Reactions to Trauma at the Community Level

Findings from Participatory Research in Four Ottawa Neighbourhoods

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March 30th, 2016

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Acknowledgments

The research team would like to thank ….

- the twenty residents who opened their hearts and shared their personal and very private experiences with our interviewers. This project doesn't exist without you, and we want to express our deep appreciation for the trust that you placed in us to receive your wisdom and experiences, and to make sure that your voices were heard.

- the Advisory Committee members for their strong, open-hearted support of this project. Your collective wisdom significantly contributed to its success.

- the support of PQCHC staff, in particular of Tammy Corner who became a *de facto* research team member. Your collaboration and dedication to carrying out this project in a careful, trauma-informed way was indispensable.

- the service providers who came forward to share their experience and wisdom, and whose input shaped the approach and data gathering protocols.

Executive Summary

In partnership with Crime Prevention Ottawa (CPO), Pinecrest-Queensway Community Health Centre (PQCHC) conducted research in four west end Ottawa Community Housing (OCH) communities on reactions to traumatic incidents at a neighbourhood level. The purpose of this research was to better understand how trauma affects residents' interactions with each other, with their neighbourhood, and with service providers. We also wanted to know how individual and neighbourhood level traumas interact. For example, does neighbourhood trauma aggravate trauma that occurred earlier in a person's life, or affect the residents' responses to neighbourhood trauma? What can service providers do to minimize the impact of neighbourhood trauma? And how can service providers grow resilience, wellbeing and connectedness at individual and community levels, knowing that many residents have experienced some type of personal trauma in their lives?

What did we do? We took a trauma-informed approach to this study. We worked hard to keep all participants safe and minimize the risk of harm. We worked with experts in the community to decide what to ask and how to ask it. The project was also guided by an Advisory Committee made up of PQCHC staff and other experts (see Appendix 1 for list of Members). Four priority neighbourhoods were chosen from within the PQCHC catchment. All four had experienced multiple traumatic events within the last 12 months. To get to know the strengths and challenges of each neighbourhood, researchers interviewed 17 staff members working in the four neighbourhoods in the summer of 2015. Between August and November 2015, researchers interviewed 20 residents from the same four neighbourhoods. Service providers and residents interviewed are diverse. People live in different types of housing (apartment buildings and town homes) and family groups (families, singles, seniors). They come from different cultural, linguistic, and religious backgrounds, and have experienced different kinds of trauma. For more information on our approach and methodology, ethical considerations, and sample, please see Appendix 2.

What is trauma? Traumatic events are experiences or situations that are emotionally painful and distressing. They overwhelm a person's ability to cope, and leave them feeling powerless or out of control. Trauma can be a single event (shooting), or repeated events (ongoing domestic abuse). It can affect an individual or a group (genocide). Trauma can also be passed down through generations (residential school survivors). In this study, we use the term trauma to talk about a continuum of stressors. These range from acute traumatic stressors as a result of life threatening incidents, to chronic ongoing toxic stressors. We asked respondents to identify the neighbourhood events or

situations that they experienced as traumatic. Interviewers then explored how these events affected residents' feelings of safety, belonging and connectedness. Some residents shared how neighbourhood events brought up previous personal trauma, and how this affected how they live in their neighbourhood. Finally, residents talked about what changes they would make in their neighbourhood to help them feel safer and more connected.

What did we hear? We heard similar things when we spoke with residents and service providers. Our findings can be used to improve the work of systems and supports that respond to acute neighbourhood traumatic events. They can also be used to improve services that develop individual and community-level resiliency and wellbeing in the face of chronic stressors and cumulative trauma.

1. **Acute traumatic events and chronic stressors explain individual behaviours and neighbourhood dynamics.** Participants found shootings and illicit drug activities to be most traumatic. This was the case even for those people who were not traumatized by these events over the long-term. Surprisingly, chronic "toxic" stressors were also commonly identified as traumatizing, and as triggering previous personal trauma. Stressors most often mentioned are interpersonal conflict and gossip, and systems and services that stigmatize and dehumanize. Respondents want services and supports that are more responsive and more sensitive to them as human beings: less judgmental, less stigmatizing, and quicker to respond.

