Mobilizing Action for Resilient Communities ACEs, Trauma, and Resilience Network Survey

MARC ATR Network Findings

Final Report

PRESENTED TO:

Health Federation of Philadelphia

PRESENTED BY:

Margaret Hargreaves
Erik Scherpf
Jodie Smylie
Camille Smith
NORC at the
University of Chicago
4350 East/West Highway
Bethesda, MD 20814
(978) 263-1284

AUGUST 2021

NORC at the University of Chicago

Table of Contents

List of Figures

List of Tables

Acknowledgements

The Health Federation of Philadelphia would like to thank the following for their thoughtful contributions to the Mobilizing Action for Resilient Communities (MARC) initiative's Adverse Childhood Experiences (ACEs), Trauma, and Resilience (ATR) Network Survey:

PACEs Connection staff
Kimberlee Coronado
Lisa Cushatt
Tamara Daley
Todd Garrison
Rick Griffin
Jennifer Jones
Jesse Kohler
Maggie Litgen
Melissa McGinn
Melissa Merrick
Geof Morgan
Caitlin O'Brien
Laura Porter
Daniel Press
Robin Saenger
Holly White-Wolfe
Jasmin Williams

We also wish to thank all the ATR network leaders who inspired or participated in the survey, as well as the Robert Wood Johnson Foundation for their generous support.

Executive Summary

Survey Overview

Survey overview. The Health Federation of Philadelphia (HFP) collaborated with NORC at the University of Chicago to coordinate the Mobilizing Action for Resilient Communities (MARC) initiative's Adverse Childhood Experiences (ACEs), Trauma, and Resilience (ATR) Network Survey. The project conducted a national study of ATR networks in the United States to learn more about the prevalence of such ATR networks, their key characteristics, their goals, and their technical assistance needs. The goal of this project is to bring to light the potential of ATR networks and better support the broader movement for creating healthy, equitable, and resilient communities.

The survey defined ATR networks as networks that: (1) used an ATR framework of key concepts, science, and practices, (2) were cross-sector community networks representing multiple sectors, (3) served a geographically targeted area, and (4) engaged with its members through in-person[1] communications and meetings.

Key Characteristics

Survey response. *The survey response rate was 75.6 percent.* In total, 361 networks were invited to participate in the survey, of which 273 networks (75.6%) submitted a valid response. Of the 273 networks, 251 networks met all survey inclusion criteria and were included in the analysis.

ATR focus. *Overall, almost all networks reported working on all three topics, adverse childhood experiences, building resilience, and using a trauma-informed lens*. In total, 98.4% reported working on addressing adverse childhood experiences and 98.0% reported working on building resilience at individual and/or community levels (see Table A-1).

Geographic locations. *Networks from 45 states (plus the District of Columbia) were included in the survey sample.* The five states that had no identified ATR networks to include in the survey sample were: Louisiana, Mississippi, Nevada, Rhode Island, and Wyoming. In addition, there were networks in five states or regions that were invited to participate in the survey, but did not respond. These were networks in Arkansas, North Dakota, South Dakota, Nebraska, and the District of Columbia. Of the 251 networks with jurisdiction-level data reported in the final analytic sample, 114 were county-based networks (45.4%), and 64 networks represented within-state or cross-state regions (25.5%). Another 40 were statewide networks (15.9%), 11 were community-level networks (4.4%), and 6 represented tribal nations (2.4%) (see Table A-2).

[1] Criteria were established prior to COVID-19 travel or meeting restrictions were imposed.

Network age. *The networks varied in age; some have been in existence for a decade or more while other networks are brand new.* Of the 249 networks that reported their age, 40 networks (16.1%), were more than 9 years old, while 22 networks (8.8%) had been in existence for less than a year (see Table A-3).

Network size. *The size of the networks varied; half of the networks surveyed had 50 or fewer members*. Of the 249 networks that reported their size, 61 networks (24.6%) reported having fewer than 25 people and 64 networks (25.4%) reported having 26 to 50 people. Among the mid-sized networks, 33 networks (13.3%) reported a membership of 51 to 75 people, and 17 networks (6.9%) reported a membership of 76 to 100 people. Among the largest networks, 15 networks (6.1%) reported a membership of 101 to 125 people, and 59 networks (23.8%) reported a membership of more than 125 people (see Table A-6).

Cross-sector participation in networks. Survey respondents were asked to identify sectors and groups participating in their networks. They chose from a list of 32 sectors and groups, which were clustered into six categories. Six in ten networks (61.9%) reported representation from at least one sector in each of the five main categories: education/youth, health, social services/basic needs, public policy, and justice/military. The sectors and groups that participated in at least three-fourths of the ATR networks were: mental health/behavioral health (in 94.8% of the networks), social services (88.7%), youth services (88.7%), K-12 education (88.3%), early childhood education and care (85.5%), child protection/child welfare services (82.7%), public health services (82.7%), health care/medical care (77.8%), and community members (77.0%) (Table A-5).

Network Infrastructure

Finances. *The level of networks' resources varied*. About half of the networks reported having no budget (31.0 %) or an annual budget of up to $25,000 (21.6%). At the other end of the spectrum, 13.5% of networks reported having an annual budget of over $250,000 (see Table A-11).

The networks were supported by wide range of resources. These sources included in-kind resources – volunteers, space, and materials (80.3%), grants or contracts from a private foundation (51.1%), public grants or contracts (49.0%), donations (23.9%), allocations from the budgets of member organizations (23.0%), service fees or reimbursements (10.0%), or member dues (4.2%) (Table A-10).

Staffing. *Almost half of the 234 networks responding to this item (41.2 %) reported having no full-time or part-time staff.* One in five networks (19.7%) reported having no full-time employees, but having one or more part-time staff. One in ten networks (10.3%) reported having a single full-time employee, but no part-time staff (see Table A-9).

Leadership and community engagement. *Almost all networks reported having a core leadership team or group that coordinated network decisions and activities (91.8 %).* This rate did not vary significantly by network age, budget, size, or geographic region (see Table A-12).

Although most networks reported having some community members, their numbers were relatively small. Regardless of network size, two-thirds of all networks (67.8%) reported having fewer than 10 community members. Another 21.1 percent reported having between 10 and 20 community members (see Table A-8).

Communications. *For internal communications, networks' use of email messages (97.5%) and in-person meetings (95.1%) was almost universal, regardless of network age, size, budget, or geographic type.* Half as many networks (43.9%) reported using conference calls (see Table A-13).

For external communications, networks most often used in-person presentations at community events (88.0%), organization-specific talks or trainings (72.3%), and conference presentations (65.3 %) (see Table A-14). Note that these data were collected largely before COVID-19 restrictions were put in place. Networks with more funding reported using a greater range of external communication methods.

Use of Data. *A majority of the networks reported using data in multiple areas.* More than half of the networks reported using data for learning and improvement (74.3%) and network strategic planning (58.4%). About half of the networks also reporting using data to work with communities to make sense of data (50.1%), monitor population-level ACEs and trauma trends (50.6%), disseminate data to external audiences (50.2%), and inform policy or systems change (49.8%). Fewer young networks that had been in existence for less than one year reported using data for these purposes (see Table A-22).

Network Member Services

Network Meetings. *Overall, almost half of all networks (48.0%) reported holding in-person meetings on a monthly basis*. One in four networks reported holding in-person meetings two or more times per year. Fewer networks (22.6%) reported holding in-person meetings two or more times per month. Very few networks (4.0%) hosted in-person meetings just once a year (see Table A-4).

Overall, about half of the networks (46.3%) reported fewer than 25 people were regular attendees at their meetings (see Table A-7). A greater proportion of smaller networks, younger networks, local networks, and networks with smaller budgets reported they had fewer than 25 regular attendees.

Member Benefits. *Members stayed involved in their networks for professional and personal reasons*. These reasons included learning about advances in ATR research and practice, facilitating personal growth, and receiving support to prevent or mitigate secondary trauma. They also wanted to share information about their activities, get updates from others, and collaborate with others on joint projects.

Their networks had increased members' knowledge of ATR-related concepts, policies, programs, or practices to a "very great extent" (14.0%), a "great extent" (44.9%) or a "moderate extent" (31.2%) (see Table A-18). The average or mean score across all networks was 3.6 on a scale of 1 – 5.[2]

Their networks had increased members' use of ATR-related concepts, programs, or practices at work to a "very great extent" (8.3%), a "great extent" (31.0%), or a "moderate extent" (44.6%) (see Table A-19). The average rating across all networks was 3.3 on a scale of 1 – 5.

Their networks had increased members' use of ATR-related concepts in their personal lives to a "very great extent" (8.9%), a "great extent" (32.3%) or a "moderate extent" (38.7%) (see Table A-20). The average rating across all networks was 3.3 on a scale of 1 – 5.

Their networks had increased members' work with other organizations on ATR-related concepts, policies, programs, or practices to a "very great extent" (7.5%), a "great extent" (29.6%), a "moderate extent" (45.4%) or a "small extent" (16.3%) (see Table A-21). The mean score across all networks was 3.26 on a scale of 1 – 5.

Network Goals

Network Capacity Building. A quarter of the networks (25.0%) focused on developing their *network's capacity* to carry out their work. These goals included building their network's membership; improving network leadership, staffing and infrastructure; and securing enough funding to sustain and expand network operations (see Table A-23).

Strategic Objectives. Nearly half of the networks (47.3%) identified specific *network activities* as network goals. These goals included convening major events, providing education, training, and professional development opportunities, and creating online platforms for members.

Less than half of the networks (40.6%) identified building *foundational ATR awareness* as a network priority. These included increasing local awareness of ACEs and their impacts, developing a common language and shared messages on ATR topics, and increasing the network's engagement with local leaders, parents, youth, and others with lived experiences.

A quarter of the networks (25.0%) wanted to *make changes in their members' organizations*. These included developing an ATR-informed and qualified workforce, implementing evidence-based ATR program models and frameworks, improving staff self-care, and helping them adopt ATR attitudes, behaviors, and habits at home and at work.

[2] Mean scores range from 1 to 5. 1 = Not at all. 2 = to a small extent. 3 = to a moderate extent. 4 = to a great extent. 5 = to a very great extent.

Cross-Sector Change. A third of the networks (32.4%) identified goals for *coordinating action across local organizations and service sectors*. These goals included creating an ATR-based coordinated continuum of care, cross-sector partnerships for collective impact, and connections among local, state, and national networks.

Fewer networks (16.1%) identified goals *advocating for policy and systems change*. Their goals included changes to increase access, availability, and affordability of ATR programs and practices, and changes to reduce duplication and fragmentation of ATR services.

Relatively few networks (15.2%) set goals related to *community capacity building.* These goals included community development and organizing to support neighborhood healing, trust, and healthy relationships, increasing social connections for families, and increasing community capacity for self-healing and resilience.

Long-term Outcomes and Impacts. Some networks (6.3%) outlined *specific outcomes for children*. These outcomes included a safe and nurturing environment with positive relationships, experiences, and other protective factors, readiness for kindergarten, overall school success, and increased child self-regulation and resilience.

Some networks (10.3%) identified *specific outcomes for families*. These outcomes included family participation in two-generational programs and approaches; enhanced family ATR knowledge, core capacities and skills; and increased parent and caregiver self-regulation and resilience.

One in five networks (21.4%) listed *population-level goals*. These focused on the overall health and well-being of children and families, the intergenerational transmission of ACEs, the population's mental, behavioral, and social-emotional health, and individual and community-level resilience.

