and practices originally designed for people receiving services. As important and well intentioned as such efforts are, they have the potential to create complexity and confusion among staff members. Scaling up from a single practice or program to trauma and resiliency-informed systems change must be grounded in best practices of organizational development, helping systems to evolve a new way of working while also ensuring effective management of day-to-day imperatives. Organizations must

also plan for human resources and other potential challenges that may go well beyond those encountered when implementing a new clinical program or approach. As a workgroup member noted: "Everyone is starting to talk about trauma and resiliency but systems changes that move beyond new language are asking a lot of everyone. Many agencies and systems are fragile. So there's hope but also trepidation."[13]

A second lesson is about the risk of this work being seen as a fad. When systems leaders invoke the language of trauma and resiliency-informed systems change but fail to commit to the ongoing work such change requires, they risk staff and stakeholders concluding that this is just the latest rhetorical exhortation that changes little.

Conversely, when leaders fully commit to this work—for example, supporting learning processes among staff to reflect on the connection between improving results and addressing trauma—they are better able to help staff trust that this change is real. This connection between results and trauma and resiliency-informed systems change is a learning edge for the movement to support trauma and resiliency-informed systems change, both in Los Angeles County and across the country. For example, systematically exploring the connection to results will require more nuanced evaluation processes than those typically undertaken to assess fidelity to evidence-based models.

A third lesson is about how much this work necessitates engaging interior dimensions of change—e.g., individual and collective beliefs; physiological responses; emotional reactions; implicit biases; and cultural norms of exclusion and oppression. Such work requires a very different pace, depth, and quality of engagement than the frantic pace of crisis-driven group exterior work that typifies much of what we encountered in the systems we engaged. Given this depth of work, senior leaders must both champion and model a commitment to engage the interior dimensions of change for staff to trust that such interior work is welcomed, appropriate, and seen as vital to a system's mission.

Four Core Competencies

Beyond these three lessons, we have also developed a hypothesis grounded in our experiences over the past year, and informed by decades of learning from our work designing and facilitating large-scale systems and community change initiatives. This hypothesis is about the four core competencies systems must develop if they want to undertake a trauma and resiliency-informed change effort.

The first core competency focuses on results. This competency arises from senior leaders, staff, and stakeholders committing to hold themselves accountable for achieving results for people served by the system. To embody this commitment, leaders, staff and stakeholders need to:

- Identify priority results and program performance measures that align with these results;
- Develop data sources for the priority results and program performance measures, and regularly collect reliable data for these results and measures;
- Share the data internally and externally in easily understandable reports designed both to track progress and invite learning; and
- Convene regular learning processes among staff and stakeholders to reflect on the data, assess the effectiveness of current strategies and programs, and develop adaptive responses as needed.

[13] As documented in C4CW's process notes from the March 29, 2018 workgroup meeting.

This competency is essential for systems to assess the need for trauma and resiliency-informed systems change. If a system is already achieving levels of success that satisfy staff, stakeholders, and the people served, why undertake something as complex as a culture change initiative? On the other hand, being able to clearly document that a system's current results are not ideal can help staff and stakeholders commit to more transformational work.

The second core competency is systems thinking. An orientation to systems thinking enables leaders, staff, and stakeholders to navigate complexity and interconnectedness by thinking and acting developmentally. That is, we do not attempt to change the system all at once, nor do we act simply to act. We develop strategies to help the system evolve over time toward its new culture, and convene reflective spaces to help us assess the impact of initial changes and discern next steps.

This orientation builds upon the core competency of results. The data and learning processes at the heart of a commitment to results can help us understand and begin to map existing feedback loops within the system, and create new ones. What actions and efforts appear to be moving us closer to our results and desired performance measures, and what may be moving us further away? Such inquiries can begin to reveal viable leverage points for helping a system evolve a trauma and resiliency-informed culture.

The third core competency is the capacity to support and enliven communities in ways that contribute to both improved results for the people served by the system, and improved wellbeing among staff and stakeholders. In our year 1 final report, we shared the following definition of *community,* developed through decades of designing and leading large-scale systems and community change efforts: *a group of people who provide tangible support to each other and can act together.*[14]

In our year 1 report we examined why this orientation to communities is vital to help people who have experienced trauma to heal, including people who receive professional services. As complex as this work can be,[15] a commitment to build communities of support among staff members is equally so. When focused on trauma and resiliency, this work invites staff members to strengthen their capacities for appropriately engaging the interior dimensions of change without undermining performance.

Central to both streams of work is a commitment to *mutuality*. For example, while staff members assume different levels of formal authority and a wide array of responsibilities, they do not have to form relationships based on hierarchy or instrumental transactions. That is, our workplace interactions contain the potential to help us individually and together evolve towards greater maturity and consciousness. Mutuality involves interior dimensions of change, including self-awareness, self-regulation, mindfulness, and reflection in action. In our experience, as mutuality enlivens authentic community, a system's capacity to achieve and sustain positive results can increase profoundly over time.