2. **Reactions to trauma are complex and call for individualized, trauma-informed systems responses**. The connection between neighbourhood violence, personal trauma, and community connectedness is complex. There are many factors that shape the kinds of incidents that take place, how the neighbourhood reacts, and how individuals react. Each neighbourhood is unique; every individual is unique. Although a small sample, the people interviewed in this study show a range of coping strategies that people use to deal with neighbourhood and personal trauma. We see that some residents are more vulnerable because of exposure to multiple risk factors (poverty, addiction, unemployment, mental and physical disability, previous trauma), and low protective factors (especially low social support). Others are 'flourishing': they use typically healthy coping strategies to deal with stressors, are employed, socially connected, in good health, and capable of supporting those around them. Systems-level responses to traumatic events need to reflect the unique ways that people respond, and be able to adjust and react appropriately. This includes drawing on the strengths of those who are flourishing to help build the capacities of those who are struggling.

3. **Support for current community development work: build on strengths**. Study participants talk about deep strengths in their neighbourhoods. Many feel very connected, and are very proud of their neighbourhood. Residents want to build on these existing community strengths and shift the atmosphere in the neighbourhood to focus on positives and mutual support. Respondents are also looking for opportunities for personal development and meaningful involvement in community. Due to their personal histories, residents have varying levels of personal resiliency to draw on. Findings from this study point to the need for more training and ongoing opportunities to "fill their resiliency cup". The need for all involved to acknowledge personal history, take self-care measures, and manage ongoing exposure to prevent vicarious trauma, emerged as an important theme for residents and service providers alike. There are opportunities to leverage individual skills, as well as neighbourhood strengths. Community development work that builds personal skills, including through peer initiatives, can help build resiliency in those at risk. These activities are important both as part of an immediate response to a neighbourhood incident, as well as over the longer-term.

4. **Targeted needs.** Respondents who are socially isolated tend to be at risk for other challenges, including physical and mental health problems. Respondents who are survivors of extreme abuse continue to feel the effects of this abuse ripple through their lives unless healing takes place. Newcomers to Canada are another group that needs particular attention: many are working multiple jobs, while also attending school to upgrade their skills or learning English. If they also have children, families have to make difficult choices as to where to place their attention and time. Even when there are opportunities to connect at the Community House, some newcomers may not have the time to invest. Finally, maximizing healthy opportunities for children and youth to grow, especially building positive social connections and a vision for the future, came up in many interviews. For all of these sub-groups, our findings suggest the importance of taking a trauma-informed approach to enhance existing initiatives, or design new activities, in order to meet these very diverse needs. This is especially true for those who fall into multiple at-risk groups.

What is next? The issue of neighbourhood violence and trauma is complex, and requires a coordinated, collaborative, multi-partner response. Immediately following a traumatic incident, residents need to be supported using a trauma-informed approach. This immediate response needs to be complemented by longer-term community development work that focuses on building individual and community resiliency. To be successful, the work of residents, local service

providers and trauma response teams needs to be supported by policies and programs at the municipal, provincial and federal levels. In keeping with best practices, interventions need to be targeted at the Individual, Interpersonal, Community, and Systems levels.

First and foremost, residents need to have access to trauma-informed appropriate supports, including mental health and addictions services. Trauma-informed approaches meet people 'where they are at'. They are non-judgmental and focus on people's safety. These approaches build trust by treating people with respect and dignity, and offer clients choice. Work on supporting resilience with vulnerable people also suggests emphasizing "low-cost, accessible strategies" that develop individuals' presence, compassion, gratitude, forgiveness, justice and temperance. Developing these capabilities strengthens residents' abilities to process, manage and respond to traumatic incidents in positive ways. These growing abilities can in turn help people be more resilient in the face of challenging circumstances. When residents cannot get timely access to mental health and addictions services, we see negative outcomes cascade from the affected individual into the lives of people closest to them, and then into the neighbourhood.

Residents also need opportunities to develop interpersonal skills, including building trust and social connections. Residents impacted by personal trauma may cope by isolating themselves in response to neighbourhood traumatic events. Unfortunately this response also cuts them off from positive supports that may be available in the community. Examples of how a trauma-informed approach can be applied following a neighbourhood traumatic event include: (1) creating opportunities for residents to see healthy behaviours being modeled by community leaders; (2) developing positive peer to peer relationships; and (3) group activities that allow residents to share, make sense of the traumatic event, and to offer and receive support.

Just as individuals need opportunities to make sense of events, similar opportunities are needed at the neighbourhood or community level. Giving communities ownership and control over how they are perceived is an important aspect of the trauma-informed approach. The stories that a community tells about itself are key to its identity, and to the identity of its members. Creating ways for the community as a whole to come together, to make sense not only of past and current traumatic events or challenges, but also to plan for the future, can support healing following a traumatic incident. This includes giving residents space to name their challenges and also identify solutions. Community-based planning needs to build on strengths; include opportunities for community ownership and leadership; take a phased

approach that builds on concrete, specific successes over time; and be sustainable.