Goal-Related Activities. Networks reported engaging in a variety of activities to achieve their goals, including: *providing training and education* (95%), *coordinating cross-sector system change efforts* (68%), *developing new programs or practices* (51%), *amplifying the voice of persons with lived experience* (50%), and *coordinating legislative policy advocacy efforts* (34%) (see Table A-22).

Network Technical Assistance Needs

Capacity Building Needs. Nearly half of the networks (49.0%) reported a need for technical assistance to develop a *more sustainable infrastructure* to support their network's activities. This included finding funding, grant writers, and development staff (see Table A-24).

Nearly a third of the networks (28.7%) identified technical assistance needs in the area of *effective network leadership, governance, and management*. These needs included strategic planning, network leadership, member recruitment; how to move from planning to action; and how to develop community visions, goals, and measures; and how to integrate racial equity into network plans and priorities.

Slightly fewer networks (38.0%) requested *communications* technical assistance. Most requests were for assistance with websites or other online platforms, marketing and communications, and social media and other messaging.

Strategic Objectives Needs. Less than half of the networks (40.1%) requested technical assistance to support a range of *data needs*. These requests included coordinating and streamlining the collection and reporting of local and regional data, development of surveys and other metrics, and developing frameworks for ATR metrics.

Nearly a third of the networks (30.2%) requested help with *training and professional development*. This included help on how to manage training requests and logistics, how to increase access to ATR experts, how to spread ATR technical skills across a region, how to provide updated ATR resources and information, and how to build a larger social movement.

Some networks (15.6%) requested technical assistance on how to *engage local partners* in policy change. These needs included how to involve front-line health workers in practice change, how to engage local media, foundations, and businesses in ATR-reled community change efforts, how to use community organizing practices, and how to leverage Medicaid billing strategies.

Cross-Sector Change Needs. Some networks (9.9%) identified technical assistance needs in *collaborating and aligning efforts* with other networks to scale up their impact, and in disseminating information to potential allies and audiences. Needs included finding more opportunities to exchange best practices and learn from other ATR networks, strengthening communications and dialogue with other ATR partners, and collaborating outside of their own silos with state networks and national ATR initiatives.

Some networks (16.7%) identified technical assistance needs in *policy, systems, and community advocacy*, including ATR policy development, training and engaging elected leaders and government policymakers, increasing awareness and buy-in on ATR policy issues among families and the general public, influencing state and local policy through positive norms campaigns, incorporating ATR concepts into state policy, implementing culturally appropriate strategies for changing legislation, and supporting culture change linking racism and trauma.

Linking Goals and Technical Assistance Needs. The networks identified specific technical assistance needs to achieve their top three goals. Across the networks, the ten themes of goals were overlaid onto the eight themes of technical assistance needs.

Survey Overview

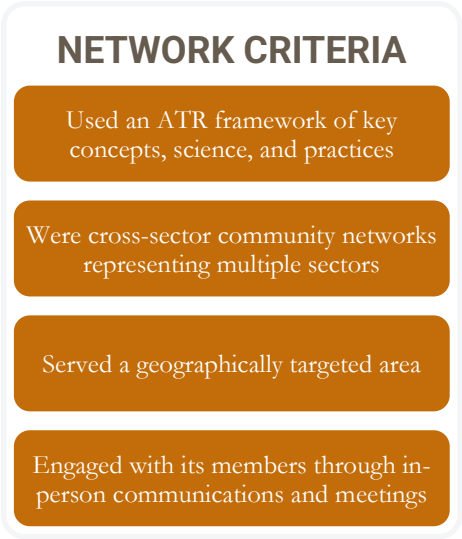
Survey Overview

Survey overview. The Health Federation of Philadelphia (HFP) collaborated with NORC at the University of Chicago to coordinate the Mobilizing Action for Resilient Communities (MARC) initiative's Adverse Childhood Experiences (ACEs), Trauma, and Resilience (ATR) Network Survey. Funding for this project came from the Robert Wood Johnson Foundation. The views reported here are those of the authors and do not necessarily represent the official views of the Foundation.

The project conducted a national study of ATR networks in the United States to learn more about the prevalence of such ATR networks, their key characteristics, their goals, and their technical assistance needs. The goal of this project was to bring to light the potential of ATR networks and better support the broader movement for creating healthy, equitable, and resilient communities.

Survey Methods

Survey sample development. The first step in the project was to develop a sample of ATR networks to receive the survey. The project team worked with an advisory group of ATR networks and professional associations to identify networks that met the survey's inclusion criteria. These were networks that: (1) used an ATR framework of key concepts, science, and practices, (2) were cross-sector community networks representing multiple sectors, (3) served a geographically targeted area, and (4) engaged with its members through in-person[3] communications and meetings.



The initial sample consisted of 327 networks. An additional 46 networks were subsequently added to the initial sample using a snowball sampling process that asked survey respondents to identify additional networks, for a total 373 networks. After removing duplicates and networks that were determined to be outside of the sample criteria, the final sample included 361 networks, representing 45 states and the District of Columbia. The first batch of survey invitation emails were sent to 327 nominated networks on December 14, 2019. The final survey invitation emails sent to newly nominated networks on March 12, 2020. The survey's data collection period ended on March 24, 2020.

[3] Criteria were established prior to COVID-19 travel or meeting restrictions were imposed.

Of the 361 networks that received an invitation to complete the survey, a total of 273 networks submitted a valid response, for a response rate of 75.6 percent.[4] Seven networks whose focus did not include one of the core topics of interest (i.e., addressing adverse childhood experiences, using a trauma-informed lens, or building resilience at the individual and/or community levels) were omitted from the *analytic* sample, since the survey did not collect any further information from these networks.[5] Moreover, during the analysis, 15 networks were found to have reported "never" having conducted in-person meetings and were also excluded from further analysis.[6] This created a final analytic sample of 251 networks from 40 states, on which the findings are based (see Figure 1).[7]

Network Characteristics

ATR Focus

The networks worked on ACEs, trauma, and resilience topics.

Question 3: Does this network currently focus on the following topics? Addressing adverse childhood experiences, building resilience at individual or community levels, using a trauma-informed lens. *Overall, almost all networks reported working on all three topics, adverse childhood experiences, building resilience, and using a trauma-informed lens*. In total, 98.4% reported working on addressing adverse childhood experiences and 98.0% reported working on building resilience at individual and/or community levels (see Table A-1). Slightly fewer networks (96.8%) reported working on using a trauma-informed lens. This was especially true for newer networks in operation for less than one year (90.9%), and smaller networks that reported having fewer than 25 members (91.8%).

Geographic Levels and Locations

The ATR networks are located across the United States.

How many states are represented among the respondents? *Networks from 45 states (plus the District of Columbia) were included in the survey sample.* The five states that had no identified ATR networks to include in the survey sample were: Louisiana, Mississippi, Nevada, Rhode Island, and Wyoming. In addition, there were networks in five states or regions that were invited to participate in the survey, but

[4] Eight networks recorded survey "progress" of between 0 and 3 percent and were not considered as responses for the purpose of determining the response rate.

[5] Indeed, these respondents recorded 100 percent "progress" on the survey since they responded to all the items that they were eligible to answer and thus were included in the numerator of the response rate.

[6] The survey was fielded prior to the shutdowns due to COVID-19, so these networks never conducted in –person meetings *pre-COVID*.

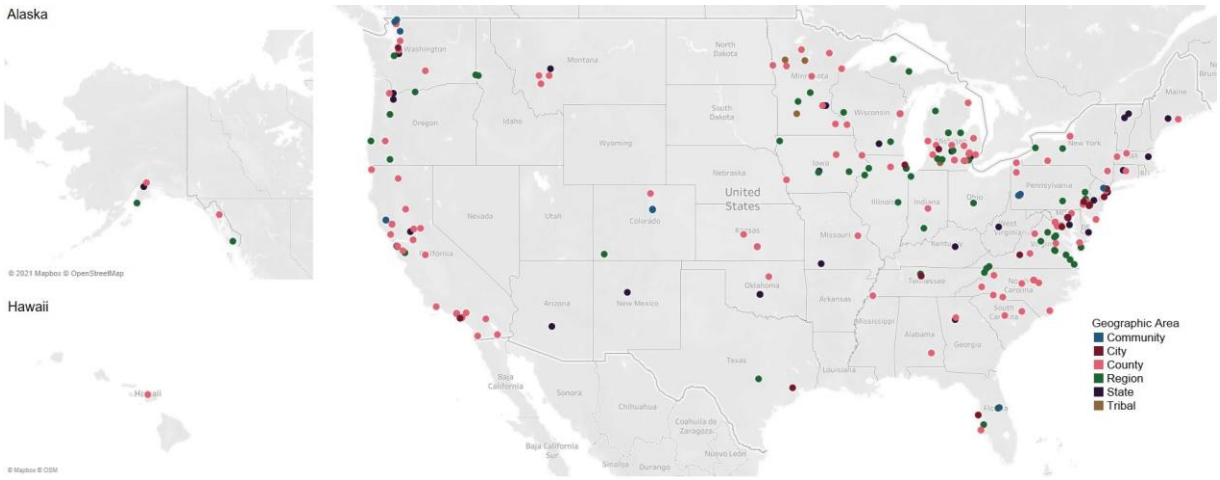
[7] Item non-response accounts for the fact that the number of responses to some survey questions totaled less than 251.

did not respond. These were networks in Arkansas, North Dakota, South Dakota, Nebraska, and the District of Columbia.

Of the 251 networks with jurisdiction-level data reported in the final analytic sample, ten states had one network, 12 states had 2-4 networks, 10 states had between 5 and 10 networks, and 8 states had more than ten networks. The two states with the greatest number of networks in the analysis are Michigan (30 networks) and California (with 27 networks) (see Figure 1).

Of the 251 networks with jurisdiction-level data, 114 were county-based networks (45.4%), and 64 networks represented within-state or cross-state regions (25.5%), such as the Alive and Well Communities, which served portions of Missouri, Kansas, and Illinois. Another 40 were statewide networks (15.9%), 16 were city-based networks (6.4%), and 11 were community-level networks (4.4%), and 6 represented tribal nations (2.4%) (see Table A-2).

Figure 1: Map of Networks



Note: Network locations represented on this map were based on the geolocation of the IP addresses associated with survey submissions.

Age of Networks

The networks varied by age; some had been in existence for only a few months, while others had been operating for more than a decade.

Question 7: To your knowledge, how long has the network been in existence? *The networks varied in age; some have been in existence for a decade or more while other networks are brand new.* Of the 250 networks that reported their age, 40 networks (16.1%), were more than 9 years old, while 22 networks (8.8%) had been in existence for less than a year old. The largest group of 77 networks (30.9%) had been operating for three to four years, 60 networks (24.1%) were 5 to 8 years of age, and 50 networks (20.1%) had been in existence for 1 to 2 years (see Table A-3).

Size of Networks

The networks varied by size from fewer than 25 people to more than 125 members.

