HOPE

Health, Opportunity, Place-making and Engagement

Creating Healthy Communities One Neighborhood at a Time

Results of a Three-Year Trauma-Informed Community Development Initiative

Abstract

In 2019, Women's Services, Inc., in partnership with Crawford County Human Services, launched a trauma-informed community development initiative called HOPE in a small neighborhood in Meadville, Pennsylvania. The framework for implementation of the initiative was developed by the Pittsburgh-based Neighborhood Resilience Project. The impetus came from a multi-year process led by Crawford County Human Services to better understand and improve trauma-informed practices in local agencies, community groups and businesses. Support from Allegheny College enabled a study of proxies of trauma using GIS technology to analyze and plot county-wide reports of crime, 911 calls, drug overdoses, suicides and incidents of domestic violence, and to overlay this data along with demographic data onto a trauma map. Six communities within the city limits of Meadville were identified as likely areas with heavy trauma loads. Further research involved door-to-door conversations and collection of social network information from residents of the identified small areas. After further evaluation of neighborhood readiness, community meetings helped to narrow the choices. One community, known locally as the 5th Ward (a former voting precinct location), was selected based on trauma data and perceived community support. Named HOPE, an acronym standing for health, opportunity, place-making and engagement, the initiative launched a number of interventions in late 2019 and early 2020, only to be put on hold as the world and our community faced an unprecedented COVID pandemic. Creative solutions were identified to maintain contact with community members, such as newsletters and home visits linking people to needed testing, vaccines and other assistance during the pandemic. While ideally the program would have proceeded without interruption and a baseline community health survey conducted in 2020 or early 2021, technical challenges and the pandemic delayed the development and administration of a survey until late 2021 and into 2022. The community health survey was developed, administered and analyzed in collaboration with the Youth and Family Training Institute (YFTI) at the University of Pittsburgh Medical Center (UPMC) in Pittsburgh. The survey was administered a second time in the summer of 2024 in an area that included some small communities contiguous to the original community. This paper presents the results of the surveys that show significant improvement in key

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Meadville's 5th Ward

targeted areas of change in factors recognized as protective with respect to violence and trauma over the two-to-three-year time frame. Improvement factors include self-perception of mental health for youth and adults; incidence of crime and resident perceptions of safety; and the levels of social connectedness and community involvement. This data supports a broad set of anecdotes from residents and community partners regarding positive individual and inter-personal change in this community.

Our Theory of Change

Our premise is that we need to recognize, address and prevent community trauma as a prerequisite for ending violence, improving health and creating resilient and vibrant communities. This perspective moves us from seeing trauma as individually based or primarily interpersonal with medical model approaches, to an integrated approach that recognizes community trauma and incorporates a broader range of strategies for healing and sustained resilience.

Interpersonal trauma, often measured by ACEs (Adverse Childhood Experiences), is the impact of trauma during childhood with known impacts on mental and physical health over the lifespan. Examples of this type of trauma include witnessing or experiencing physical or emotional abuse, sexual assault, substance abuse, incarceration of a parent and more.

Community trauma includes cumulative interpersonal trauma but also considers historical and structural trauma from conditions such as poverty, discrimination and other social inequities. Characteristics of trauma-affected communities often include:

- No, or very weak, social networks
- Weak or broken relationships
- Lack of positive norms (i.e. property maintenance; noise; tolerance for illegal activity)
- Lack of confidence regarding agency and capacity to effect change
- Crumbling infrastructure and associated poverty (roads, bridges, lights, etc.)
- Unequal access to resources (healthy food, activities)
- Difficulty implementing successful interventions (don't take hold or not sustained)
- Poor health status and health behaviors of individuals.

Our mission is to support healing so that residents of the community are healthy enough to realize opportunities and reach their full potential and to build a resilient community that can thrive despite adverse events or experiences. This framework has three dimensions that are not necessarily always linear.