Systems and services intended to help can re-traumatize. Trauma-informed best practices emphasize the importance of neighbourhood-level work to address pre-existing risk factors and toxic stressors, and to build individual and community resilience. They also point to the importance of effective post-incident response. CPO's Post-Incident Response Network Framework has many elements that are in keeping with trauma-informed principles. For example, it focuses on developing multi-level partnerships, clear communications, and targeted responses to incidents. The Framework gives communities a template to assist in identifying the range of partners, responsibility areas, and specific actions that are appropriate when responding to an acute neighbourhood incident. The Framework highlights the importance of good communication, including making sure that community voices and priorities are heard, and reflected back to community members, in a timely way. Finally the Framework is also clear about the need for post-incident responders to work with ongoing community development work that work with the community's strengths. The Framework could be applied using the principles of trauma-informed service delivery so that these principles are reflected across the system, and within its component organizations.

Introduction and Purpose

The *Ottawa Gang Strategy – A Roadmap for Action*[1] 2013-2016 is a holistic approach to gang violence. It focuses on the issues of healthy neighbourhood cohesion, early prevention, intervention and enforcement. Other community-based research has pointed to the need to better understand how neighbourhood trauma shapes community engagement and cohesion. This includes understanding both the ways in which services respond to neighbourhood traumas and the residents who live there[2], as well as the ways in which community members respond to these neighbourhood traumas.

In partnership with Crime Prevention Ottawa (CPO), Pinecrest-Queensway Community Health Centre (PQCHC) conducted research in four west end Ottawa Community Housing (OCH) communities on reactions to traumatic incidents at a neighbourhood level. The purpose of this research was to better understand how trauma affects residents' interactions with each other, with their neighbourhood, and with service providers. We also wanted to know how individual and neighbourhood level traumas interact. For example, does neighbourhood trauma aggravate trauma that occurred earlier in a person's life, or affect the residents' responses to neighbourhood trauma? What can service providers do to minimize the impact of neighbourhood trauma? And how can service providers grow resilience, wellbeing and connectedness at individual and community levels, knowing that many residents have experienced some type of personal trauma in their lives? Findings from this research suggest ways to improve systems-level responses to traumatic neighbourhood events, as well as to support healing and healthy development among residents and neighbourhoods.

Why is this Research Important?

This research was undertaken in response to ongoing violent incidents in neighbourhoods across Ottawa. Neighbourhood level trauma often occurs in response to an incident that affects a geographic neighbourhood, for example a murder or a shooting. In some neighbourhoods, these incidents are not one-time events. Instead, they are repeated, and become more of a 'continuous stressor' that can have complex, cumulative effects on those living in the affected communities, and surrounding areas.[3]

A growing body of research is looking at the connection between trauma and a range of health and wellbeing outcomes at the individual and group levels.[4] Holistic approaches like the one used in this PQCHC study look at the range of individual and contextual factors[5] (e.g. housing, food, education, employment). These factors affect not only individual-level outcomes (like addiction and mental health, high school completion), but also those at the group and

community level (like social cohesion and positive relationships).[6] Research into trauma, risk and resilience is also being used to examine the impact of *how* services and supports are delivered across a full range of health and social services sectors. There is a growing recognition that even with the best of intentions, systems and services can traumatize or re-traumatize.[7] In these sectors, researchers, clinicians and service providers are asking "What do trauma-informed supports look like?" They are applying a trauma-informed lens to assess the effectiveness of a wide range of services and supports, from community-based housing, to education, to health and social services.[8]

What Do We Mean By Trauma Practice?

For the purposes of this study, traumatic events are experiences or situations that are emotionally painful and distressing. They overwhelm a person's ability to cope, and leave them feeling powerless or out of control.[9] In this study, we use the term trauma to talk about a continuum of stressors. These include traumatic stressors due to life threatening, acute incidents; and toxic stressors that come from chronic, ongoing trauma.[10] Trauma can be a single event (shooting), or repeated events (ongoing domestic abuse). It can affect an individual, or a group (genocide). Trauma can also be passed down through generations (residential school survivors). According to The Trauma Toolkit, traumatic events have three things in common[11]:

> *It is not the event that determines whether something is traumatic to someone, but the individual's experience of the event and the meaning they make of it.*

- It was unexpected.
- The person was unprepared.
- There was nothing the person could do to stop it from happening.

