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For more information, visit **http://marc.healthfederation.org/building-stronger-networks** or contact MARC at **MARC@HealthFederation.org**.

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Andrea K. Blanch

David L. Shern

Mary Clare Reidy

Leslie Lieberman

May 2019

Author Note

Andrea K. Blanch, Campaign for Trauma-Informed Policy and Practice (Sarasota, FL). David L. Shern, Mental Health America (Alexandria, VA) and Department of Mental Health, Bloomberg School of Public Health, Johns Hopkins University (Baltimore, MD). Mary Clare Reidy, Health Federation of Philadelphia (Philadelphia, PA). Leslie Lieberman, Health Federation of Philadelphia (Philadelphia, PA).

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It is widely known that complex community problems demand complex solutions. However, responses are all too often piecemeal and siloed, "with efforts (however passionate, intense, and even exhausting) that aren't sufficient to address the problems at the scale at which they exist" (Becker & Smith, 2018).

A response of adequate magnitude will only be achieved through coordinated cross-sector action. Yet, developing cross-sector collaboration capable of effecting large-scale change has long been a central problem in promoting the health of families and communities. For example, individuals with complex problems often need meaningful engagement with and coordinated services from traditionally fragmented systems. Innumerable efforts at increasing collaboration and coordination of services have been tested, with varying outcomes. Efforts such as the Robert Wood Johnson Foundation's (RWJF) program on chronic mental illness in the early 1990s (Goldman, Morrisey & Ridgely, 1994) and the ACCESS demonstrations (Rosenheck et al., 1998) to address problems of homelessness are examples of national efforts to develop effective collaboration and increase coordination of services. While these efforts have witnessed varying degrees of success, they have confronted obstacles including differing agency mandates, restrictions on use of funding, lack of an integrated accountability system, and competition for resources.

The Mobilizing Action for Resilient Communities (MARC) initiative, coordinated by the Health Federation of Philadelphia with support from RWJF and The California Endowment, sought to better understand how fourteen communities were adopting the Adverse Childhood Experiences (ACEs) science and resilience as a framework to accelerate development of

dynamic cross-sector networks and advance innovative, collaborative efforts to achieve community change and improve wellbeing. ACEs science and a large body of related research demonstrate that exposure to toxic stress and trauma, especially in childhood and adolescence, increases the likelihood of a number of poor outcomes including substance use, mental health problems, anti-social behavior, learning problems, and a host of chronic physical illnesses in later life (Shern, Blanch, & Steverman, 2016). The mechanisms that underlie these developmental consequences are increasingly understood, and involve the 'biological embedding' of experiences through their effects on the nervous, endocrine and immune systems (Hertzman, 2013).

In this paper, we use the community problem of service fragmentation as an entry point to explore ways in which the ACEs/Trauma/Resilience (ATR) framework is helpful in fostering and strengthening cross-sector networks capable of collaborative action to advance the complex solutions necessary to promote community health and well-being.

Background

Models of Community Collaboration

The problem of public sector fragmentation of services has long been recognized. Virtually every major federal human services policy initiative since the 1970s has emphasized the importance of preventing service recipients from "falling through the cracks." Early efforts to address this problem focused on case management, establishing a single point of accountability, or other mechanisms to help service recipients negotiate between service systems. In the first decade of the 21st century, the focus of both public and private sector organizational development moved strongly in this direction. Prior organizational change efforts had focused largely on improving performance by re-engineering internal structures and processes (for

example, continuous quality improvement). In the past two decades, far more attention has been paid to building effective external partnerships. Scholars suggest that this shift reflects the networked nature of society, a growing awareness of the complexity of problems and solutions, improved tools for communication, and perceived redundancy of services (Linden, 2003). In general, collaboration has been seen to be difficult. As one author put it, organizations typically have to "fail" into collaboration, either recognizing that they can't achieve their goals without it or being mandated to do so by government or funders (Bryson, Crosby, & Stone, 2008).