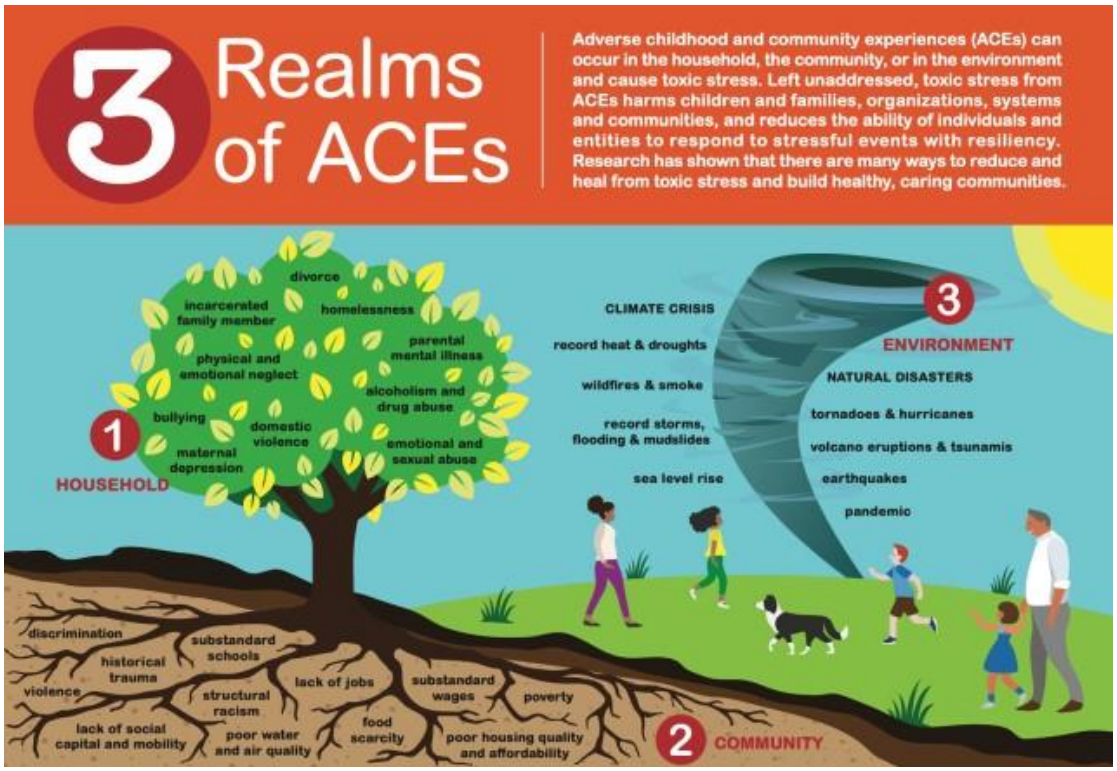
Community Support → Healing and Well-Being → Leadership Development

Building community support and trust is a foundational first step. This phase is ongoing and takes considerable time and patience to establish an initial toehold. People in trauma-affected communities lack trust in one another and in social and governmental entities. As people are supported in their healing process, they

develop agency and seek opportunities to help others; when they feel supported, they speak up, and when they feel seen and heard, they feel empowered and hopeful and become effective advocates for themselves and the community.

A Trauma-Informed Community Development Framework

Our trauma-informed approach to community development consists of a series of intra-neighborhood-centered and connected activities that include the assessment and determination of interest from residents in small neighborhoods. We refer to these as micro-communities, and we aim for a target population of about 70 households. Trained canvassers go door-to-door introducing themselves, providing a simple explanation of what they are doing and using tools of deep-listening and motivational interviewing to engage residents in discussions. These conversations enable the canvassers to assess the level of interest, to provide data for a social network analysis and to gather initial ideas about neighborhood strengths and areas of improvement from the perspective of residents. The framework aims to connect with at least 70% of the households in an area. An important outcome of this phase is to identify potential leaders or "connectors" based on the social network analysis and impressions gathered through conversations. Once contact has been made with a majority of residents, a community meeting is held to review the feedback from residents about strengths and opportunities for improvement and goals for their community. Additional information is shared about the HOPE framework: the process and outcomes that have been experienced in other similar neighborhoods, what they might expect and their roles. It is important that residents and initiative organizers reach a shared decision about whether to proceed and, if so, to mutually identify and commit to next steps.



The ACEs in these three realms—household, community, and environment—intertwine throughout people's lives, and affect the viability of families, communities, organizations and systems.