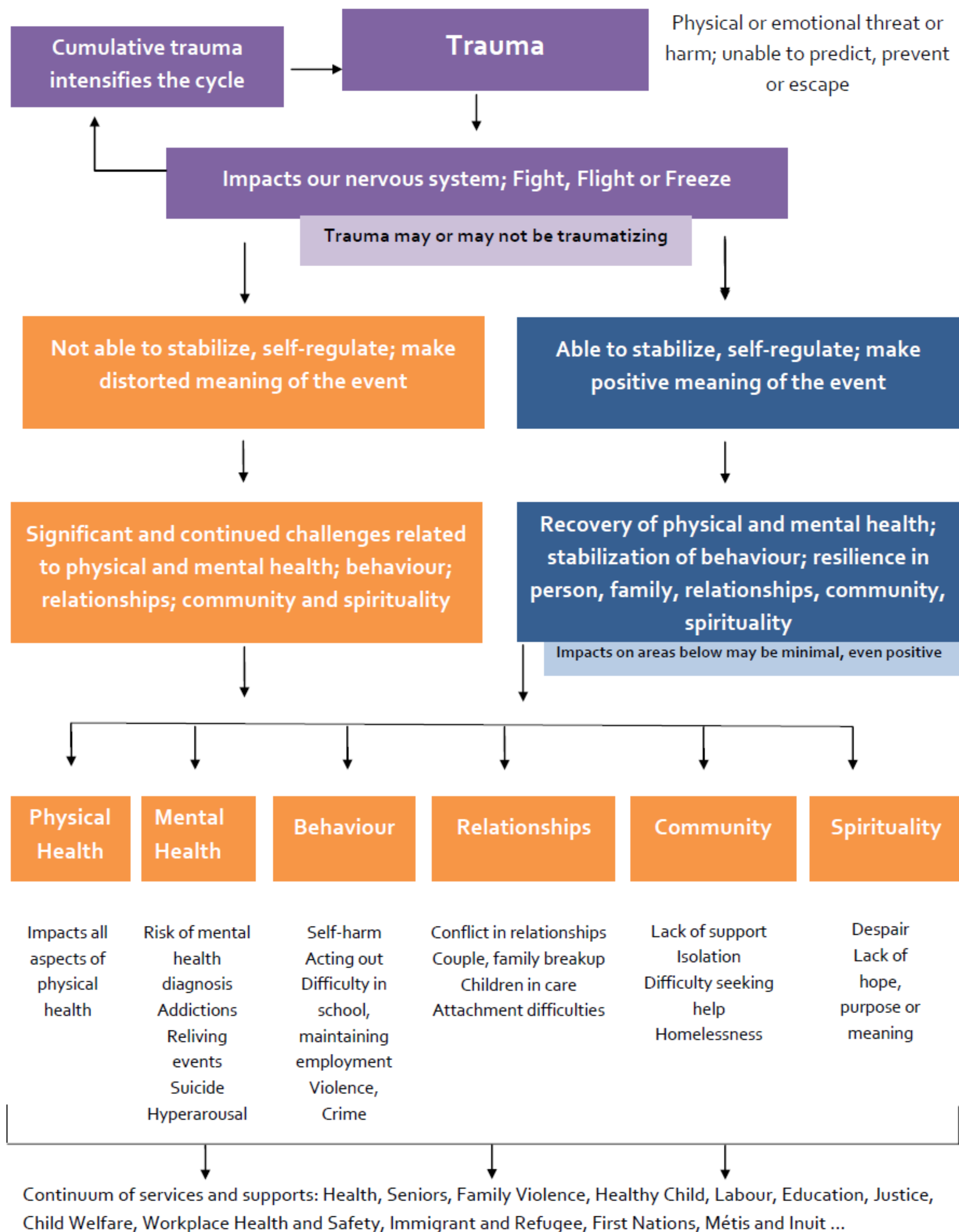
Not everyone who experiences a traumatic event will respond in the same way. Responses can be short or long-term, and vary in their intensity and severity. Stress reactions to trauma are "normal reactions to abnormal circumstances". Common responses to trauma can include:

- Physical: headaches, vomiting, disturbed sleep, rapid heart rate
- Mental: Confusion, flashbacks, poor memory, difficulty concentration
- Emotional: fear, anxiety, panic, numbness, shame
- Behavioural: avoiding reminders of the event, using substances to numb, losing touch with normal routines
- Relationships: difficulty forming healthy attachments, trusting others
- Spiritual: Cannot see a future, loss of hope, assume 'normal' life won't happen (education, job)[12]

Other people may feel shock or horror immediately following the same situation or incident, but given a supportive environment and healthy ways to process the event, they may not experience lasting effects.