Many challenges to community collaboration have been identified. Even in successful cross-sector networks, people continue to do the bulk of their work in individual organizations, with studies estimating that only 15% – 20% of total work time is consumed by collaborative activities (Agranoff, 2006). Given that most performance incentives are tied to sector-specific outcomes, collaborative work often suffers. Other common challenges include forging a shared sense of purpose among organizations with different mandates and cultures; developing leaders who can be effective across boundaries; creating a sense of trust between partners; being seen as legitimate by external actors; simultaneously planning for individual and collective futures; and managing power and conflict (including competition for funds) (Bryson, Crosby, & Stone, 2008). Conflict that remains hidden and unaddressed appears to have a particularly destructive impact (Blanch, Boustead, Boothroyd, Evans, & Chen, 2015). Despite these difficulties, several authors note that the capacity to collaborate effectively can be developed over time, involving changes in member knowledge and skills, internal and external relational abilities, leadership, organizational processes to support partnership, and programmatic or service delivery capability (Foster-Fishman, Berkowitz, Lounsbury, Jacobson, & Allen, 2001).

While some collaborative efforts have focused solely on service delivery and resource coordination/mobilization, others explicitly attempt to create progressive community change and/or to restructure the relationship between service recipient and service provider (Hodges, Hernandez, & Nesman, 2003). However, engagement of service recipients and community members has often proven difficult. Even when service recipients or community members are invited to the table, they are often outnumbered by professionals and providers who are treated as experts and are often better organized and funded. Conversely, community members—including those who are representing marginalized groups—are usually not provided with adequate training, logistical supports, or compensation for their time. As a result, it is often hard for them to have a real influence. As Chavis (2001) notes, "In most cases, coalitions are good management techniques for the implementation of social welfare activities (e.g., planning, coordination, resource development) but not necessarily for actively promoting greater control and participation by the leaders of disenfranchised members of the community" (p. 313).

In some ways, this failure is not surprising. Much of the work on community collaboration comes out of the private sector organizational development/change management tradition, which is largely aimed at improving agency performance. In contrast, power building among disenfranchised groups is largely a public sector, community organizing concern. These two disciplines are quite distinct, and rarely overlap. However, the people who are most often failed by our service systems are precisely those who are most disenfranchised. Reaching them effectively requires both interagency collaboration and the power-building approaches most often found among community organizers. Some community development practitioners are beginning to promote approaches that do just that (Weinstein, Wolin, & Rose, 2014).

The ATR Framework and How it Relates to Other Models of Collaboration

Since the 1980s, many models of collaboration have been developed. Some have focused on specific problems, like serious emotional disturbances in children and youth (e.g., Substance Abuse and Mental Health Services Administration's Systems of Care), youth problem behaviors (e.g., University of Washington's Communities that Care), or substance abuse prevention (e.g., Community Anti-Drug Coalitions of America and the Iowa State University's PROSPER model). Others have been more general, such as the "collective impact" (Kania & Kramer, 2011) and "movement network" (Leach & Mazur, 2013) models, which focus on helping multi-stakeholder groups work collectively to address self-identified community problems. Collective impact, in particular, has received substantial attention over the past decade for its emphasis on developing shared outcome measures and integrated data systems. However, it has sometimes been criticized for problems that plagued earlier collaborative efforts, including a failure to explicitly address social justice concerns or to provide assistance in meaningfully engaging disenfranchised community members (Christens & Inzeo, 2015; Wolff, 2016). While these models of collaboration vary widely in how they are structured, all provide concrete guidance for how to bring different stakeholders together to increase the likelihood of successful collaborative efforts.

Biddle, Mette and Mercado (2018) document the importance of problem framing in either facilitating or hindering the development of coordinated community response to problems. They demonstrate that concordant frames can help diverse community stakeholders coordinate action while discordant frames can frustrate these efforts.

Explicit use of the ATR framework may address many of the concerns regarding discordant framing. The ATR framework does not specify a single problem to be solved or

provide concrete guidance about how to go about making change. Rather, it is a way of understanding the factors that contribute to causes of many community problems that can be applied in conjunction with other collaborative models. While several structured "trauma-informed approaches" based on the ATR framework have been developed, all emphasize the durable effects of trauma and adversity and are guided primarily by a set of values or principles for practice based on an understanding of the impact of trauma. Most are applicable across a wide variety of sectors. The ATR framework thus provides *unity* in understanding the root causes of social problems, while promoting *diversity* of solutions.

Implementing the ATR framework also requires within-sector changes in practice and service delivery. It is not enough to bring existing services together more effectively; services and service settings themselves must be transformed to address the underlying root causes. In addition, much of the momentum for using the ATR framework to transform communities comes from community members, direct service providers and consumers of services. While both government and academia have played a role in developing and promoting new approaches, there has been no widespread promotion or funding made available for any particular model or approach.

Since the MARC initiative explicitly involved networks using the ATR approach, it provides a natural laboratory to address the impacts of the ATR framework on the development and strengthening of community networks. By interviewing key informants from the projects as well as national experts in community development and the ATR framework, we hoped to gain insights into the ATR framework and its impact on coalition formation and functioning.