This graphic was created by PACEs Connection with inspiration and guidance from Building Community Resilience Collaborative and Networks and the International Transformational Resilience Coalition.

The next phase is engagement and relationship building. Depending on local trust levels, this phase can be time-consuming and resource heavy. Efforts are made to connect residents around shared interests and concerns using a variety of forums and activities. For our initiative in the 5th Ward, these included regular times set aside for neighbors to meet over coffee and snacks; mental health cafes; game nights or other recreational opportunities for adults and children; neighborhood clean-ups or yard sales; and holiday meals and celebrations. Most of the ideas are generated by the residents of the micro-community. The activities aim to connect residents with one another, build mutual trust and a feeling of looking out for one another, as well as trust in the process and sponsor. An important outcome of this period is the identification of current or potential leaders.

To generate baseline information a community health survey was administered in our initial area in 2021-22. Ideally, this should occur as close to the beginning of the intervention as possible. Technical problems and the COVID pandemic delayed this for about a year. The success of achieving a reasonable number of survey participants is related to the level of trust established between the community and sponsor, as many of the questions are related to economic status, mental and physical health. Our survey assessed individual perceptions of physical and mental health as well as social indicators of health for the community. The survey also identified immediate needs for safety or well-being, e.g. lack of heat, roof leaks, food insecurity, health and safety issues. These were addressed immediately with in-kind assistance from neighbors, local social services providers and local businesses.

Survey results were compiled, analyzed and shared with the community during an all-community meeting (usually a picnic with a combination of fun and information sharing). In the case of HOPE in 5th Ward, we also conducted a qualitative analysis using a tool called PhotoVoice that equipped residents with cameras over a six-week period to develop a photo-based description of neighborhood challenges and strengths. During the neighborhood meeting, community members brainstormed ideas about what to do over the next year to build on strengths and to create a healthy neighborhood. Volunteers were recruited during this meeting to work with staff to look at the community input along with the health survey, other qualitative information and to develop an annual health plan (HOPE plan). In the case of HOPE, most of these individuals also became part of the micro-community's Resident Council.

The annual health plan was organized around the goals related to the acronym of HOPE (health, opportunity, place-making and engagement). Key objectives with measurable outcomes and time-bound deadlines were organized under each goal and responsibilities assigned for leadership or coordination of the specific tasks or objectives. Initially, responsibility was shared among staff and residents; over time, residents have taken more responsibility for leadership with a goal of functioning independently.

Early in our process, a neighborhood volunteer with a combination of strong interpersonal skills, organization and lived trauma experiences was identified and began volunteering as a community leader. This individual was later hired by Women's Services, Inc. with funding from Crawford County Human Services as a behavioral health organizer or community organizer to support the ongoing process of trust-building, partnership development and to support the HOPE plan implementation. Currently, she directs another part-time person, two senior volunteers who receive compensation from the federal Pathstone program and volunteer workers from Allegheny College's Bonner program.

Initial Intervention Area – 5th Ward, Meadville

The community selected for piloting the framework suffers from historic disinvestment and is characterized by a high percentage of sub-standard housing and rentals. Its location across a bridge over one of the state's most pristine and beautiful rivers results in a geographic separation from the City of Meadville. The separation creates transportation challenges and limits access to healthy food sources and health care, especially for those without cars. The river and two small tributaries meet in this area and in the past have caused flooding, resulting in the designation of this area by FEMA as a floodway. This designation makes it extremely difficult and expensive to add new housing units and even to repair existing buildings. As a result, no new housing has been added to the area in the last 50 plus years. Strengths included access to recreational areas and related activities, quiet streets and an element of strong pride in the area's heritage and history. Our social network analysis indicated very low levels of trust and connectedness within the community. The initial area included several portions of city blocks with an estimated population of about 70 households and 140 individuals. The area was gradually expanded after about two years to include contiguous areas that include two partially occupied trailer courts and has an estimated population of about 50 households, bringing our total outreach area to 120 households and an estimated 240 individuals.