Figure 1 below is modified from *The Trauma Toolkit*[13], and shows how individuals can respond differently to the same event. One person may experience the event as traumatizing with potentially longer-term, negative impacts, compared to another who may draw strength and develop personal resiliency following the same event.

Figure 1: Graphic of the Different Reactions to Traumatic Events



What is Trauma-Informed?

Trauma-informed practice (TIP) means bringing an understanding of past and current experiences of violence and trauma into all aspects of service delivery supports. One of TIP's main goals is to prevent re-traumatization of survivors of past trauma. The approach pays attention to the safety of both survivors and service providers, who can also be at risk for traumatization (called vicarious trauma) through their helping role. TIP includes opportunities for survivors to rebuild a sense of control and empowerment by offering them choice, and meeting them where they are at on their healing journey.[14] A trauma-informed approach can be put in place in any service setting or organization. It is *not* a specific type of intervention, treatment or technique. Incorporating a trauma-informed approach into a service does not mean that all providers must treat trauma, or that trauma even needs to be disclosed. It does mean that providers will approach their work with the understanding of how common trauma is among those they serve, and how it may show up in peoples' lives.[15]

In the context of supporting neighbourhoods affected by traumatic incidents, being trauma-informed means understanding that many of the behaviours that are often labeled as "risky" have their origins in personal trauma. This means that those who may be identified as perpetrators of violence or of other traumatizing events in a neighbourhood are also likely trauma survivors.[16] This happens when people adopt risky behaviours as a coping strategy following personal trauma, risky behaviours which can result in traumatic events which then ripple away from the individual into the community. Working from a trauma-informed approach can help ensure that critical incident responses, or the way that services in general are delivered, do not re-traumatize.

What do Trauma-Informed Services Look Like?

According to the Substance Abuse and Mental Health Services Administration (SAMSHA)[17], a "program, organization or system that is trauma-informed:

1. REALIZES the widespread impact of trauma and understands potential paths for recovery;
2. RECOGNIZES the signs and symptoms of trauma in clients, families, staff, and others involved with the system;
3. RESPONDS by fully integrating knowledge about trauma into policies and procedures, and practices;
4. Seeks to actively RESIST RE-TRAUMATIZATION."

Trauma-informed approaches acknowledge common connections between substance use and trauma by recognizing

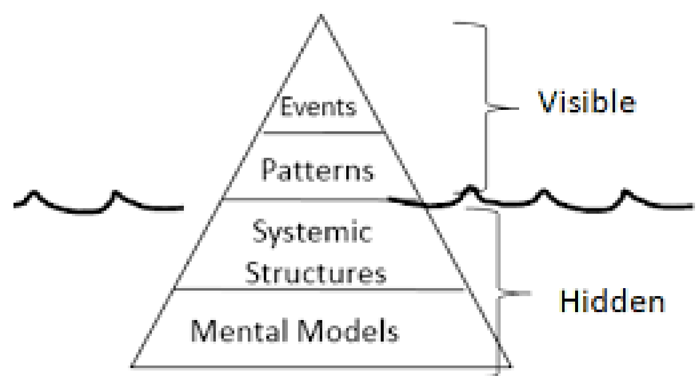
- the range of responses people can have
- that because of trauma responses, developing trusting relationships (engagement, retention, concentration. . .) can be difficult
- the importance of making adaptations in the setting to reduce re-traumatization and respond to awareness of trauma.[18]

What We Did and How We Did It

The study took a trauma-informed approach, including using a screening tool to determine participants' readiness to participate so as to minimize harm. We purposely did not reach out to the most isolated individuals. We worked with experts in the community to decide what to ask and how to ask it. The project was also guided by an Advisory Committee made up of PQCHC staff and other experts (see Appendix 1 for list of Members). We worked to keep all participants safe, and minimize the risk of harm. We also made sure that respondents could choose what questions to answer, and how much they wanted to share.
Four priority neighbourhoods were chosen from within the PQCHC catchment. All four had experienced multiple traumatic events within the last 12 months. To get to know the strengths and challenges of each neighbourhood, researchers interviewed 17 staff members working in the four neighbourhoods in the summer of 2015. Between August and November 2015, researchers interviewed 20 residents from the same four neighbourhoods. Service providers and residents interviewed are diverse. They live in different types of housing (apartment buildings and townhomes) and family groups (families, singles, seniors). Study participants also come from different cultural, linguistic, and religious backgrounds, and have experienced different kinds of trauma. For more information on our approach and methodology, ethical considerations, and sample, please see Appendix 2.