Methods

In addition to a targeted review of the literature on organizational development, community coalitions and networks, this paper is based primarily on a series of key informant interviews with eight individuals experienced in developing community collaboration and cross-sector networks. Some of the respondents are participants in the MARC initiative while others are not, but all have a broad range of expertise in developing or studying collaborative human service systems. We used a semi-structured interview procedure in which we asked the respondents to: 1) Characterize the collaborative activities in which they have been involved; 2) Describe their familiarity and experience with various approaches for developing and supporting collaboration such as Communities that Care and the SAMHSA Systems of Care Program; 3) Verify their familiarity with the ATR framework; 4) Identify the typical challenges involved in developing interagency collaboration; 5) Identify the approaches that they thought had worked particularly well; and 6) Compare and contrast the effectiveness of doing community collaborative work with and without the ATR framework.

Each interviewer independently recorded observations from the interviews, which typically lasted an hour. No formal coding or analytic system was used, but observations were synthesized across interviews by identifying emergent themes. Themes were subsequently organized according to a series of issues that are typically considered in the literature on collaboration, presented below. Themes and initial observations were then presented for discussion to twenty-five participants in a "focus group workshop" at a convening of MARC communities. The reactions and observations of workshop participants helped to clarify and refine our findings. The results reflect our interpretation of the interview content and do not necessarily represent the views of the individuals who were interviewed.

Results

Basic findings from interviews have been organized below according to major tasks in community collaboration commonly identified in the literature. Specific examples have been included to illustrate important points. While some observations were made in multiple interviews, no attempt has been made to rank themes according to frequency or importance.

Establishing a Common Purpose and Vision

One of the fundamental elements in building successful collaboration involves establishing a common purpose and vision that is genuinely endorsed by the membership. In the typical community, education systems focus on academic achievement, mental health on treating mental illnesses, criminal justice on reducing crime, child welfare on children's safety and family functioning, etc. Differing mandates and target outcomes often reflect differences in perceptions regarding the root causes of the problems at hand. This lack of agreement on root causes and effective intervention undermines efforts at coordination and collaboration.

Our respondents were clear that the ATR framework helps to provide a common understanding by highlighting the root causes of a wide variety of social problems. Once individuals understand the ATR framework and the multiple negative outcomes associated with exposure to these influences, their apparently discrepant mandates can be seen as fundamentally related. The ACE study (Felitti et al., 1998), in particular, helped to move the trauma conversation from a focus on discrete clinical interventions to an understanding of how trauma affects all aspects of life, and from single, acute traumatic experiences to an understanding of the cumulative nature of traumatic exposure. The ACE study also helped to establish a common, population-based approach to addressing social problems. It clearly specifies several of the domains in which adversity can occur, is accompanied by a measurement strategy that makes it

possible to gauge the level of toxic exposure of an individual or community, and provides a quantifiable population health target that is easily shared across collaborating organizations and individuals. While it addresses only a small slice of all potentially traumatic events, the ACE study encourages people to consider the goal of reducing the overall level of adversity and increasing resilience in individuals and communities. It also helps participants envision how the world could be different if underlying problems were addressed, creating a new sense of possibility, responsibility, and urgency.

The trauma-informed approach also emphasizes the potential for inter-generational transmission of adversity through biological and social mechanisms. Approaching these challenges inter-generationally provides a holistic approach to families, recognizing that parents with trauma histories are at increased risk for experiencing related challenges when raising children, and suggesting that the best way to help a child might well be to provide support to his parents. Working with the whole family therefore becomes a common purpose across child- and adult-serving organizations. Work with families might involve trauma sensitive criminal justice interventions, educational supports for the family, whole family psychotherapy, etc. The purpose of reducing adversity and building resilience, however, is common across collaborating organization and individuals – including community residents.

One respondent related her experience in trying to develop community action coalitions in a state-sponsored initiative. She initially encountered difficulty in engaging community members in a deep conversation regarding the root causes of their community challenges. There was a ‘checklist mentality’ in which the communities wanted to know what they had to do in order to satisfy the state mandate and receive funding. Once the ACEs research was effectively presented to the community (which required effort with a willing scientist), it fostered a more

engaged and coherent conversation about root causes and the integrated roles that individuals and organizations could play in addressing the problems. The shared understanding of the development of community challenges led to a genuine sense of common purpose and mutual responsibility.