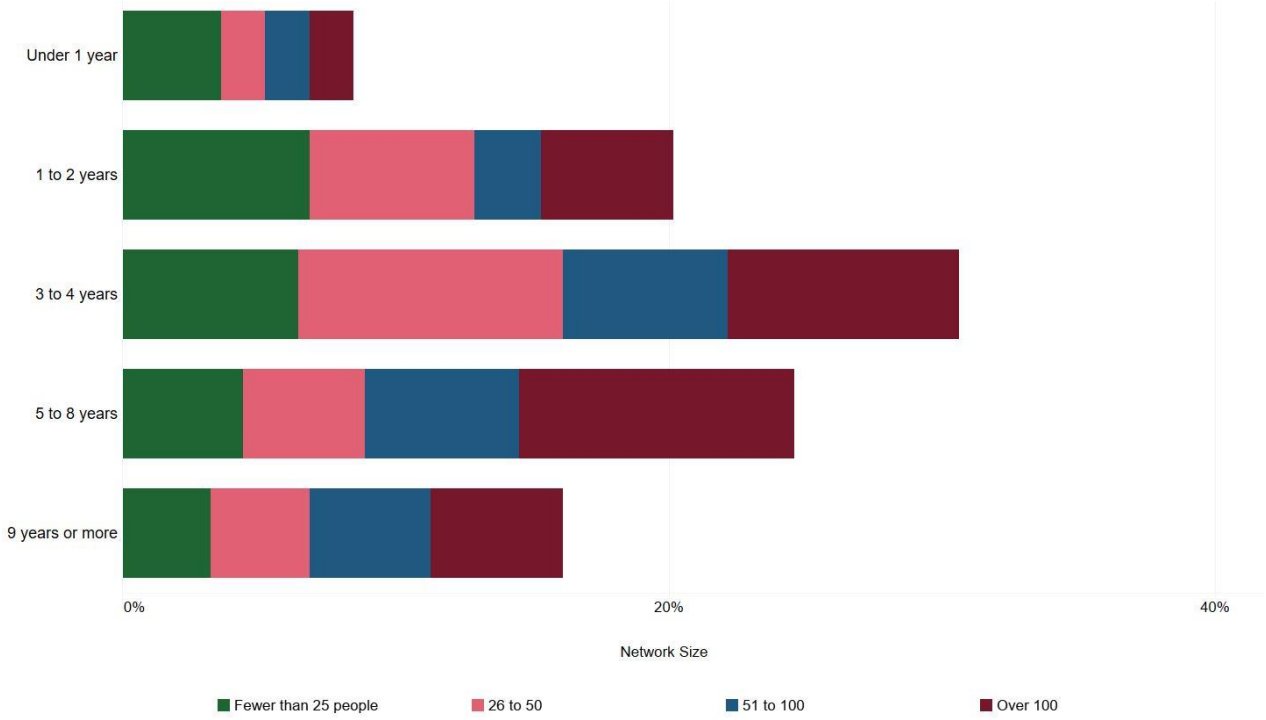
Question 10: What is the current size of the network, including individuals and organizational representatives? *Half of the networks surveyed had 50 or fewer members*. Of the 248 networks that reported their size, 61 networks (24.5%) reported having fewer than 25 people and 63 networks (25.4%) reported having 26 to 50 people. Among the mid-sized networks, 33 networks (13.3%) reported a membership of 51 to 75 people, and 17 networks (6.9%) reported a membership of 76 to 100 people. Among the larger networks, 15 networks (6.1%) reported a membership of 101 to 125 people, and 59 networks (23.8%) reported a membership of more than 125 people (see Table A-6).

The networks with fewer than 25 members were more likely to be younger, operate at the county level, and have small budgets. This included networks less than one year old (42.9%), networks 1 to 2 years old (34.0%), county networks (31.0%), networks with no budget (35.5%), and networks with an annual budget of up to $25,000 (34.0%).

Compared to all networks, a greater proportion of younger networks and networks with smaller budgets reported having 26 to 50 members. This included: networks 1 to 2 years old (30.0%), networks 3 to 4 years old (31.6%), networks with no budget (27.6%), and networks with annual budgets up to $25,000 (34.0%) (see Figure 2). Among 3-4 year old networks, for example, the most frequently reported network size was 26-50 members, followed by over 100 members, less than 25 members, and 51-100 members.

Compared to all networks, a greater proportion of older networks, state and city networks, and networks with larger budgets reported having more than 125 members. This included: networks 5 to 8 years old (35.0%), networks 9 years or older (27.5%), state networks (56.4%), city networks (31.3%), and networks with annual budgets of $25,001 to $100,000 (35.1%), $100,001 to $200,000 (36.4%), and over $200,000 (40.0%).

Figure 2: Network Age and Size



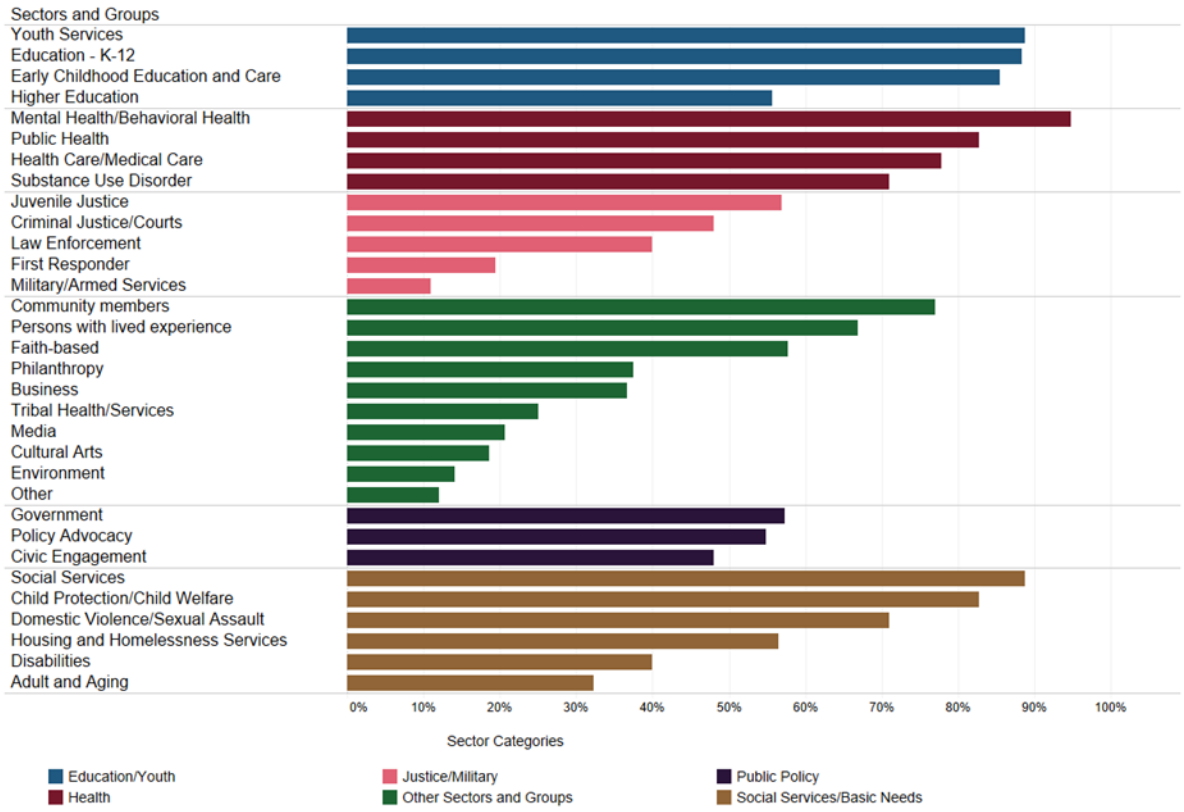
Cross-Sector Participation in Networks

People from 32 different sectors and groups participated in the networks.

Question 9: What sectors are represented by your network – select all that apply. Survey respondents were asked to identify sectors and groups participating in their networks. They chose from a list of 32 sectors and groups, which were clustered into six categories. Six in ten networks (61.9%) reported representation from at least one sector in each of the five main categories: education/youth, health, social services/basic needs, public policy, and justice/military.

The sectors and groups that participated in at least three-fourths of the ATR networks were: mental health/behavioral health (in 94.8% of the networks), social services (88.7%), youth services (88.7%), K-12 education (88.3%), early childhood education and care (85.5%), child protection/child welfare services (82.7%), public health services (82.7%), health care/medical care (77.8%), and community members (77.0%) (see Table A-5). Other sectors and groups that participated in more than half of the networks were faith-based groups (57.7%) and housing and homelessness services (56.5%). Other important sectors and groups that participated in the networks were philanthropy (37.5%) and business (36.7%).

Figure 3: Sectors and Groups Participating in Networks



Network Infrastructure

Network Finances

The level of network resources varied, with half of the networks reporting no budget or an annual budget of $25,000 or less.

Question 16: What is the network's typical annual budget? *About half of the networks reported having no budget (31.0%) or an annual budget of up to $25,000 (21.6%).* At the other end of the spectrum, 13.5 % of networks reported having an annual budget of over $250,000 (see Table A-11).

Network budgets varied by geographic level. Compared to all networks, a greater proportion of city networks (37.5%), county networks (36.0%) and regional networks (33.3%) reported having no budgets. A greater proportion of city networks (31.3%) and county networks (27.9%) also reported having budgets up to $25,000. A greater proportion of state networks (21.6%) and community networks (45.5%) reported budgets over $250,000. Community-based networks relied more heavily on donations for their funding,

whereas state-based networks relied more on public funding from contracts and grants relative to other networks.

Network budgets also varied by networks' size and the length of time they had been in existence. Compared to all networks, a greater proportion of networks with fewer than 25 members (45.8%) and networks with 26 to 50 members (33.9%) had no budgets. Also, a greater proportion of networks less than one year old (52.4%), networks from 1 to 2 years of age (36.7%), and networks from 3 to 4 years of age (33.3%) had annual budgets up to $25,000. A greater proportion of networks with 51 to 100 members (18.0%) and networks with over 100 members (23.0%) reported having an annual budget of more than $250,000.

The networks relied on multiple sources of funding, including in-kind resources, public and private grants, organization budget allocations, and members' service fees and membership dues.

Question 15: What are typical sources of funding for the network? *The networks reported being funded by a wide range of sources.* These sources included in-kind resources – volunteers, space, and materials (80.3%), grants or contracts from a private foundation (51.1%), public grants or contracts (49.0%), donations (23.9%), allocations from the budgets of member organizations (23.0%), service fees or reimbursements (10.0 %), or member dues (4.2%) (see Figure 4). Almost three-fourths of the networks (71.5%) received grants or contracts from both public and private sources; a smaller proportion of networks received only public grants or contracts (21.5%) or only private grants or contracts (24.0%).

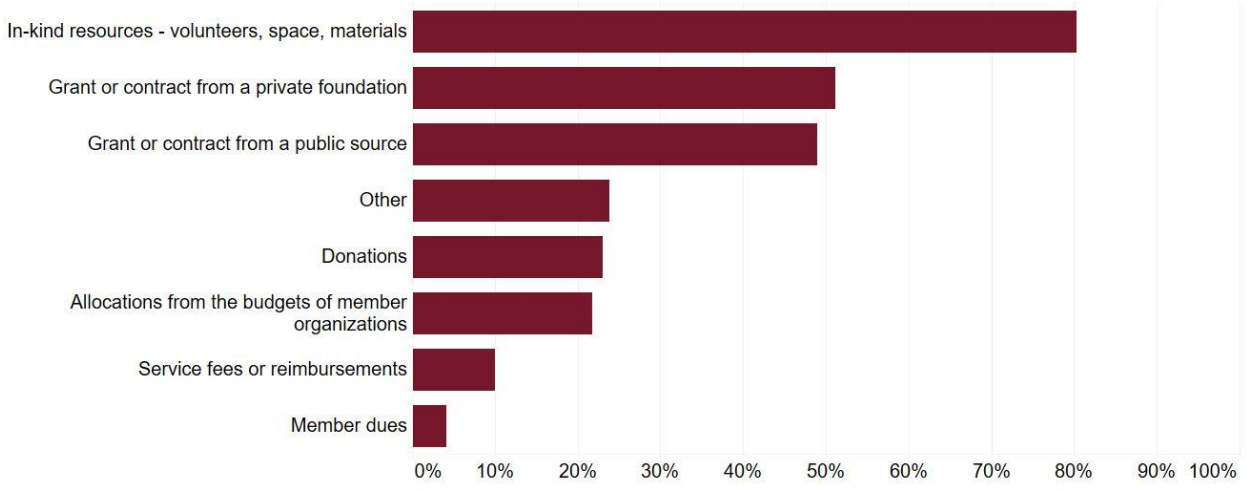
Network funding sources varied by networks' size, total budget, and the length of time they had been in existence. Compared to all networks, a greater proportion of small networks with up to 25 members received funding from in-kind resources (89.1%), donations (29.1%) or allocations from member organizations' budgets (29.1%). In contrast, a greater proportion of larger networks with 51 to 100 members and networks with over 100 members received funding from a wider range of sources, including donations (25.0% and 27.0%, respectively), private grants or contracts (52.1% and 67.6%), public grants or contracts (54.2 % and 54.1%), service fees or reimbursements (20.8% and 13.5%), and member dues (6.3% and 6.8%).