What We Heard

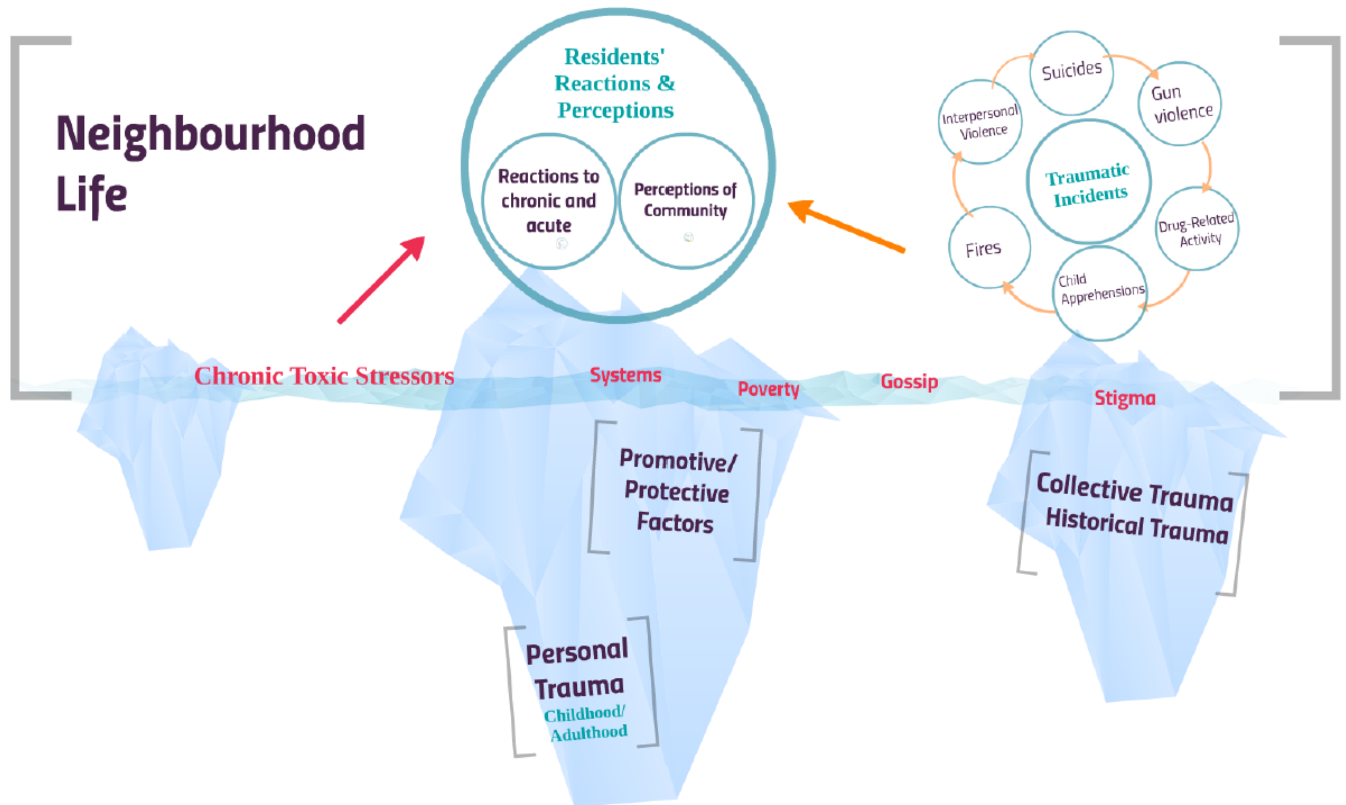
We use an Iceberg Model to help understand residents' reactions to neighbourhood and personal trauma. [19] The iceberg model reminds us that what we see above the water line – people's behaviours, interactions among residents, and even traumatic events – are an expression of beliefs, cultural values and systems that lie 'beneath the



surface'.[20] Most of the effects of trauma, just like an iceberg, are unseen and 'underwater'. Service providers see, deal with, and respond to what is on the surface, but most of what explains these behaviours is hidden below the water line.

This idea is captured well by one respondent: "*I think my neighbours have been through a lot of things – a lot of people are depressed, sick. You never know someone's story until you talk to them … people may seem happy outside but you don't know the hurts they are carrying.*"
Figure 2 below captures the main themes shared by residents. Similar themes were shared in interviews with service providers, and again in a focus group with residents who are community leaders.

