

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

MARC ATR Network Findings

EXECUTIVE SUMMARY

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The full report for the MARC ATR Network Survey can be accessed by visiting MARC.HealthFederation.org/national-survey

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-person¹ 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.