Compared to all networks, a greater proportion of networks with budgets up to $25,000 received funding from in-kind sources (84.9%) and private grants or contracts (54.7%). A greater proportion of networks with budgets of $100,001 to $200,000 received funding from private grants or contracts (59.1%), public grants or contracts (72.7%), and donations (31.8%). An even greater proportion of networks with budgets over $200,000 reported receiving funding from private grants or contracts (75.0%), public grants or contracts (75.0%), service fees or reimbursements (32.5%), and member dues (7.5%).

Compared to all networks, a greater proportion of networks that had been in existence for 5 to 8 years received funding from in-kind resources (81.4%), private grants or contracts (64.4%), public grants or contracts (49.2%), and member dues (5.1%). A greater proportion of networks that had been in existence for 9 years or more received funding from in-kind resources (80.0%), private grants or contracts (65.0%),

public grants or contracts (27.5%), budget allocations from member organizations (27.5%), and member dues (12.5%).

Figure 4: Types of Resources used by Networks



Network Staffing

Network staffing levels varied; almost half of all networks reported having no full-time or part-time staff.

Question 14: How many paid staff worked for the network? *Almost half of the 233 networks responding to this item (41.2%) reported having no full-time or part-time staff.* One in five networks (19.7%) reported having no full-time employees, but having one or more part-time staff. One in ten networks (10.3%) reported having a single full-time employee, but no part-time staff (see Table A-9).

Larger networks included networks with 2 full-time employees and one or more part-time staff (2.6%) and networks with two full-time employees and no part-time staff (5.2%). The largest networks reported having three or more full-time employees with part-time staff (9.0%) and networks with three or more full-time employees and no part-time staff (4.3%).

Network Leadership and Community Engagement

Almost all networks were governed by core leadership teams or other groups that coordinated network decisions and activities.

Question 17: Does the network have a core leadership team or group that coordinated network decisions and activities? Overall, almost all networks reported having a core leadership team or group that coordinated network decisions and activities (91.8%) (see Table A-12). This rate did not vary significantly by network age, budget, size, or geographic region.

The networks used multiple recruitment processes.

Question 20: How do organizations come to be involved in the work? Select all that apply. *Networks most frequently used informal recruitment processes through word-of-mouth (86.1%) and participant networking with colleagues (85.3%).* Networks also used more formal methods through trainings, workshops or presentations (83.6%) and targeted recruitment (69.3%). The third approach used by the networks focused on public media through public meeting announcements (46.7%) and social media messages (37.7%) (see Table A-15).

These patterns of member recruitment were consistent, with some exceptions. Community-level networks more frequently reported networking with colleagues (100.0%), and using more targeted recruitment (81.8%), more public meeting announcements (72.7%), and social media messages (54.6%), but making less use of trainings, workshops, or presentations (63.6%). Very young networks (under one year old) reported less use of several strategies, including word-of-mouth (70.0%), networking with colleagues (60.0%), and trainings, workshops, or presentations (60.0%).

Networks with budgets from $100,001 to $200,000 were more active than other networks in networking with colleagues (95.5%), and using trainings, workshops, or presentations (95.5%), targeted recruitment (81.8%), social media messages (68.2%), and public meeting announcements (59.1%).

Question 21: How do individuals who are not representing organizations come to be involved in the network? Please select all that apply. *Networks were more likely to attract new members that do not represent organizations through word-of-mouth (86.9%) and training, workshops, or presentations (72.6%).* They were less likely to use targeted recruitment (53.2%) or networking with professional colleagues (58.9%). Networks were also less likely to use public meeting announcements (46.8%) and social media messages (41.4%) to engage unaffiliated community members.

These patterns of community member recruitment were consistent, with some exceptions. Community networks more frequently reported networking with colleagues (81.8%), and using targeted recruitment (72.7%), public meeting announcements (72.7%), and social media messages (54.6%), but were making less use of trainings, workshops, or presentations (36.4%). Very young networks (under one year of age) reported less use of several strategies, such as word-of-mouth (70.6%), networking with colleagues (47.1%), and trainings, workshops, or presentations (58.8%).

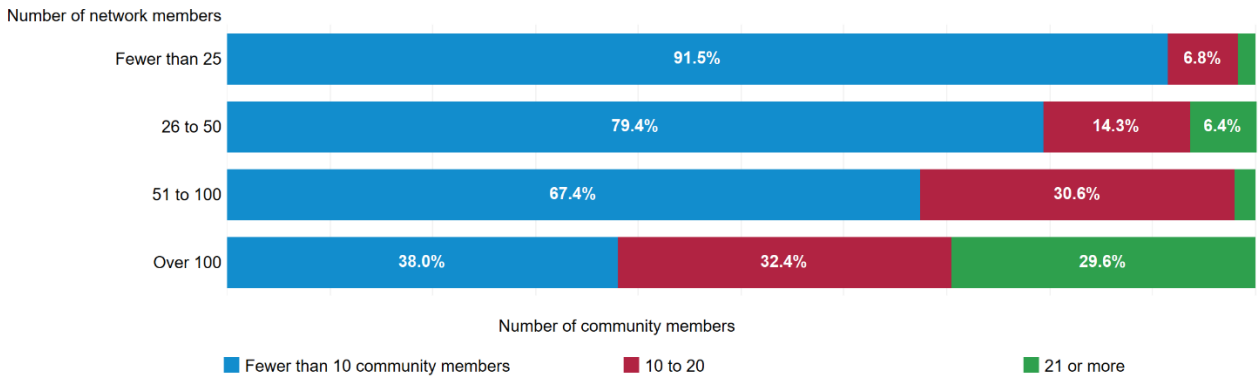
Networks with budgets from $100,001 to $200,000 were more active than other networks in using trainings, workshops, or presentations (81.0%), networking with colleagues (61.9%), targeted recruitment (61.9%), social media messages (61.9%), and public meeting announcements (57.1%) to recruit community members.

Among the 74 largest networks (with 100 or more members), those with the largest share of community members (21 or more) were more likely to use social media messages for recruitment (65%) than those with 10 to 20 community members (39.1%) or fewer than 10 community members (33.3%). Networks

with the largest share of community members also made relatively greater use of targeted recruitment (65% vs. 47.8% and 48.2%) and networking with colleagues (75% vs. 60.9% and 66.7%) than networks with fewer community members.

Question 12: Of NETWORK's participants, how many individuals are typically community members, not participating as professionals representing specific organizations? *Overall, over two-thirds of the networks (67.8%) reported that fewer than 10 of their meeting participants were community members not representing organizations (see Table A-8). A greater proportion of the smaller networks, younger networks, county networks, and networks with smaller budgets reported that fewer than 10 of their meeting participants were community members not representing organizations.* This included networks with memberships of fewer than 25 people (91.5%), networks with memberships of 26 to 50 people (79.4 %), networks less than one year old (76.2%), networks from 1 to 2 years of age (77.6%), networks from 3 to 4 years of age (70.3%), county networks (31.0%), networks with no budgets (84.0%), and networks with annual budgets up to $25,000 (75.5%) (see Figure 5).

Figure 5: Participation of Community Members by Network Size



Labels for proportions less than 5% are not shown.

Networks' Internal and External Communications

For internal communications, networks used primarily email messages and in-person meetings.

Question 18: How does the network communicate internally with network participants? *Overall, the use of email messages (97.5%) and in-person meetings (95.1%) for internal network communications was nearly universal, regardless of network age, size, budget, or geographic level.* Used only half as often, conference calls were the third most frequently reported form of internal communication across all types of networks (43.9%). For broadcasting messages to members, networks reported using online platforms such as Facebook (40.2%), ACEs (now PACEs) Connections groups (29.9 %), Twitter (9.8%), and Instagram (7.8%), as well as online newsletters (26.2%). Less used were paper mailings (4.9%) (see Table A-13).

Networks varied more in their use of less common modes of internal communication. For example, networks less than one year of age reported no use of paper mailings; county networks reported almost no use of paper mailings (0.9%). Regional and state networks reported greater use of Twitter (14.3% and 21.1% respectively). City networks reported less use of ACEs Connections groups (18.8%). Networks with up to 25 members also reported less use of Twitter (1.7%) and ACEs Connections groups (20.7%).

Networks with larger budgets reported greater use of online methods. Networks with budgets of $100.001 to $200,000 and networks with budgets over $200,000 reported much greater use of Facebook (63.6% and 60.0%, respectively), online newsletters (36.4% and 57.5%, respectively), Twitter (22.7% and 30.0%, respectively), and Instagram (13.6% and 20.0%, respectively).

Networks' efforts to recruit and engage community members netted a modest level of community engagement.

Question 19: How does the network communicate externally with others outside the network? *Overall, the networks made most of use of in-person presentations at community events (88.0%), organization-specific talks or trainings (72.3%), and conference presentations (65.3%) at roughly the same rates across almost all network ages, sizes, budgets, and geographic levels*. Note that these data were collected largely before COVID-19 restrictions were put in place.

Online, radio, and print forms of external communication were also used by the networks. These included: network websites (57.0%), Facebook (51.7%), ACEs Connection (40.9%), TV, radio, or newspapers (26.5%), online newsletters (24.0 %), online webinars (14.1%), Twitter (13.2%), and Instagram (10.3%).

Networks varied in their use of communication modes. For example, the youngest networks (under one year of age) reported less use of almost every external communication mode, including: community presentations (68.4%), organization-specific talks or presentations (57.9%), conference presentations (42.1%), and a network website (36.8%). They also reported no use of online webinars. In contrast, the oldest networks (9 or more years old) reported much more use of a network website (80.0%) and Facebook (60.0%).

Funding also seemed to affect networks' choice of communication methods. For example, networks with no budgets reported less use of a network website (33.8%), Facebook (39.2%), TV, radio, or newspapers (13.5%), and online newsletters (10.8%). In contrast, networks with budgets over $200,000 reported much more use of a network website (95.0%), Facebook (75.0%), TV, radio, or newspapers (42.5%), online newsletters (47.5%), Twitter (32.5%), and Instagram (25.0%).

State networks tended to communicate differently than networks at other geographic levels. State networks reported much more use of conference presentations (84.2%), online webinars (36.8%), online newsletters (39.5%), and Twitter (26.3%). Other communication differences stand out. For example, all eleven community networks reported using community presentations (100.0%), and regional networks reported more use of organization-specific talks or trainings (85.5%).

Use of Data

A majority of networks reported using data for learning and improvement and for network strategic planning.