Figure 2: Using the Iceberg Model to Show the Relationship Between Personal Trauma, Community Trauma, and Connectedness and Wellbeing



Perceptions of Neighbourhood: Belonging and Safety

Our "way in" to the interview was to ask people to share the first words that come to mind when they think about their neighbourhood; what are they proud of; and what makes them feel safe. When asked what words come to mind to describe their neighbourhood, the majority (16/20) highlighted community strengths, even while acknowledging the challenges of living in the area. Words used included: ups and downs, good and bad, multiculturalism, nice area, family, united and strong, activities, shopping, and "I can make a difference". A small number (4/20) had a different perspective, highlighting the negative atmosphere in the neighbourhood:"*It is a hard and tough neighbourhood [and we] don't wish to live here",* and "*It is sad – full of prostitution, drugs, people with mental illness and so on – people with very sad lives, people who are shunned and made fun of by those in charge*".

The vast majority of participants (18/20) could identify things that make them **proud**, including good programs, location (close to shops, transit), gardens, cultural diversity, and the Community House. People were also mentioned frequently, for example "*People are very supportive*", and "*Everyone helps out*". A couple of interviewees (2/20) had a difficult time identifying something they were proud of.

More than half (15/20) of our participants could identify some situations where they feel **safe** in their neighbourhood. Among these, typical responses included "*knowing that there are people around (so if there is a problem, they can help me*)"; people using public space; positive police presence; lighting; and cameras. Interestingly, respondents typically pointed to 'outsiders' as being the cause of incidents within the neighbourhood, with several (6/20) citing this fact as one reason why they continue to feel safe. Some (4/20) indicated that regular police patrols make them feel safer, although others had a different perspective, suggesting that more work needs to be done to develop a strong, positive relationship between police and residents (3/20).

One participant recounted an incident that brought a lot of media and police attention to her neighbourhood: "There was an uneasy feeling around the community. Police come over here and there, but not often enough to develop

a comfort…sometimes they play 3 on 3 basketball, sometimes come to events, but that's about it. I see fear in the kids when police come." Other respondents were more measured: "Sometimes yes I feel safe [but] sometimes no, it doesn't matter where you are, you don't have control over what is going to happen around you". A small number (3/20) indicated that while they have adapted to their neighbourhood, they never feel truly safe. For example: "People will never be able to understand who I was or what happened to me ; they don't even give me the respect of wanting to know, they just make their own assumptions. This is why I never feel safe. They just take my past, the hurt that I have, and drive it back into me – 'What a loser'. I already feel like that".

About half of respondents (11/20) know their neighbours and have friends. By contrast, a large minority know people well enough to say hello on the street, but do not trust anyone or feel close to any of these people (9/20). Difficulty trusting has been identified as a common challenge to community cohesion in trauma-impacted neighbourhoods.[21] Even so, most (18/20) indicated they are involved as volunteers in their neighbourhoods (including some who reported not trusting their neighbours), often through the Community House. Activities include belonging to the tenant circle, or volunteering at the food bank, with children and youth programs, and with various committees (soup club, gardening, decorations, BBQs, celebrations and so on). Almost all (18/20) had taken one or more capacity building trainings offered through PQCHC or other local organizations, including Safe People and United Neighbours Levers of Change (UNLOC).[22]

Of note, even those respondents who have a strong sense of belonging have adapted their behaviours to ensure their personal safety. For example, "[I] will even walk late at night, walking home – no one will bother me, although I do teach my children to always be smart and make good choices, including walking in pairs, and if they don't feel safe to walk home from the bus and I will meet them." In this way, both respondents who demonstrate a strong sense of connectedness, as well as those who are less connected, use similar (possibly subconscious) strategies to avoid putting themselves or their families at risk. A common strategy of living in the neighbourhood is expressed by this female respondent: "I feel safe when I do not get in people's business. I can talk and joke with people but I do not tell them what to do. Stay away from the drugs and violence and it stays away from you."

In summary, participants identify a number of community strengths and assets, while at the same time recognizing the challenges of living in their neighbourhood. Respondents frequently identify people from inside as one of their neighbourhood's greatest assets, pointing to individuals from outside of the neighbourhood as posing the greatest 'threats'. Finally, participants show the

different levels of connection that people can have in their neighbourhoods. The majority are connected to family, neighbours and service providers, a couple act as 'social connection' or hubs in their communities, and 3-4 are more isolated on the periphery.