5th Ward Interventions: 2020-2024

Staff and volunteer outreach workers continued to canvass households and to deliver monthly newsletters and flyers about neighborhood events and available services. A weekly coffee hour was initiated as an opportunity for residents to get to know one another, to share ideas about neighborhood improvements and to collectively work on problems and challenges. Challenges over the last four years have included localized flooding from insufficient sewer lines, drug dealers, homelessness and perceptions of unfair scrutiny from City inspectors. These conversations continue to generate a number of ideas about events and services to engage local families. Examples include annual community picnics and get-togethers; weekly coffee hours where residents can meet and get to know one another and share ideas, challenges and solutions; mental health cafes; holiday decorating contests; summer lunch program for children; after-school program; annual junk hauls and neighborhood clean-ups; improvements in streets and drainage issues; a community garden; and the launch of a cooperative lawn care and snow removal service. Residents have developed strong community partnerships with local businesses, local employers and employment services, the City of Meadville, Meadville Police, Crawford County Commissioners, juvenile probation, Drug and Alcohol, area first responders and many others who share our goals of community health improvement. A resident council of community leaders makes decisions about use of resources and serves as the clearinghouse for consideration of new opportunities and challenges as they arise. We have learned that building trust in an area where people feel isolated and abandoned takes time, and after four years residents report much stronger social networks, lower crime, a greater willingness of neighbors to help one another and the seeds of hope to create a more vibrant, safe and healthy community.

Health Survey Results: 2021/22– 2024

Staff working with outside consultants from the Youth & Family Training Institute (YFTI) at UPMC, developed a health survey that could be administered using tablets, computers (for on-site enrollment) and via paper. Questions were drawn from other surveys that had been proven valid and reliable and were designed to capture information about Center for Disease Control protective factors to prevent violence. These included access to safe and stable housing, access to safe and engaging community activities for children and families, access to economic and financial help, self-perceptions of physical and mental health, connections to one another and community involvement. Individuals who were 18 years of age and older could respond. Small incentives were used to encourage participation in the survey. Results from both surveys were collated by the YFTI and presented in dashboard format for easy analysis and comparison across demographics and surveys. The first or baseline survey was administered in 2021-22 in the initial intervention area of about 70 households, and it was administered again in 2024 to the initial community and an expanded area covering in total about 120 households. For the first survey there were 72 respondents. In the second survey, there were a total of 83 respondents of whom 39 were individuals who had also completed the first survey. Table 1 presents demographic data for the two sets of survey respondents compared to the City of Meadville.

Table One. Demographic Information

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	Overall Community		Meadville
	Survey 1 2021-22	Survey 2 2024	Census
n=	72	83	
GENDER	PERCENT		
Male	51.4	49.4	48
Female	45.8	48.2	52
Other	2.8	2.4	NA
AGE			
18-21	6.9	6	28
21-40	23.6	29.6	36
41-65	45.8	48.2	24
66+	23.6	15.7	16.3
RACE			
White	91.5	91.5	87
Households with Members <18	31.9	26.5	NA

Comparing the two community-wide surveys, the Survey 2 responders are slightly younger and more female than those in the first survey. When compared to total demographic data (from US Census) for all of Meadville, the over 65 population in Survey 2 is about the same. The percentage of individuals identifying as white is higher (91.5% as compared to 87.2% in all of Meadville); the male population is somewhat higher (48% in Meadville and 49.4% in the target community).

Table 2 compares the cross-sectional (all community) data for the two surveys. Boxes are shaded to highlight responses that differed more than **five percentage points,** in either a **positive (green) or negative direction (red).** The results are grouped by categories, and the percentages reflect changes in well-being in each component of the category.

Table 2. HOPE 5th Ward Survey – 2022-2024. Cross-Sectional Results

Category	Outcome	Initial Survey (2022) n=72	Second Survey (2024) n=83	Change
Housing	Secure place to live	84.7	88	+3.3
Housing	Very satisfied and satisfied	77.8	79.5	+1.7
Housing	Utilities – Gas (No shutoff)	84.7	92.8	+8.1
Housing	Utilities – Electric (No shutoff)	81.9	89.2	+7.3
Housing	Utilities – Water (No shutoff)	86.1	92.8	+6.7
Safety	Feel safe in neighborhood	88.9	96.4	+7.5
Safety	Not a victim of crime	65.3	74.7	+9.4
Safety	Family member not a victim of crime in last year	87.5	92.8	+5.3
Safety	Never threatened with harm	81.9	85.5	+3.6
Safety	Not physically hurt by someone	94.4	95.2	+.08
Overall Health	Self-evaluation of health (excellent, very good, good)	65.3	67.5	+2.2
Mental Health (overall)	Self-evaluation (excellent, very good, good)	70.8	80.8	+10
Mental health	Depressed (not at all or only a few days per month)	79.2	88.0	+8.8
Mental Health	Never or rarely feel lonely	65.3	71.1	+5.8