Question 29: How has the network used data to support its efforts in the last 12 months? A majority of the networks reported using data for learning and improvement (74.3%) and network strategic planning (58.4%). Almost half of the networks also reported using data in the last year to work with communities to make sense of data (51.1%), monitor population-level ACEs and trauma trends (50.6%), disseminate data to external audiences (50.2%), and inform policy or systems change (49.8%) (see Table A-23). Less than two in ten networks reported using client-level data, monitoring client-level ACEs and trauma trends (18.9%) and monitoring client-level resilience and well-being trends (15.0%). One in ten networks reported not having used data at all in the last year (9.4%) (see Table A-23).

Networks that were less than one year old, reported less use of data in every area: learning and improvement (57.9%), strategic planning (52.6%), working with communities to make sense of data (26.3%), monitoring population-level ACEs and trauma trends (36.8%), disseminating data to external audiences (31.6%), and using data to information policy or system change (26.3%).

Network Member Services

Network Meetings

The networks' in-person meetings varied in frequency and membership attendance.

Question 8: How often does the network hold in-person meetings? *Overall, almost half of all networks (48.0%) reported holding in-person meetings on a monthly basis*. One in four networks reported holding in-person meetings two or more times per year. Fewer networks (22.6%) reported holding in-person meetings two or more times per month. Very few networks (4.0%) hosted in-person meetings just once a year (see Table A-4).[8]

This pattern was the same for networks of all ages, all sizes, and budgets of less than $100,000 per year. In contrast, networks with larger budgets most often reported holding in-person meetings two times or more per month (40.9%), followed by monthly meetings (27.3%).

The frequency of in-person meetings varied by geographic level. County, city, and regional networks reported holding monthly in-person meetings most frequently (with rates of 59.3%, 56.3%, and 44.4%

[8] Note: the data collection period for this survey ended on March 24, 2020, before nation-wide COVID-19 travel or meeting restrictions were imposed.

respectively). In contrast, a majority of community networks (63.6%) reported conducting in-person meetings two or more times per month.

Question 11: Of the network's participants, how many are actively engaged (for example, consistently attending regular network meetings)? *Overall, about half of the networks (46.3%) reported fewer than 25 people were regular attendees at their meetings (see Table A-7). A greater proportion of smaller networks, younger networks, local networks, and networks with smaller budgets reported they had fewer than 25 regular attendees*. This included almost all networks with a total membership of fewer than 25 people (96.7%), and networks with memberships from 26 to 50 people (66.7%), networks less than one year old (66.7%), networks from 1 to 2 years old (62.0%), county networks (56.3%), community networks (54.6%), networks with no budgets (64.0%), and networks with annual budgets less than $25,000 (60.4%).

Benefits to Network Members

Respondents were asked to report their perceptions of members' motivations to participate in the network and the impacts of members' participation.

Question 22: What motivates members to stay involved in the network? Please select all that apply. *Members stayed involved in their networks for professional and personal reasons*. They were motivated to learn about advances in ACEs, trauma-informed, or resiliency-related research and practice (85.6%), and to receive professional development and training (65.4%). They also stayed involved to facilitate personal growth (54.3%) and receive support to prevent or mitigate secondary trauma (49.0%) (see Figure 6).

Members were also motivated to share information about their activities (81.9%) and to get updates on others' activities (79.4%). They also stayed involved to collaborate with others on joint projects or activities beyond their organization's capacity to do so on its own (86.4%) and to advocate for ACEs, trauma-informed, or resiliency-related program, policy, or system reforms (78.2%) (see Table A-17).

These findings were consistent across networks, with some exceptions. For example, older networks (that had been existence for 9 years or more) reported higher rates in every area: learning about advances (92.5%), receiving professional development (80.0%), facilitating personal growth (70.0%), receiving support (65.0%), sharing information (90.0%), collaborating with others (90.0%), and advocating for change (87.5%). Networks with annual budgets of $100,001 to $200,000 also reported higher rates in many areas: learning about advances (100.0%), receiving professional development (95.5%), facilitating personal growth (72.7%), and sharing information with others (90.9%).

Question 23: From your viewpoint, to what extent has the network increased members' knowledge of ATR-related concepts, policies, programs, or practices? *Overall, the networks reported that their network had increased members' knowledge of ATR-related concepts, policies, programs, or practices to*

a "very great extent" (14.0%), a "great extent" (44.9%), or a "moderate extent" (31.2%) (see Table A-18). *The average or mean score across all networks was 3.6 on a scale of 1 – 5.*[9]

The ratings varied somewhat by type of network. For example, older networks that had been in existence for 5 to 8 years or 9 years or more had average ratings of 4.0 and 3.8, respectively. In contrast, the youngest networks (less than one year old) had an average rating of 3.0.

The ratings of the networks with no budgets were more evenly distributed; their networks had increased members' knowledge to a "very great extent" (14.7%), a "great extent" (36.0%), a "moderate extent" (32.0%), a "small extent" (16.0%), and "not at all" (1.3%). Their average rating was 3.5. In contrast, no community networks reported that they had increased their members' knowledge to "a very great extent." Their average rating to this question was 3.3.

Question 24: From your viewpoint, to what extent has the network increased network members' use of ATR-related concepts, programs, or practices at work? *Overall, the networks reported that their network had increased members' use of ATR-related concepts, programs, or practices at work to a "very great extent" (8.3%), a "great extent" (31.0%), or a "moderate extent" (44.6%) (see Table A-19).* The average rating across all networks was 3.3 on a scale of 1 – 5.

The ratings varied somewhat by type of network. For example, smallest networks (with up to 25 members) reported that none of their networks had increased members' use of ATR-related concepts, programs, and practices at work to a "very great extent." They were also less likely to report that members' use at work had increased to a "great extent" (17.5%) or a "moderate extent" (54.4%). Their average rating was 2.9.

The youngest networks (less than one year of age) and the networks with no budgets were also less likely to report that their networks had increased members' use at work to a "great extent" (25.0% and 27.0%, respectively) or a "moderate extent" (20.0% and 37.8%, respectively). Their average ratings to this question were 2.8 and 3.1, respectively.

Question 25: From your viewpoint, to what extent has the work increased network members' own use of ATR-related concepts in their personal lives? *Overall, the networks reported that their network had increased members' use of ATR-related concepts in their personal lives to a "very great extent" (8.9%), a "great extent" (32.3%), or a "moderate extent" (38.7%)* (see Table A-20). The average rating across all networks was 3.3 on a scale of 1 – 5.

The ratings varied somewhat by type of network. Compared to all networks, the youngest networks (less than one year of age) and networks with no budgets were less likely to report that their networks had increased members' use to a "very great extent" (10.5% and 9.7% respectively), a "great extent" (10.5%

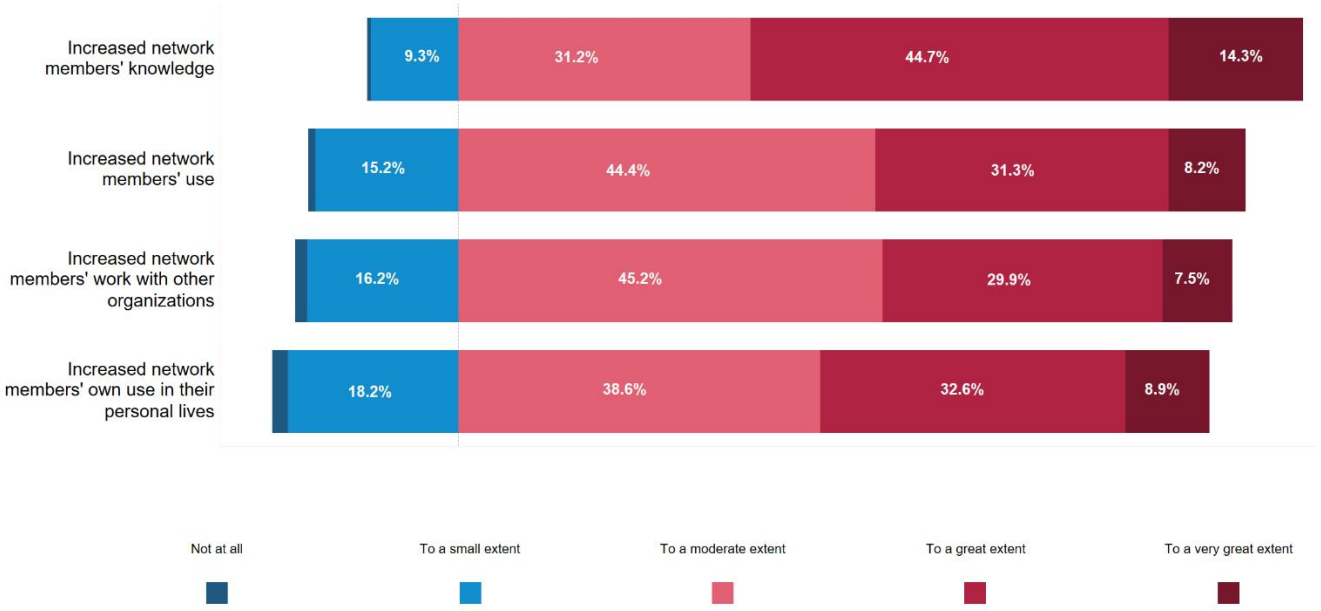
[9] Mean scores range from 1 to 5. 1 = Not at all. 2 = to a small extent. 3 = to a moderate extent. 4 = to a great extent. 5 = to a very great extent.

and 23.6%), or a "moderate extent" (26.3% and 34.7%). Their average ratings to this question were 2.7 and 3.1.

Question 26: From your viewpoint, to what extent has the network increased members' work with other organizations on ATR-related concepts, policies, programs, or practices? *Overall, the networks reported that their network had increased members' work with other organizations on ATR-related concepts, policies, programs, or practices to a "very great extent" (7.5%), a "great extent" (29.9%), a "moderate extent" (45.2%), or a "small extent" (16.2%)* (see Table A-21). The mean score across all networks was 3.3 on a scale of 1 – 5.

These ratings varied somewhat by type of network. Compared to all networks, the youngest networks (less than one year of age) and the smallest networks (with up to 25 members) reported that their networks had increased members' work with other organizations to a "very great extent" (5.3% and 3.5% respectively), a "great extent" (21.1% and 17.5 % respectively) or a "moderate extent" (26.3% and 50.9% respectively). Their average ratings to this question were 2.8 and 3.0 respectively.

Figure 6: Network Members' Benefits



Each network was represented by one respondent who answered on behalf of the network's membership.
Labels for proportions less than 5% are not shown.

Network Goals

In the survey, the networks were asked the following question, "What are the network's top three ACEs, trauma-informed, and resilience-related goals?" This was an open-ended question with no response options offered (see Table A-24). The survey team used thematic analyses to code the networks' hundreds of responses into four categories encompassing 10 goal themes: (1) network capacity building (network capacity); (2) strategic objectives (network activities, foundational ATR awareness, and member organization change); (3) cross-sector change (change across organizations and sectors, policy advocacy and systems change, and community capacity building); and (4) long-term outcomes and impacts (outcomes for children, outcomes for families, and population-level impacts) (see Table A-25).

Across the ten identified network goal themes, almost half of all networks (47.3%) identified network activities goals. The other two most frequently identified goals were goals concerning foundational ATR awareness (40.6%), and change across organizations and sectors (32.6%) Their responses are summarized below.

Network Capacity Building

The networks identified specific capacity building tasks as goals. These were related to developing and sustaining their networks.