Establishing Legitimacy

The core ACE study was a joint product of the Centers for Disease Control and Prevention and Kaiser Permanente. Simultaneous and subsequent work has extended the knowledge base to other age groups, sources, and impacts of trauma. Research has also elaborated the biological mechanisms that underlie the development of negative consequences of exposure to toxically stressful events. The sophistication of the science and its continued examination of the interaction between the person and his/her environment lends strength and legitimacy to the community work. The grounding in science and the applicability across domains also helps to frame the issue as one that transcends liberal and conservative worldviews.

Several participants noted that the science of adversity and trauma legitimizes a common understanding of "the why" but not necessarily "the how." However, once individuals come to understand the basic processes involved in the stress/resilience response system and the effects of prolonged toxic stress, they have a new basis upon which to discuss and devise strategies. Translating the science, which can be quite complex and esoteric, into accessible terms was reported as being an essential element in establishing this common understanding. Once individuals grasp the essential 'story' underlying important aspects of the development of health or illness, they can more effectively work together to address these problems than they could operating from separate paradigms. The strength of the science lends power and legitimacy to the approach and can bring the scientific, practice and local community together effectively.

Common Conceptual Framework

Once a common understanding is achieved, collaborators have a unifying conceptual framework on which to discuss strategies for addressing problems. Although various sectors are likely to use slightly different language and terminology, the ATR framework can help "translate" between sectors and provide a foundation for mutual understanding and action. Development and acceptance of the ATR framework may take some time. One interviewee reported that he had initially rejected the trauma model (and language) because it appeared to be another way of pathologizing families. Others noted that community members may be uncomfortable with the language of trauma because it can be interpreted as implying they are "brain damaged." However, interviewees reported that families in fact embraced the language enthusiastically, because it connected so well with their own experiences, and that the resilience component of the framework helped people embrace a more positive view of possibilities. Similarly, one person noted that the education system in her community initially resisted "trauma language" because to them it implied a mental health condition. However, after learning more about the impact of trauma on attention, learning and self-regulation, they saw the relevance to education and embraced the concepts.

The developmental framework and the language of ATR can also be personal, helping individuals to understand and discuss how life experiences have affected them. It provides new insights into personal development and, with effective translation, can be easily understood by everyone. The commonality of experience helps to 'democratize' the process, breaking down some of their hierarchies where professionals have higher status than para-professionals who, in turn, have higher status than community residents. The common framework also can permit

greater and more meaningful engagement of collaborators in community planning and accountability.

Several participants noted that the ATR framework made it possible for them to develop unifying metaphors and visual symbols which were readily adopted by all network members. They commented that these metaphors and images were more powerful than words in bringing people together around a common vision. One respondent noted that all terms in current usage are limited in some way. For example, "trauma" is often seen as the result of a singular, acute event, overlooking ongoing conditions of adversity, or it is expanded to include everything, thereby losing its meaning. On the other hand, "resilience" can lead people to a simplistic view of solutions, as if providing one protective factor in a child's life would make everything OK.

Trust

One of the essential ingredients for successful collaboration is the development of trust. Not coincidentally, trust is one of the basic elements of all trauma-informed approaches. Trust can be thought of as occurring at both individual and agency levels. The trauma-informed paradigm explicitly recognizes the experience of traumatic experiences as destructive of trust. Often, adversity and trauma occur in the context of relationships with individuals (like caregivers) who should be trustworthy. To the degree to which this trust is violated, individuals may become wary about trusting others. Other forms of trauma, such as community violence or natural disasters, may affect an individual's trust in God, for example, or in the ability of society to keep them safe. When translated to a community resident perspective, exploitation and failed promises often lead to cynicism and a lack of trust. Community members may ask: "We've seen programs come and go and nothing ever really changes. How is this different from all those failed attempts?" Researchers were also identified as individuals who have often approached

communities to participate in projects, and who were seen as taking from the community and failing to give anything back. This type of behavior is not uncommon and damages trust. Explicitly addressing reactions to historical trauma or disappointment through the ATR framework helps to elucidate common threats to trust and explains the basis for a lack of trust. These insights are helpful in establishing a trusting relationship but obviously require that individuals operate with mutuality and integrity.