Category	Outcome	Initial Survey (2022) n=72	Second Survey (2024) n=83	Change
Mental Health	Adult satisfaction with services (very satisfied and satisfied)	45.8	37.2	-8.6
Mental Health	Youth with no mental health concern	52.9	71.4	+18.5
Mental Health	Youth access to services (very satisfied and satisfied)	62.5	75	+12.5
Basic Needs - Affordability	Food – Difficulty affording (never or rarely)	73.7	73.5	-.2
Basic Needs - Affordability	Food Security-Never or rarely worried	70.8	78.4	+7.6
Basic Needs -Affordability	Housing – Difficulty affording (never or rarely)	79.2	84.3	+5.1
Basic Needs - Affordability	Heating-Difficulty affording (never or rarely)	75	81.9	+6.9
Basic Needs - Affordability	Medical Care-Difficulty affording (never or rarely)	73.6	85.5	+11.9
Health Behavior	Dentist in last year	30.6	41	+10.4
Health Behavior	Exercise-At least once a month	79.2	86.7	+7.5
Health Behavior	No tobacco use	48.6	44.6	-4.0
Health Behavior	Rx Compliance	48.6	48.2	-.4
Health Behavior	Use primary care doctor for needed health care	80.5	74.6	-5.9
Health Behavior	Use ER when need health care	34.7	30.1	-4.6

Category	Outcome	Initial Survey (2022) n=72	Second Survey (2024) n=83	Change
Support	Get all that is needed for daily activities	88.9	95.2	+6.3
Support	Family or friends provide support as needed	77.7	80.7	+3
Support	Neighbors provide support	0	12	+12
Community Involvement	Very or somewhat involved	NA	38.5	NA
Community Involvement	More than two years ago	NA	22.9	NA

Table 3.
Longitudinal Data – Individuals who answered both surveys (n=39)

Table 3 shows longitudinal data for the group of 39 who completed both surveys. Again, the data is shaded to indicate at least a five point change in percentage points in either a positive or negative direction for respondent well-being.

Category	Outcome	Initial Survey (2022)	Second Survey (2024)	Change
Housing	Secure place to live	94.9	92.3	-2.6
Housing	Very satisfied and satisfied	97.1	97.1	0
Housing	Utilities – Gas (No shutoff)	92.3	92.3	0
Housing	Utilities – Electric (No shutoff)	87.9	89.7	+1.8
Housing	Utilities – Water (No shutoff)	94.9	87.2	-7.7

Category	Outcome	Initial Survey (2022)	Second Survey (2024)	Change
Safety	Feel safe in neighborhood	89.7	94.9	+5.2
Safety	Not a victim of crime	69.2	84.6	+15.4
Safety	Family member not a victim of crime in last year	87.2	97.4	+10.2
Safety	Never threatened with harm	81.9	85.5	+3.6
Safety	Not physically hurt by someone	94.4	95.2	+.08
Overall Health	Self-evaluation of health (excellent, very good, good)	71.8	74.4	+2.6
Mental Health (overall)	Self-evaluation (excellent, very good, good)	87.2	84.6	-2.6
Mental health	Depressed (not at all or only a few days per month)	84.6	92.3	+7.7
Mental Health	Never or rarely feel lonely	79.5	76.0	-3.5
Mental Health	Youth with no mental health concern	20	85.7	+65.7
Mental Health	Youth access to services (very satisfied and satisfied)	62.5	75	+12.5
Basic Needs - Affordability	Food – Difficulty affording (never or rarely)	82.1	82.1	0
Basic Needs -Affordability	Housing – Difficulty affording (never or rarely)	87.2	87.2	0
Basic Needs - Affordability	Heating-Difficulty affording (never or rarely)	82.1	79.5	-2.6