Network capacity. *Over a quarter of the networks (25.0%) focused on developing and sustaining their network's capacity to carry out their work.* They identified several areas for improvement including building and supporting their network's membership, expanding their networks to include greater representation from more sectors and locations, improving network leadership, staffing and "backbone" infrastructure, and securing enough funding to sustain and scale up their network operations.

> One network summarized this up as, "Developing an infrastructure for promotion of protective factors to build resilience and well-being."

Strategic Objectives

The networks identified strategic objectives related to specific network activities, creating foundational ATR awareness, and supporting member organization change.

Network Activities. *Nearly half of the networks (47.3%) identified specific activities as network goals.* Important activities included convening major events to support network goals; providing education, training, and professional development opportunities on ATR topics; creating online platforms for members to share information; and developing and sharing other ATR resources.

> One network offered, "Coordinate a gathering or event (i.e. policymaker education, policy forum, etc.) to bring policymakers, advocates, and those who are most impacted together to learn more

about child adversity, cultivate relationships, and strengthen connections between those proposing policy changes with professional and lived expertise."

Foundational ATR awareness. *Less than half of the networks (40.6%) identified different types of ATR awareness as network priorities*. These included increasing local awareness of ACEs and their impacts, developing a common language and shared messages on ATR topics, and increasing the network's engagement with local leaders, parents, youth, and others with lived experience.

One network noted, "Ensure that all county initiative participants, including lawmakers (mayors and city council members, county commissioners, school board members, and state lawmakers) and stakeholders understand the costs of an epidemic of childhood trauma, the data-driven prevention of ACEs and trauma, and the promotion of family and community resilience."

Member organization change. *A quarter of the networks (25.0%) wanted to make changes in their members' organizations*. These included developing an ATR-informed and qualified workforce; implementing evidence-based ATR program models and frameworks with demonstrated fidelity and effectiveness; improving staff self-care, reducing their stress; and helping them to adopt more ATR-informed attitudes, behaviors and habits at home and work.

One network responded, "Develop trauma-informed standards of practice for [the] County DHS."

Cross-Sector Change

The networks identified cross-sector change goals, including supporting change across organizations and sectors, policy advocacy and systems change, and community capacity building.

Change across organizations and sectors. *Over a third of the networks (32.6%) identified goals for coordinating action across local organizations and service sectors*. Their responses addressed creating an ATR-based coordinated continuum of care for prevention, early intervention, and treatment services, cross-sector collaborative partnerships for collective impact, and increasing growth and connections among local, state, and national networks of champions and leadership groups.

One network reported, "Strengthen a cross-systems city-wide trauma and resiliency approach to promote healing and well-being in communities impacted by persistent trauma."

Policy advocacy and systems change. *Fewer networks (16.1%) identified advocating for policy and systems change*. Their goals included policy and systems change to increase community access, availability, and affordability of ATR programs and best practices, and legislative and structural changes to eliminate silos and reduce duplication in ATR services.

One network responded, "Advocate for our campaign for a trauma-informed state with a unified policy agenda and legislative advocacy events."

Community capacity building. *Relatively few networks (15.2%) set goals related to community capacity building.* These included community development and organizing to support neighborhood healing, trust, and healthy relationships; increasing social connections and social support for families; reducing their isolation; and strengthening communities to have increased capacity for self-healing and resilience.

> One network answered, "Build trust and healthy relationships as a foundation for resilience."

Long-Term Outcomes and Impacts

The networks identified improving outcomes for children, families, and population-level impacts as long-term goals.

Outcomes for children. Some networks (6.3%) outlined *specific outcomes for children*. These outcomes included a safe and nurturing environment with positive relationships, experiences, and other protective factors; kindergarten readiness and school success; and increased child self-regulation and resilience in school, at home, and in other settings.

> One network replied, "Children and their caregivers experiencing one or more ACEs will decrease their risk factors and increase protective factors."

Outcomes for families. Some networks (10.3%) identified *specific outcomes for families*. These outcomes included family participation in two-generational programs and approaches; enhanced family ATR knowledge, core capacities, and skills; increased parent and caregiver self-regulation and resilience; and strengthened housing and other economic supports for families.

> One network reported, "By 2027, every family in our counties will have the knowledge, skills, and supports so that 100% of our children enter kindergarten ready to learn."

Population-level impacts. One in five networks (21.4%) listed *population-level goals*. They focused on the overall health and well-being of children and families; the intergenerational transmission of ACEs; the population's mental, behavioral, and social-emotional health; and individual and community-level resilience.

> Several networks identified specific measures of population-level change such as, "Increase resilience as measured by the Child and Youth Resilience Measure and the Adult Resilience Measure," "By 2024, all counties in the region will rank within the top two quartiles for health behaviors," and "By 2040, [our communities]will have the lowest child trauma indicators in the State of California."

Goal-related activities. Networks were asked about the activities they engaged in to achieve their goals. ***Question 28: What types of activities has the network engaged in to achieve its goals?*** *Overall, the great majority of networks reported that they had provided training and education (95.0%) and had shared their knowledge and experience with other networks (85.7%).* Over half of the networks had also

coordinated cross-sector system change efforts (67.7%), expanded existing programs or practices (58.8%), coordinated external media messages (51.3%), and amplified voices of persons with lived experience (50.0%). Less than half of the networks (43.7%) reported having implemented culturally responsive programs or practices or having coordinated legislative policy advocacy efforts (33.6%) (see Table A-22).

Technical Assistance Needs

In the survey, the networks were also asked the following question, "What are the network's top three needs for technical assistance to help it meet its goals?" This was an open-ended question with no response options offered (see Table A-26). The survey team used thematic analyses to code the networks' hundreds of responses into three categories encompassing eight themes: (1) capacity-building needs (infrastructure support, effective leadership, and communications); (2) strategic objectives needs (data needs, training and professional development, and network engagement with local partners); and (3) cross-sector change needs (collaboration and alignment, and policy, systems, and community advocacy) (see Table A-27).

Across the eight themes of identified technical assistance needs, almost half of the networks (49.0%) requested assistance with infrastructure support. The other two most frequently identified needs were assistance with data needs (40.1%), and communications (38.0%). The networks' responses are summarized below.

Capacity Building Needs

The networks identified specific technical assistance needs related to developing and sustaining their networks.

Infrastructure support. Nearly half of the networks (49.0%) reported a need for technical assistance to develop a *more sustainable infrastructure* to support their network's activities. This included technical assistance to help find funding sources, structures, streams, and multi-year operational grants for dedicated staff support to maintain network momentum. This also included grant writers for cross-sector proposals and philanthropic investment, as well as development staff to create sustainable fundraising strategies. They also requested assistance on how to maximize available resources, including coordinating funding from multiple sources.

Effective leadership. Nearly a third of the networks (28.7%) identified technical assistance needs in the area of *network leadership, governance, and management*. Among the topics identified were strategic planning, network leadership, member recruitment, and how to move from planning to action. Networks requested help with how to develop a community vision, strategic goals, and measures; how to integrate racial equity into network plans and priorities; how to manage volunteer workgroups; how to move

beyond network education and training; and taking effective action to change programs, policies, practices, and systems.

Communications. Slightly fewer networks (38.0%) requested *communications* technical assistance. Most requests were for assistance with websites or other online platforms, marketing and communications, and social media and other messaging. Networks needed technical and financial assistance for the creation and management of websites and other online platforms. They also needed help with marketing and communications, including branding, graphic design, and narratives about the network's value and impact. The third area was in the framing and crafting of clear, culturally competent messages for internal and external audiences, including online newsletters and social media.

Strategic Objectives Needs

The networks requested assistance with specific strategic objectives related to training to develop foundational ATR knowledge and awareness and to engage specific sectors in ATR practices.

Data needs. Less than half of the networks (40.1%) requested technical assistance to support a range of *data needs*. These requests included the coordination and streamlining of the data collection and reporting of local and regional data related to ACEs, resilience, trauma, and data at individual and population levels. Other requests were for the development of surveys and other metrics of community awareness and other outcomes and impacts of network activities, including the network's return on investments of specific stakeholders. Other TA requests focused on developing frameworks for ATR metrics, identifying what to measure to track ongoing network progress, and results.

Training and professional development. A third of the networks (30.2%) requested help with training logistics and content. Specifically, they requested help with how to manage training requests and logistics in terms of how to organize free or inexpensive structured workshops, event planning, train-the-trainer processes, and coaching training. In terms of planning, they wanted guidance on how to increase access to experts for ATR professional development, how to scale ATR technical skills across a geographic region, how to provide continuously updated ATR resources and information, and how to turn a single network into a larger social movement. Topics of interest were: trauma-informed care, facilitation skills, positive messaging, ATR best practices for K-12 education, and equity and ACEs.

Network engagement with local partners. Some networks (15.6%) requested technical assistance in three areas: how to engage communities in policy change, how to engage mental health and primary care providers (especially front-line health workers) in practice change, and how to engage more community partners from businesses and other sectors in collective impact projects. Networks want to learn how best to navigate engagement of community members using community organizing best practices. They want to know how best to leverage Medicaid billing strategies to integrate ATR practices into health care, mental health, and behavioral health settings. Finally, they want to know how to engage more local media, foundations, and businesses in ATR-related community change efforts.

Cross-Sector Change Needs

The networks identified need for assistance with developing the leadership, collaboration, and policy advocacy skills needed to achieve their cross-sector change goals.

Collaboration and alignment. Some networks (9.9%) identified technical assistance needs in *collaborating and aligning efforts* with other networks to scale up their impact, and disseminating information to potential allies and audiences. Networks are interested in finding more opportunities to exchange best practices and learn from other ATR networks, especially networks in urban areas. They want to strengthen communications and dialogue with other ATR partners, especially those who are farther along on the journey. Networks are also interested in collaborating outside of their own silos by coordinating with state trauma-informed networks and national ATR initiatives.

Policy, systems, and community advocacy. Some networks (16.7%) identified technical assistance needs in *policy, systems, and community advocacy*, including ATR policy development, engaging elected leaders and government policymakers on ATR issues, and increasing awareness and buy-in on policy issues. Networks wanted to know how to inform and influence policy at state and local levels, how to develop policy advocacy training, and to learn more about the states' models for incorporating ATR concepts into state policy.

They also wanted to know how to provide more in-depth ATR training to elected leaders and government policymakers, how to implement culturally appropriate strategies for changing legislation, and how to make service systems more ATR-informed. Finally, networks wanted to know how to increase public awareness and support for network goals, how to build or expand the base of support for ATR policies among families and the general public, how to mount positive social norms campaigns and other evidence-based interventions to shift mindsets and perceptions on ATR issues, and how to support ATR-related culture change, especially the link between racism and trauma.

Alignment of Network Goals and Technical Assistance Needs

Networks identified three specific technical assistance needs to achieve their goals. An additional analysis was conducted regarding the overlay and alignment of ATR network goals and technical assistance needs. The analysis examined the connections or associations between the ten themes of goals (Table A-25, Column 2) and the eight themes of technical assistance needs (Table A-27, Column 2). Each network could report up to three goals and up to three technical assistance needs. If a network reported three distinct goals and three distinct technical assistance needs, the analysis would associate the three reported technical assistance needs with each of the network's reported goals. In total, the analysis identified 1078 associations or connected pairs of reported goals and reported technical assistance needs (Tables A-28 and A-29).

The purpose of the analysis was to capture the specific technical assistance needs associated or connected with each goal reported by a network. The results of this analysis are presented in a table (Figure 7) and in

a chart (Figure 8). An interactive analysis of the overlay and alignment of ATR network goals and technical assistance needs is also available on the MARC website, MARC.HealthFederation.org.