In a trauma-informed framework, an individual's actions are interpreted as responses to environmental circumstances (i.e., What happened to you?) rather than making attributions to personal motives, flaws, or characteristics (i.e., What is wrong with you?). Actions are seen as situationally dependent, and people are assumed to be doing the best they can, given their history and circumstances. Understanding those constraints builds trust in the integrity of collaborators. Many of the same dynamics operate at an interagency level. A trauma-informed framework provides the basis for understanding other agency's actions as a response to their mandates, missions and organizational memories, rather than being seen as thoughtless, incompetent, or worse. It also provides the context to understand these actions in terms of the shared purpose of the network.

Motivation for Participation

One of the most common barriers to successful collaboration is the reluctance of organizations and staff to take on additional work. In general, staff in the helping professions work long hours in demanding jobs for modest pay. They are often extraordinarily committed to the people they serve, but they are also prone to compassion fatigue and vicarious trauma. Many service providers have experienced trauma in their own lives, and may be re-traumatized by what they confront in their jobs. Several respondents noted that use of the ATR framework helps to

reduce burnout and to address vicarious trauma by emphasizing staff wellness and resilience and the human value of staff, promoting understanding and support by supervisors, and reducing the use of punitive management techniques. In these circumstances, staff members have additional freedom to act creatively and foster innovation. Their empowerment and nurturance, when consistently present, help to further build trust and safety in the work environment, which are two of the signature characteristics of a trauma-informed environment.

Even those organizations and staff who choose to get involved in collaborative efforts may find themselves torn between their responsibilities to their agency and to the network. The ATR framework helps to address this issue by improving alignment between individual agency goals and culture and that of the collective. As individual organizations work to become trauma-informed, they are likely to see improvement in their own performance as well as in collective impact, lessening the tension between the two. With a deeper understanding, collaborators can arrive at effective solutions, and nothing is more motivating than success.

Resolving Competition for Funds and Turf

Often, the same organizations that are trying to collaborate must simultaneously compete for funds or influence to survive. Respondents noted that competition and turf battles do not disappear when the ATR framework is adopted, but they can be lessened. At the most basic level, understanding that trauma affects the people they serve helps partner organizations to see that they are getting something of real benefit from the collaboration, rather than feeling that they are being asked to help with another agency's problem. The sense of safety and trust generated by the ATR approach also contribute to a general culture of cooperation, as does the possibility for community networks to collectively address large structural and political issues (like racism and poverty) that they could not tackle on their own.

Other strategies to lessen the negative aspects of competition are not inherent in the ATR framework, although they appear to be closely associated with it. One example was an ATR collaboration that decided not to deliver direct services, which could have been seen as duplicative, but to focus efforts on helping existing organizations to align better with each other. Another example occurred during a competitive grant process, where organizations involved in a collaborative decided to cooperate on grant proposals rather than competing. Forging clear interagency agreements that reflect and value each agency's role and strengths also helps to reduce duplication and increase efficiency. One interviewee concluded by saying that if people are predisposed to cooperate, the ATR framework gives them something to cooperate around.

Several respondents also noted that many trauma-informed community collaborations have begun as grassroots efforts with little or no funding. They commented that too much money too soon can foster negative competition rather than cooperation: "Money complicates things." If partners are working to ensure that they get their "fair share" of a resource, they are less likely to be thinking about how to pool existing resources, which is often considered one marker of a mature collaborative effort.

Community Member/Service Recipient Engagement and Capacity Development

Several respondents addressed what is perceived by some as a lack of self-confidence among disenfranchised community members. Historical trauma, ongoing racism, structural barriers to success, and a society that blames people for their problems can manifest in what one person referred to as "an almost complete absence of self-esteem." As noted above, disenfranchised groups have little reason to trust professionals, to believe that they will actually be heard, or to hope that things can actually change. As one person stated, trust has to be earned, and: "Just getting people to the table is hard." Another noted that over time, people have turned

responsibility for solving social problems over to government or its agents, and when these fail, it is difficult for ordinary community members to reclaim personal authority or responsibility. Others noted that traditional modes of professional and provider behavior can make it difficult to incorporate the voice of lived experience into the conversation. The fact that the ATR framework works to break down distinctions between "us" and "them" can open the door to confronting unintentionally exclusionary practices.

The ATR framework alone cannot undo the structural violence and stigma that disempowers so many individuals. However, several respondents talked at length about the healing power of the model for both staff and community members. Respondents noted that when people "connect the dots" between their early history and their current problems, it makes it easier to understand their own behavior, to become more compassionate towards self and others, to forgive, and to liberate oneself from internalized oppression and racist attitudes. One participant noted that the healing process frees people from the burden of anger, releases a burst of energy, and creates an immediate boost in self-esteem – all of which plant seeds of hope and encourage active participation.