The capacities for self-awareness, self-regulation, mindfulness, and reflection in action are also essential aspects for the core competency of leadership. This competency is not simply about the behavior of senior leaders within a system, but speaks to the capacity of all staff and stakeholders to exercise leadership in support of the trauma and resiliency-informed systems change effort. Reduced to its essence, *leadership* is the capacity to enable effective action among a group of people. From this

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[14] Ott, John, Rose Pinard, et al. *Trauma and Resiliency: A Systems Change Approach. op. cit.,* p. 19.

[15] Ott, John, and Rose Pinard. *Community Capacity-Building Learning Collaborative: Final Report, op. cit.*

perspective, any person, in any context, has the capacity to exercise leadership, to act in ways that support a group of people becoming more capable of effective action.

Indeed no one person, even someone with formal authority, can mandate a system to meaningfully engage the levels of interior work needed for successful trauma and resiliency-informed systems change. Such work requires the sustained effort of staff members and partners across the system. In this context, then, the core competency of leadership is about creating a *leader-ful* organization, an organization in which each person is invited and encouraged to exercise leadership in service of increasing the organization's effectiveness through trauma and resiliency-informed systems change.

Potential Next Steps Moving Into Year 3

Given the progress and lessons learned to date, we see several potential next steps that can help accelerate and deepen this movement. These actions, which are not mutually exclusive, include:

- Organizing one or more summits or other high-profile events to continue building awareness of and commitment to the movement within particular systems;
- Organizing and supporting stakeholder workgroups for any system in which senior leaders are committed to embracing the developmental framework;
- Advocating for action by the Board of Supervisors and other local and county leadership structures to heighten awareness of efforts already underway within the county; and
- Initiating one or more pilot efforts to connect systems and community change efforts focused on trauma and resiliency.

More Complexity, Not Less

At the end of the first year's report, we wrote:

> [E]ven if no one adopts the framework, and none of the potential strategies are implemented—the movement will continue. The historical roots of this work are too deep, the ACEs and related research too compelling, the positive results already being documented too promising, and the numbers of people and systems who already have said *yes* too large—for the movement to wither in Los Angeles County anytime soon.
>
> So the question is not whether the movement will continue. It will. The question is whether there is sufficient will and commitment—what we describe in our work as alignment of intention[16]—to support a next level of organizing and action to advance the movement.[17]

[16] Please see c4cw.org for details of our work.

[17] Ott, John, Rose Pinard, et al. *Trauma and Resiliency: A Systems Change Approach. op. cit.,* p. 49.

One year later, the movement *is* continuing, and our experiences and the data from this past year convince us it will continue to grow and evolve.

And … the lessons we have gleaned through this year reveal the complexity of bringing coherence to all that is unfolding within the county. Confronted with such dizzying complexity, a natural impulse can be to seek to radically simplify the task: just do this training or adopt this practice.

Our impulse and invitation have been different. We have encouraged ourselves and our learning partners to embrace more complexity, not less: to focus on trauma *and* resiliency; to focus on *systems change*, not simply a particular assessment tool or treatment modality; and systems change not just for one system, but for multiple systems. Oh yes, and not just systems change, but *community* change as well.

Why make this work harder and even more complicated?

Because our immersion in this exploration, and our decades of work in communities and systems, lead us to hypothesize that the impulse toward trauma and resiliency-informed systems change is not the point, but rather is pointing to something larger: an urgent call for all of us to engage together to evolve a larger culture of healing, loving support, and wellbeing.

Reduced to its essence, we see the movement toward trauma and resiliency-informed systems change, and the larger impulse toward a culture of health and wellbeing, as an invitation for individual and collective spiritual work. Peter Senge has been one of the theorists at the forefront of efforts to invite a spiritual perspective into organizational change work, as made evident by his reflections on the theory and practice of learning organizations:

> The learning organization embodies new capabilities grounded in a culture based on transcendent values of love, wonder, humility, and compassion; a set of practices for generative conversation and coordinated action; and a capacity to see and work with the flow of life as a system … [Such work can create] a field of alignment that produces tremendous power to invent new realities in conversation and to bring about these new realities in action.[18]

Rather than being overwhelmed by this insight, we are energized by it. We hope you are too … and look forward to discovering together what is wanting to unfold now.

[18] Peter Senge, "Creating Quality Communities," in Kazimierz Gozdz, (Ed.), *Community Building: Renewing Spirit and Learning in Business*. San Francisco: New Leaders Press. 1995, pp. 49-50.