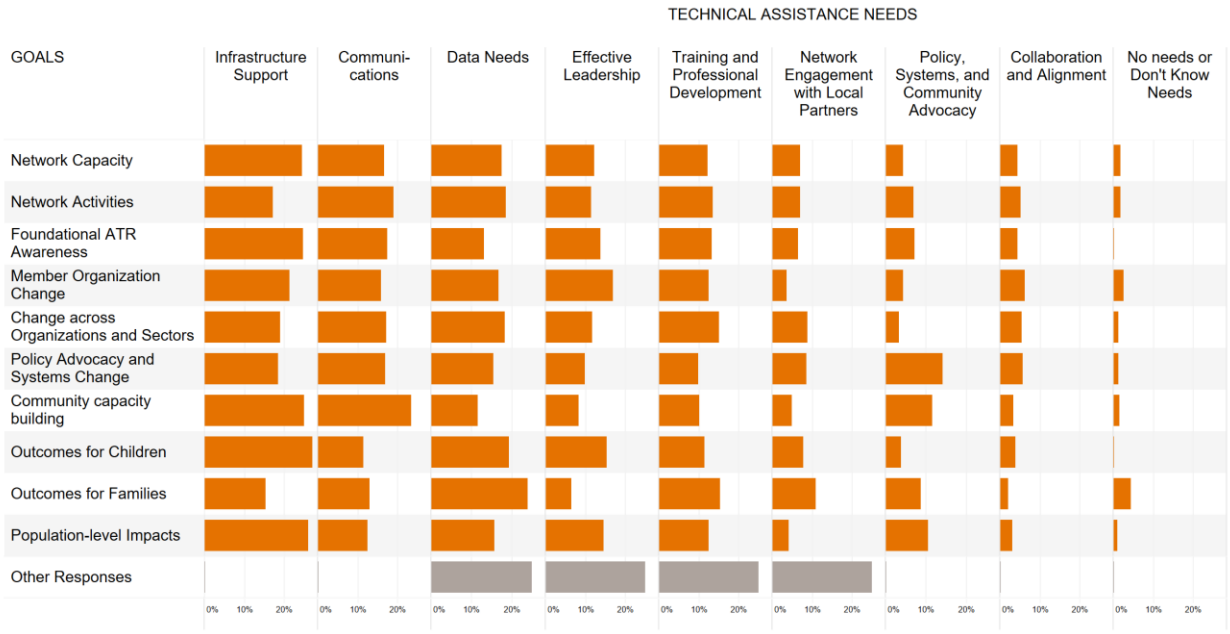
In Figure 7, the eight goal themes are listed in the far left column of the table. The columns to the right list the top three technical assistance needs identified for each reported goal. For example, the three top technical assistance needs most frequently identified by the networks striving to achieve the goal of *change across organizations and sectors* was help with 1) *infrastructure, 2) data, and 3) communications*.

Figure 7: Top Three Technical Assistance Priorities for Each Reported Goal

GOALS	TECHNICAL ASSISTANCE NEEDS		
	PRIORITY 1	PRIORITY 2	PRIORITY 3
Network Capacity	Infrastructure Support	Data Needs*	Communications*
Network Activities	Infrastructure Support	Data Needs	Communications
Foundational ATR Awareness	Infrastructure Support	Communications	Effective Leadership
Member Organization Change	Infrastructure Support	Effective Leadership*	Data Needs*
Change across Organizations and Sectors	Infrastructure Support	Data Needs	Communications
Policy Advocacy and Systems Change	Infrastructure Support	Communications	Data Needs
Community Capacity Building	Infrastructure Support	Communications	Policy, Systems, and Community Advocacy
Outcomes for Children	Infrastructure Support	Data Needs	Effective Leadership
Outcomes for Families	Data Needs	Training and Professional Development*	Infrastructure Support*
Population-level Impacts	Infrastructure Support	Data Needs	Effective Leadership
Other Responses	Training and Professional Development	Network Engagement with Local Partners	Effective Leadership

Figure 8 presents the magnitude of the connections between each goal theme and its associated technical assistance needs. For example, 217 (20.1%) of the total 1,078 connections between goals and technical assistance needs are associated with the *network activities* goal (Table A-28). Figure 8 shows that within this 20.1% of connections, the top three technical assistance needs reported were *infrastructure support* (19%), *data needs* (18%), and *communications* (17%).

Figure 8: Distribution of Technical Assistance Needs Connections to Reported Goals



Limitations

The survey has some limitations. First, the survey may not have captured some networks that were under development when the survey sample was being created. Because no complete list of ATR networks exists, multiple strategies were used to try to find and identify potential networks, including asking survey participants to name additional networks. Still, some existing networks may have eluded detection and inclusion in the survey. Second, to manage and minimize the burden of data collection on the survey participants, not all potential topics and questions were included in the final survey instrument. Finally, the survey findings included in this report are extensive, but not exhaustive. HFP will publish more findings about the networks' accomplishments and other analyses in the future.

Conclusion

This survey was undertaken in the spirit of spotlighting the power—both realized and potential—of ATR networks around the country. The findings reported here represent just one of many steps in the process. The Health Federation of Philadelphia (HFP) will continue to share lessons grounded in survey data, including those based off of additional analysis of key accomplishments reported by participating ATR networks.

Going forward, HFP intends to use these findings to benefit ATR networks by fostering peer connection and innovation exchange, crafting technical assistance offerings, and making the case for sustained financial investment.

We hope that others will join us in our support of ATR networks so they can continue to lift up community-generated solutions, develop leadership, and transform practices, systems, and policies. These collective efforts to prevent ACEs and promote healing are critical for our children's future.

Together, we move towards a more just, healthy and resilient world.

Health Federation of Philadelphia

Appendix: MARC ATR Survey Tables

The tables below present frequencies and relative frequencies of responses to survey items.

Section 1: Network Characteristic Tables

Table A-1

Does this network currently focus on the following topics? Please select all that apply.	%	n
Addressing adverse childhood experiences	98.4	247
Building resilience at individual and/or community levels	98.0	246
Using a trauma-informed lens	96.8	243

Table A-2

What geographic area does the NETWORK encompass?	%	n
County	45.4	114
Region	25.5	64
State	15.9	40
City	6.4	16
Community	4.4	11
Tribal Nation	2.4	6
Total	100	251

Table A-3

To your knowledge, how long has the NETWORK been in existence?	%	n
Less than six months	2.4	6
Six months to less than twelve months	6.4	16
1 to 2 years	20.1	50
3 to 4 years	30.9	77
5 to 6 years	16.1	40
7 to 8 years	8.0	20
9 years or more	16.1	40
Total	100	249

Table A-4

How often does NETWORK hold in-person meetings?	%	n
2 or more times per month	22.6	56
Monthly	48.0	119
2 or more times per year	25.4	63
Once a year (annually) or less frequently	4.0	10
Total	100	248

Table A-5

What sectors are represented by your NETWORK? – Select all that apply.	%	n
Education/Youth:	**98.4**	**244**
Youth Services	88.7	220
Education - K-12	88.3	219
Early Childhood Education and Care	85.5	212
Higher Education	55.7	138
Health:	**97.6**	**242**
Mental Health/Behavioral Health	94.8	235
Public Health	82.7	205
Health Care/Medical Care	77.8	193
Substance Use Disorder	71.0	176
Justice/Military:	**73.4**	**182**
Juvenile Justice	56.9	141
Criminal Justice/Courts	48.0	119
Law Enforcement	39.9	99
First Responder	19.4	48
Military/Armed Services	10.9	27
Social Services/Basic Needs:	**93.2**	**231**
Social Services	88.7	220
Child Protection/Child Welfare	82.7	205
Domestic Violence/Sexual Assault	71.0	176
Housing and Homelessness Services	56.5	140
Disabilities	39.9	99
Adult and Aging	32.3	80

What sectors are represented by your NETWORK? – Select all that apply.	%	n
Public Policy:	**79.4**	**197**
Government	57.3	142
Policy Advocacy	54.8	136
Civic Engagement	48.0	119
Other Sectors and Groups:	**92.3**	**229**
Community members	77.0	191
Persons with lived experience	66.9	166
Faith-based	57.7	143
Philanthropy	37.5	93
Business	36.7	91
Tribal Health/Services	25.0	62
Media	20.6	51
Cultural Arts	18.6	46
Environment	14.1	35
Other	12.1	30

Table A-6

What is the current size of NETWORK, including individuals and organizational representatives?	%	n
Fewer than 25 people	24.6	61
26 to 50	25.4	63
51 to 75	13.3	33
76 to 100	6.9	17
101 to 125	6.1	15
Over 125	23.8	59
Total	100	248

Table A-7

Of NETWORK's participants, how many are actively engaged (for example, consistently attend regular network meetings)?	%	n
Fewer than 25 people	46.3	114
26 to 50	29.7	73
51 to 75	11.4	28

Of NETWORK's participants, how many are actively engaged (for example, consistently attend regular network meetings)?	%	n
76 to 100	3.7	9
101 to 125	2.0	5
Over 125	6.9	17
Total	100	246

Table A-8

Of NETWORK's participants, how many individuals are typically community members, not participating as professionals representing specific organizations?	%	n
Fewer than 10 people	67.8	164
10 to 20	21.1	51
21 to 30	5.4	13
31 to 40	2.5	6
Over 40	3.3	8
Total	100	242

Section 2: Network Infrastructure Tables

Table A-9

Full- and Part-Time Staff	%	n
No FT Staff, No PT Staff	41.2	96
No FT Staff, One or more PT Staff	19.7	46
One FT Staff , No PT Staff	10.3	24
Three or more FT Staff, One or more PT Staff	9.0	21
One FT Staff, One or more PT Staff	7.7	18
Two FT Staff, No PT Staff	5.2	12
Three or more FT Staff, No PT Staff	4.3	10
Two FT Staff, One or more PT Staff	2.6	6
Total	100	233

Table A-10

What are typical sources of funding for the NETWORK?	%	n
In-kind resources - volunteers, space, materials	80.3	192
Grant or contract from a private foundation	51.1	122
Grant or contract from a public source	49.0	117
Donations	23.9	57
Allocations from the budgets of member organizations	23.0	55
Other	21.8	52
Service fees or reimbursements	10.0	24
Member dues	4.2	10

Table A-11

What is the NETWORK's typical annual budget?	%	n
No budget	31.0	76
$1 to $25,000	21.6	53
$25,001 to $50,000	9.0	22
$50,001 to $100,000	6.1	15
$100,001 to $150,000	5.3	13
$150,001 to $200,000	3.7	9
$200,001 to $250,000	2.9	7
Over $250,000	13.5	33
Don't know	6.9	17
Total	100	245

Table A-12

Does the NETWORK have a core leadership team or group that coordinates network decisions and activities?	%	n
Yes	91.8	224
No	8.2	20
Total	100	244

Table A-13

How does the NETWORK communicate internally with network participants?	%	n
Email messages	97.5	238
In-person meetings	95.1	232
Conference calls	43.9	107
Facebook	40.2	98
ACEs Connection Group	29.9	73
Online newsletters	26.2	64
Twitter	9.8	24
Other	8.6	21
Instagram	7.8	19
Paper mailings	4.9	12
Online instant messaging platform (for example: Slack, Discord)	1.2	3

Table A-14

How does the NETWORK communicate externally with others outside the network?	%	n
Presentations at community events	88.0	213
Organization-specific talks or trainings	72.3	175
Conference presentations	65.3	158
NETWORK Website	57.0	138
Facebook	51.7	125
ACEs Connection	40.9	99
TV, radio, or newspapers	26.5	64
Online newsletters	24.0	58
Other	15.3	37
Online webinars	14.1	34
Twitter	13.2	32
Instagram	10.3	25