There are several other aspects of the ATR framework that appear to contribute directly to community capacity development. One is that knowledge is power. When community residents are in possession of the information, data and conceptual models based on credible research, they can better understand their own experiences and reactions. Likewise, the knowledge can help providers identify and end practices which tend to exclude community residents from discussions. The resulting broader participation can shift power dynamics, according to one respondent, and may threaten some traditionally powerful individuals. For example, an institutional partner once questioned the wisdom of giving "professional tools" to

untrained community members, asking if they could be trusted to use trauma-based language in the community without doing damage.

Another source of power inherent in the ATR framework is that of storytelling. In a more pathology- or problem-oriented conceptual model, professionals make the diagnosis and control the solutions. The shift to "What happened to you?" lifts up the personal story, recognizing that every situation is unique and that the affected individual gets to define what is important and what is not. In addition, storytelling is a uniquely powerful mechanism for communication and social change (Ganz, 2011), which also builds capacity among community members and service recipients.

The ATR framework is not a zero-sum proposition, and the empowerment of community members and service recipients does not imply the disempowerment of helping professionals. In contrast, seeing negative behaviors as adaptations to bad circumstances rather than failings makes it easier for staff to build on client strengths and to engage in authentic relationships and true partnerships. One respondent noted that social workers who previously blamed parents for not protecting their children, when equipped with an understanding of the parents' own trauma histories, were able to appreciate all the ways in which parents were trying to make their children's lives better.

Leadership

Effective leadership is critical for sustainable working collaboration. However, leaders from individual sectors may not automatically be accepted by community networks. One respondent noted that from her experience, the best solution was to have rotating leadership, so that no single sector was seen as "in charge." To the extent that the ATR framework is widely accepted and existing leaders are seen as champions for that approach, cross-sector leadership

may well become more acceptable. Since leadership capacity may not be equally distributed, the need to encourage and support leadership development becomes a priority.

In addition, forceful leadership styles and techniques that are often effective in advancing traditional measures of agency success may not translate well to a trauma-informed approach, with its concerns about collaboration and empowerment. Several respondents noted that they had encountered initial reluctance of established leaders to embrace the ATR framework. Some instances appeared to involve the personal style of existing agency leaders. Others appeared to reflect resistance to the ATR framework, which was seen as "medically oriented" by service environments that more traditionally embrace a psychosocial orientation. This was particularly true of academic colleagues. A related issue involved reluctance to lose professional prerogatives by empowering community residents to perform some functions that typically are the domain of professionals. The degree to which individuals with these perspectives were involved in leadership roles impacted the difficulty of developing successful collaborations.

However, respondents reported that as individuals in the collaboration became more aware of the ATR framework, their reluctance to use it diminished. It may be that the training processes that were used to familiarize individuals with the ATR framework served a diffuse leadership development process. As individuals and organizations began to understand the common purpose and use common language, the need for a strong individual leader may have decreased, and multiple leaders emerged.

Conclusion

The ATR framework, therefore, embodies several features that foster and accelerate the development of interorganizational and community cross-sector collaborative networks. Perhaps its most salient characteristic is the degree to which trauma and resilience are understood as

common root causes for a wide range individual, family and community outcomes. While we have long known that the social determinants of health are by far the most powerful influence on health and wellbeing, the insights into the mechanisms involved in the biological embedding of these determinants through the experience of adversity provide a common platform on which an integrated perspective on common causes and effects can be built. Once explained such that both a lay and professional audience can grasp the concepts, the ATR framework provides a common conceptual basis for better understanding the experience of individuals and communities. From this perspective, it becomes easier to understand the roles that can be played by each of the organizational partners and community members and their collective sense of purpose. The ubiquity of adversity in nearly everyone's experience further reinforces this shared understanding and begins to provide a more egalitarian environment in which community residents and organizational personnel can more effectively work together. Since the concepts of trust and safety are fundamental to a trauma informed approach, as the common understanding develops and a trauma informed approach evolves, trust among the network collaborators is more easily achieved. Differentiation of roles with a shared common purpose can help to reduce competition and turf concerns. Additionally, attention to the wellbeing of both community residents and staff creates a healthy atmosphere and comradery that promotes successful collaboration for positive outcomes. Thus the legitimacy of the science that explains common root causes for a multitude of individual, family and community outcomes creates a strong sense of common purpose that is fundamental to the development of a successful collaborative network.

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