Table 3.
Longitudinal Data – Individuals who answered both surveys (n=39)

Category	Outcome	Initial Survey (2022)	Second Survey (2024)	Change
Basic Needs - Affordability	Medical Care-Difficulty affording (never or rarely)	89.7	82.1	-7.6
Health Behavior	Dentist in last year	43.6	46.2	+2.6
Health Behavior	Exercise-At least once a month	82.1	89.7	+7.6
Health Behavior	No tobacco use	48.6	44.6	-4.0
Health Behavior	Rx Compliance	48.6	48.2	-.4
Health Behavior	Use primary care doctor for needed health care	80.5	74.6	-5.9
Health Behavior	Use ER when need health care	34.7	30.1	-4.6
Support	Get all that is needed for daily activities	94.9	89.7	-5.2
Support	Family or friends provide support as needed	77.7	80.7	+3
Support	Neighbors provide support	0	12	+12
Community Involvement	Very or somewhat involved	NA	38.5	NA
Community Involvement	More than two years ago	NA	22.9	NA

Discussion

The follow-up survey indicates positive change across numerous reported characteristics and well-being for both the cross-sectional and longitudinal groups. Both groups also had negative changes in a few areas. It is important to point out that the data reflects small numbers, so a change in response of two to five individuals may show up as a change of five points or more. Furthermore, the sample only includes individuals who were willing to complete the survey and was not a random sample of the population. An effort was made to collect surveys that were distributed across the geography of the intervention area. Data was collected on tablets, either completed by respondents or with assistance from the canvasser, or by a paper form for those uncomfortable with the tablets. Some residents with intellectual disabilities or limited literacy were assisted with completion of the survey by staff and trained volunteers from outside the neighborhood. The limitations of the survey are such that we cannot assume that the observed changes are directly the result of the HOPE interventions, and we cannot rule out other changes in individual and community circumstances that may also have influenced the outcomes.

Housing well-being showed little or no change with respect to a secure and stable place to live. These numbers, already high in the initial survey, were unchanged in the longitudinal group and somewhat lower in the cross-sectional group. The lower numbers in the follow-up group may be related to the inclusion of two mobile home parks which have threatened closure and eviction. When asked whether residents had been threatened with or experienced utility shutoff, the cross-sectional results improved, with a negative change for water shutoff in the longitudinal group. During the period between surveys there were no increases to rates for water and electric and a significant increase in natural gas prices in the summer of 2003. The HOPE initiative has actively informed and promoted eligible residents to apply for and receive assistance through the LIHEAP program in Pennsylvania that helps to pay for electric and heat (gas) but not for water. One resident was able to get a completely new furnace during this time period, and several others are new participants in the program, which is very helpful during winter months. Another explanation for the improvement in gas and electric utility maintenance is seasonal. The initial survey was conducted in the winter months and the follow-up in the summer.

An example of blight.

The category of safety shows positive improvements over most of the questions for both groups. This supports anecdotes and crime data from police reports for the area. The Meadville Police Chief has noted that the neighborhood, formerly viewed as a higher crime area, is now one of the safer neighborhoods in the City of Meadville. Many residents have installed security cameras. Social media is widely used by residents to communicate safety concerns of all types. Most importantly, residents have improved their relationship with the police from one of distrust to collaboration to prevent crime. Known drug dealers and houses suspected of meth production have been exposed and have left the area. Individuals struggling with recovery are welcomed into community activities and provided support to sustain sobriety from local recovery experts who are frequent participants in the weekly coffee hour. In one case, two former residents in recovery worked together to repair a roof for an older resident who was being cited by the city. Smaller improvements are also present for threats or actual physical harm. As a program of Women's Services, all of our staff are trained and certified to look for warning signs and provide assistance to anyone who comes forward with a concern about physical harm or abuse.