Section 3: Member Services Tables

Table A-15

How do organizations come to be involved in the NETWORK? Please select all that apply.	%	n
Word-of-mouth	86.1	210
Participant networking with colleagues	85.3	208
Trainings, workshops, or presentations	83.6	204
Targeted recruitment	69.3	169
Public meeting announcements	46.7	114
Social media messages	37.7	92
Other strategies	11.1	27

Table A-16

How do individuals who are not representing organizations come to be involved in the NETWORK? Please select all that apply.	%	n
Word-of-mouth	86.9	205
Trainings, workshops, or presentations	72.5	171
Participant networking with colleagues	60.2	142
Targeted recruitment	53.4	126
Public meeting announcements	46.6	110
Social media messages	41.1	97
Other strategies	12.7	30

Table A-17

What motivates members to stay involved in the NETWORK? Please select all that apply.	%	n
Collaborating with others on joint projects or activities beyond their organization's capacity to do on its own	86.4	210
Learning about advances in ACEs, trauma-informed, or resiliency-related research and practice	85.6	208
Sharing information about their activities	81.9	199
Getting updates on others' activities	79.4	193
Advocating for ACEs, trauma-informed, or resiliency-related program, policy, or system reforms	78.2	190
Receiving professional development and training	65.4	159

What motivates members to stay involved in the NETWORK? Please select all that apply.	%	n
Facilitating personal growth	54.3	132
Receiving support to prevent or mitigate secondary trauma	49.0	119
Other	15.6	38

Table A-18

From your viewpoint, to what extent has the NETWORK increased network members' knowledge of ATR-related concepts, policies, programs, or practices?	%	n
To a very great extent	14.0	34
To a great extent	44.9	109
To a moderate extent	31.2	76
To a small extent	9.5	23
Not at all	0.4	1
Total	100	243

Table A-19

From your viewpoint, to what extent has the NETWORK increased network members' use of ATR-related concepts, policies, programs, or practices at work?	%	n
To a very great extent	8.3	20
To a great extent	31.0	75
To a moderate extent	44.6	108
To a small extent	15.3	37
Not at all	0.8	2
Total	100	242

Table A-20

From your viewpoint, to what extent has the NETWORK increased network members' own use of ATR-related concepts in their personal lives?	%	n
To a very great extent	8.9	21
To a great extent	32.3	76
To a moderate extent	38.7	91

From your viewpoint, to what extent has the NETWORK increased network members' own use of ATR-related concepts in their personal lives?	%	n
To a small extent	18.3	43
Not at all	1.7	4
Total	100	235

Table A-21

From your viewpoint, to what extent has the NETWORK increased network members' work with other organizations on ATR-related concepts, policies, programs, or practices?	%	n
To a very great extent	7.5	18
To a great extent	29.6	71
To a moderate extent	45.4	109
To a small extent	16.3	39
Not at all	1.3	3
Total	100	240

Table A-22

What types of activities has the NETWORK engaged in to achieve its goals? Please select all that apply.	%	n
Provided training and education	95.0	226
Shared knowledge and experiences with other networks	85.7	204
Coordinated cross-sector system change efforts	67.7	161
Applied for grants or contracts	61.3	146
Expanded existing programs or practices	58.8	140
Coordinated external media messages	51.3	122
Developed new programs or practices	51.3	122
Amplified voice of persons with lived experience	50.0	119
Implemented culturally responsive programs or practices	43.7	104
Coordinated legislative policy advocacy efforts	33.6	80
Other activities	21.0	50

Table A-23

How has NETWORK used data to support its efforts in the last 12 months?	%	n
Use data for learning and improvement	74.3	173
Use data in network strategic planning	58.4	136
Work with communities to make sense of data	51.1	119
Monitor population-level ACEs and trauma trends	50.6	118
Disseminate data to external audiences	50.2	117
Use data to inform policy or system change	49.8	116
Monitor population-level resilience and well-being trends	35.2	82
Monitor program client-level ACEs and trauma trends	18.9	44
Monitor program client-level resilience and well-being trends	15.0	35
Does not monitor or use data	9.4	22

Section 4: Network Goals Tables

Table A-24

Goals Reported	% of Networks*	n
Network Activities	47.3	106
Foundational ATR Awareness	40.6	91
Change across Organizations and Sectors	32.6	73
Network Capacity	25.0	56
Member Organization Change	25.0	56
Population-level Impacts	21.4	48
Policy Advocacy and Systems Change	16.1	36
Community Capacity Building	15.2	34
Outcomes for Families	10.3	23
Outcomes for Children	6.3	14
Other Responses	1.3	3
Total	* Respondents could select up to three goals, so percentages will not sum to 100.	224

Table A-25

Goals – Qualitative Themes		
Primary Themes	**Secondary Themes (see Table A-24)**	**Tertiary Themes**
Network Capacity Building	Network Capacity	Refine and align network goals and strategic plans
		Secure funding to sustain and scale network operations
		Support network leadership, staffing, and backbone infrastructure
		Building and supporting network membership
		Expanding Network to more sectors and locations
		Refine and align network goals and strategic plans
		Secure funding to sustain and scale network operations
Strategic Objectives	Network Activities	Convene network events and facilitate network meetings and processes
		Create online space for peer learning exchanges
		Provide education, training, and professional development on ATR topics
		Create and share ARC resources and toolkits
		Conduct communications/marketing campaigns and activities
		Use research/data/evaluation-informed decision making
	Foundational ATR Awareness	Increase awareness of ACEs and its impacts
		Use common ATR language and shared messages
		Increase ATR knowledge across sectors and groups
		Increase network's community engagement with leaders, parents, youth, and others with lived experience
	Member Organizational Change	ATR-informed and competent workforce
		ATR-informed standards of practice, programs, policies, and service delivery
		Implementation and institutionalization of evidence-based ATR models and frameworks with demonstrated fidelity and effectiveness
		Improved staff self-care, reduced stress, and new ATR-based attitudes, behaviors, and habits at home and work
Cross-Sector Change	Change across Organizations and Sectors	ATR-based coordinated continuum of care for prevention, early intervention, and treatment systems and services
		ATR research integrated into multiple sectors - healthcare, mental health, early childhood, education, juvenile justice, and family services

Goals – Qualitative Themes		
		Universal screening for ATR, linked to evidence-based programs and practices
		Cross-sector and cross-system collaborative partnerships for collective impact
		Connections and growth of state, regional, and national networks of champions and leadership groups
	Policy Advocacy and Systems Change	Policy and systems change to increase access, availability, and affordability of ATR best practices and programs
		Legislative and administrative policy advocacy and outreach
		ATR strategic and structural change to eliminate silos and reduce duplication
		Communities become more ATR/trauma-informed
	Community Capacity Building	Community development and organizing to support neighborhood healing, trust, and healthy relationships
		Increased social connections and support among families, reducing social isolation
		Strengthened communities with increased capacity for self-healing and resilience
Long-term Outcomes and Impacts	Outcomes for Children	Safe and nurturing environments with positive relationships, experiences, and other protective factors
		Increased child self-regulation and resilience in school, at home, and other settings
		Children are ready for kindergarten and for school success
	Outcomes for Families	Enhanced family ATR knowledge, core capacities, and skills
		Strengthened economic, housing, and other supports for families
		Increased parent and caregiver self-regulation and resilience
		Family participation in 2-gen programs and approaches
	Population Impacts	Overall health and well-being for children and families
		Prevention, mitigation, and reduction of ACEs, child abuse, and neglect
		Intergenerational transmission of ACEs
		Mental health, behavioral health, social emotional health
		Positive outcomes for youth
		Individual- and community-level resilience
		Community environmental conditions, and social and economic determinants of health
		Intersection of racial/ethnic health equity and culturally responsive ATR efforts

Section 5: Network Technical Assistance Needs Tables

Table A-26

Technical Assistance Needs Reported	% of Networks*	n
Infrastructure Support	49.0	94
Data Needs	40.1	77
Communications	38.0	73
Training and Professional Development	30.2	58
Effective Leadership	28.7	55
Policy, Systems, and Community Advocacy	16.7	32
Network Engagement with Local Partners	15.6	30
Collaboration and Alignment	9.9	19
No needs or Don't Know Needs	3.1	6
Total	* Respondents could select up to three goals, so percentages will not sum to 100.	192

Table A-27

Technical Assistance Needs – Qualitative Themes		
Primary Themes	**Secondary Themes (see Table A-26)**	**Tertiary Themes**
Capacity Building Needs	Infrastructure Support	Funding: grants, resources, funding streams
		Paid staff: funding, support, retention
		Sustaining and scaling network efforts
		Organizational structure, management, and support
		Time to do the work
		Informational Technology (IT) support
		Grant writing and writers
		Equipment
		Accounting help
		Human resources (HR) issues
	Effective Leadership	Network leadership, engagement, and development
		Steering Committee/Governance guidance
		Strategic planning and goal setting
		Moving from planning to action/implementation
		Stakeholder and volunteer recruitment and support

Technical Assistance Needs – Qualitative Themes		
		leadership – recruitment and support
		Getting network buy-in and commitment to network goals
	Communications	Social media
		Messaging development
		Online platforms/technology for discussion, learning
		Graphic design for marketing and branding
		Website development and support
		Marketing and communications strategies, plans, tools
		Creating communications materials
		Shared language and shared messages
Strategic Objectives Needs	Data Needs	Data collection, processing, management
		Data analysis
		Monitoring, evaluation outcome, impact measurement
		Reporting, using data at system, community, regional levels
		Community and organizational needs, resource assessments
	Professional Development	ATR topic training and technical assistance
		Training events, management, and curricula
		Skill-building and professional development opportunities
		Training access, funding, expertise and other resources
		Community capacity building and leveraging capacity
		Access to best practices, newest research on ATR topics
		Network facilitation training and support
		Equity and culturally competent approaches
	Engage with Local Partners	Community engagement and organizing strategies
		Engaging with healthcare, mental health, primary care
		Engaging business and other partners for collective impact

Technical Assistance Needs – Qualitative Themes		
Cross-Sector Change Needs	Collaboration, Alignment	Networking, sharing practices and experiences with other communities and levels
		Collaborating and aligning efforts with other networks and communities to scale impact
		Disseminating, spreading information to other communities
	Policy, Systems Advocacy	ATR policy development, training, and effectiveness
		Elected leaders/govt. policy maker education and training
		Increasing awareness among families, community, public
		Legislative policy advocacy and support
		Community norm and culture change campaigns and efforts
		Building community resources
		ATR policy development, training, and effectiveness

Section 6: Alignment of Network Goals and Technical Assistance Needs Tables

Table A-28

Goals Reported	% of Connections	n
Network Activities	20.1	217
Foundational ATR Awareness	17.0	183
Change across Organizations and Sectors	13.6	147
Network Capacity	10.7	115
Member Organization Change	10.5	113
Population-level Impacts	8.9	96
Policy Advocacy and Systems Change	6.6	71
Community Capacity Building	5.6	60
Outcomes for Families	4.3	46
Outcomes for Children	2.4	26
Other Responses	0.4	4
Total	100	1078

Table A-29

Technical Assistance Needs Reported	% of Connections	n
Infrastructure Support	21.2	229
Communications	16.9	182
Data Needs	16.7	180
Training and Professional Development	12.9	139
Effective Leadership	12.4	134
Policy, Systems, and Community Advocacy	7.0	75
Network Engagement with Local Partners	6.8	73
Collaboration and Alignment	4.6	50
No needs or Don't Know Needs	1.5	16
Total	100	1078