There was a very small positive change in self-perception of physical health. This is an expected result given the level of chronic disease in the population. In both surveys, two thirds of the respondents indicated that they had one or more chronic diseases such as diabetes, high blood pressure, respiratory illness and heart disease. Knowing this, it becomes more important to look at supportive health behaviors such as medication compliance, exercise and food security. With respect to compliance with medication recommendations, we found that more than half of respondents in both groups report failure to take prescribed medications at some time in the last year. This is an important and complex area for improvement. There are many possible reasons for non-compliance with medications including access to care, cost, transportation and lack of information about the reason for the medication. More positive results were observed for regular exercise with an increase in both groups reporting regular exercise. It is possible that HOPE interventions including the development of a community garden and lawn care program, as well as an annual walk-a-thon for the city-wide summer parks program contributed to this improvement. It is also possible that with increased feelings of safety, residents are walking more in the neighborhood. Use of tobacco remained essentially unchanged at a very high rate of 44% as compared to 19% for county-wide data (PA Department of Health). This presents another important

Allegheny College Service Saturday.
Land prep for HOPE Memorial Community Garden.

and challenging area for improvement given the level of chronic disease. Mental health is an important component of overall health and of particular interest in individuals and communities that have long histories of trauma. Access to mental health services for individuals for other than self-pay is challenging throughout the county, primarily because of difficulty in recruiting and retaining mental health professionals. When asked to assess their own mental health, respondents in the cross-sectional survey reported a significant improvement over the two-year period. However, in the longitudinal group there was very little change. For depression both groups showed improved well-being as evaluated by how many days a month they felt down or depressed. Loneliness is increasingly recognized as a widespread and important public health issue. The cross-sectional group indicated improvement (never or rarely lonely + 5.8 percentage points), and the longitudinal group showed less than a five-point change. It is interesting to note that the group who took the survey twice reported that they were less lonely than the cross-sectional group for both surveys. This may suggest that they have had greater exposure and opportunity to participate in HOPE-related events and/or to develop new relationships in the community. Nevertheless, loneliness continues as an area for improvement in the overall community.

HOPE at Celebration Meadville

Youth mental health was evaluated separately from adult reports and is of particular interest in our community on the part of child-facing services providers. In both surveys the number of respondents reporting children under 18 in the household was a subset of all respondents. So, with the caveat that these numbers are lower than the overall populations of respondents, there were significant improvements observed in both the number of youth with mental health concerns and the level of satisfaction with access to services. Possible associated interventions include an after-school program for all school-age children and youth that emphasizes the development of social skills and assistance with academic work. HOPE has worked with the local elementary school to promote the program; however, transportation home is an obstacle to greater participation.

Questions in the survey about the affordability of basic needs were included to look at economic well-being by measuring changes in the ability to afford food, housing and medical care. In the initial survey on average about 25% of the community expressed difficulty in affording housing, food and medical care. In the follow-up for the cross-sectional group affordability of these basic needs improved to an average level of about 80%, with about 20% still expressing affordability challenges with one or more of these basic needs. The biggest

reported improvement in the overall community surveys was in medical care (+11.9 percentage points) and the lowest was with housing (+5). However, in the group that repeated the survey there was a significant negative change in those who reported never or rarely having difficulty affording care, and the difference between these groups warrants further examination. The positive trend for affordability for food and housing is surprising given inflation levels during this period for food and medical care. HOPE regularly provides residents with information about food distributions and medical care access for those without insurance. During the time between surveys, and as pandemic support began to wane, there were several additional food distributions and sites established throughout the county. Additionally, the second survey was conducted in the summer as compared to the first survey in the winter months. It is possible that the improvement in food security in the second survey is related to more affordable produce (and state programs that support purchases at farmer's markets) and the availability of produce in the community garden. Community organizers also feel strongly that food insecurity has started to increase post-survey as they encounter new families who are struggling with food security. Improved reports of affordability of heating is very likely a seasonal effect.

HOPE Community Health and Wellness Picnic in conjunction with FCCA's Developing Greatness Graduation event.

In addition to the questions and findings with respect to the medication compliance and exercise, the surveys also looked at health behaviors that included use of dental care, tobacco use and use of primary care and emergency room services. Results here are mixed.

For the cross-sectional group, the survey shows positive changes in annual dental visits and no changes of five points of more in tobacco use. A negative change was observed with respect to use of primary care. Results for the longitudinal group are similar: a decrease in use of primary care and no changes in the other areas. The questions of how people access medical care require further study, as this question did allow multiple answers that included use of specialists and urgent care centers in addition to primary care and emergency room use. It is possible that with high levels of chronic disease, many residents are receiving more care through specialists, but this cannot be determined with current survey results.

One of the most important protective factors for violence of all types and health is the level of support and connections that individuals have with others that can come from family, friendship groups and a community. To examine this area, the survey included questions about assistance and the level of support individuals receive and community participation. For the cross-sectional survey there are positive increases in the number of residents reporting that they get the help they need and an even larger increase (+12 points) for those who also look to neighbors for support. In the initial survey no one indicated that they get assistance from neighbors. For the longitudinal group there was a decrease of five points for individuals reporting they get all the help that they needed, and the same positive increase (+12 points) for those receiving assistance from neighbors.

HOPE Community Health and Wellness Picnic

These changes affirm observations and anecdotes about the level of attention and assistance being provided to one another. Types of assistance include help with clean-up of the neighborhood and individual properties when owners cannot do so; regular check-in visits on vulnerable neighbors from health outreach workers; and alerting others when someone is struggling with food security or mental health crises. The intervention area includes a homeless encampment just across the river, and HOPE has often worked with representatives of the group to provide clothing, food and drinkable water.

Domestic Violence Awareness walk.

Supportive of what appears to be stronger social connections in the neighborhood, the second cross-sectional survey (83 respondents) asked residents about their level of community involvement. More than a third of residents (38.5%) reported that they were very or somewhat involved in the community, and 23% indicated that their level of involvement was higher than two years ago. Given that when the initiative started, we observed very low levels of social networks and capital, this represents significant gains in one of the most important protective factors related to violence and health in communities.

Conclusions and Next Steps

The survey information shows positive changes in important areas that are protective of violence. Findings appear to indicate that the community has developed stronger social ties and connections with one another. We know from a wide range of recent research that human connections are vitally important to physical and mental health. Some of the results seem counter-intuitive such as a greater ability to afford basic needs during a time when costs have gone up. One possible explanation is that HOPE is creating hope. We have observed growing levels of confidence and optimism as community members feel that their voices and collective action matter.

Our approach to the evaluation of impact and outcomes is centered around these surveys, which will be repeated as the program expands to new neighborhoods. However, we also are including qualitative analysis, and the analysis of the survey will be followed by focus groups from the initial community group and the expanded group to further understand what the data is showing and to get a more robust understanding of possible interventions to improve areas that show either very little or negative changes in well-being.

Once we complete the qualitative analysis, our findings will be widely shared with stakeholders, including community members and partners, health care and mental health providers, elected officials, funding agencies and grant-makers as well as with other groups who share in and continue to build our understanding and effectiveness of trauma-informed community development. Findings will also be used locally by the 5th Ward community to develop their 2025 community health plan and by the staff at Women's Services to build upon and improve our experiences with the pilot of this framework.

Card Night in the HOPE community.

Goals and Aspirations Moving Forward

HOPE Memorial Community Garden

Our community is experiencing urgent needs related to trauma and health. Demand for mental health services and support has rapidly outpaced the availability of services, especially for youth. Underinvestment in community infrastructure and well-being has been amplified following elimination/ reduction of pandemic support. Women's Services is a leader in community collaboratives that are working outside of traditional short-term fixes that have proven unreliable with respect to sustainability and impact. For the past half dozen years, we have cobbled together funding to support our aspirations to expand and strengthen work with local partners and to create a safe, trauma-responsive city and county. Moving forward, we would like to:

- significantly expand trauma-informed community development work;
- develop more robust metrics for assessing the outcomes and impact of the full range of our work;
- expand outreach with incarcerated women and work with partners for pre- and post-release planning and support; and strengthen efforts to seal or remove past criminal records for increased access to safe housing and employment;
- work with local partners to create more transitional housing for those recovering from violence and trauma;
- create a mobile trauma-response unit to provide on-scene support after incidents of violence or disaster to reduce the impact of secondary trauma;
- increase our capacity to provide mental health services for children and youth to help alleviate on-going challenges with access and availability;
- train non-traditional service providers (e.g. beauticians, barbers, massage therapists) to recognize and respond to symptoms or disclosures of violence, abuse and human trafficking.

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Women's Services