Types of Traumas Reported

Because people respond differently in a given situation, in this study we defined a traumatic event as "… *experiences that might make some people feel unsafe, upset, scared or anxious*". We then asked people to name neighbourhood events or situations that were traumatic to them. Each neighbourhood had experienced its own set of traumatic events, with some having experienced a greater number of incidents. Participants living in their neighbourhood for longer naturally could recall incidents from farther back in the past. For some, there is the sense of a 'layering' of neighbourhood level traumas that have taken place over the course of a decade or more. For these respondents, the impact of these multiple incidents is almost 'baked into' the neighbourhood collective memory.[23]

Participants named the following kinds of traumas: suicide, illicit drug use and dealing, fires, gun violence, interpersonal violence (both domestic and non-domestic, rape), break and enters, home invasions, kidnapping, food insecurity, child apprehensions, infestations, racism, living with residents with significant mental health issues, and the daily stigma of living in poverty, including media portrayals of their neighbourhood. These reported traumas can be grouped into two main kinds: those that are related to an acute incident (with a clear beginning and end), versus those that are more chronic or

Table 1: Types of Traumatic Events

Type of Event	
Acute	Chronic
Shooting	Illicit drug use
Fire	Racism
Suicide	Food insecurity
Interpersonal violence	Poverty
Child apprehension	Child apprehension
Kidnapping	Interpersonal violence
Home invasion	Behaviours related to Mental Illness
Break and enter	Gossip
Discrimination	Infestations
Illicit drug use	Media Portrayals
System responses	System responses

persistent (those that recur so often, they become part of the backdrop). Some traumas may be both acute and chronic, depending on the individual and the context (see Table 1).

Some reported that system-level responses to a traumatic event can also be traumatizing (6/20). Examples included situations where violence in the neighbourhood triggered a large police presence over multiple days or weeks, during which time respondents didn't understand what was going on and felt 'out of the loop': "[After all of the shootings, there were] so many police, 10 cruisers every day, undercover cars. They were here to Serve and Protect, but made it more stressful in some ways. [We] didn't understand why they were there, in those numbers … [It] looked like military fort, which created stress as well."

Finally, other respondents (6/20) perceived that they had experienced unequal treatment from social service organizations or the media that they attributed to racism, the stigmatization of poverty, or other judgments. In the words of one respondent, the "biggest issue is being treated poorly by systems people: people make a lot of assumptions about [my] behaviour based on history instead of based on [the] present." A few (4/20) respondents commented on the unfair portrayal of their neighbourhood in the media, who too often "sensationalize the story. [They] knock on doors and ask questions without people even knowing they are being interviewed. They invade our space because they want a story". Comments about stigmatization through the media are in keeping with other research that has shown that media attention can be a double-edged sword: on the one hand it can help to bring attention to challenges in a community. On the other, it can serve to stigmatize community members, and have a negative impact on residents' perception of themselves, and of their community.[24]

Of all of the neighbourhood incidents mentioned, interviewers asked whether there was one type that really stood out. Responses varied from person to person, and most respondents named more than one type of incident. Overall, two types were mentioned most frequently: shootings and illicit drug use (16/20). The randomness of gun violence seems especially difficult to deal with, and the illicit drug use brings with it a number of other challenges (including violence, or the threat of violence). One respondent shared that "you never know if bullets are going to end up in our house". In contrast, interviewees' responses suggest they feel they can avoid some of the other incidents listed, often by minding their own business, and as a result feel less 'exposed' by them.

In addition to these traumatic incidents, a majority (11/20) also highlighted two types of chronic stressors as "standing out": the toxic effects of gossip, and the

'daily grind' of living in poverty and dealing with racism and systems that stigmatize. According to one, "[The] stuff related to suicides [is hard, and the] stuff related just to awful interactions and the 'climate' in the community – so much interpersonal conflict, [it's like] a soup we are swimming in." Another said "I am more concerned and afraid of being defamed or attacked for my character…it is easier to deal with physical attacks, I'm not afraid of that." Another respondent pointed to the attitude of systems: "There is a real attitude that stigmatizes people like me, living in poverty; instead of giving people the support they need, systems are quicker to act and punish, as opposed to support".

Several (7/20) interviewees pointed to the challenge of taking a lead in their neighbourhoods (e.g. being a Safe Person, chairing a committee), where power struggles between residents, personal attacks and gossip can be common. These individuals regularly use their conflict resolution and leadership training. But for some, the need to be constantly negotiating and problem solving wears them down, especially when they face personal attacks on an almost daily basis.

There is so much interpersonal conflict, [it's like] a soup we are swimming in…"

For example: "As a Safe Person I try to step in and help, then they turn on you […]We need more training on how to help ourselves – how to disconnect, how to bring your sense of safety and well-being back to an acceptable level. How to deal with people with disabilities, suicide, mental health issues, newcomers – we get lots of training to deal with other people's sh**, but not anything around feeling safe with yourself." Another respondent referred to the impact on her children of living with chronic trauma. For her, "the most difficult to deal with is what the children witness every day …. the kids know about the dead people falling out of windows […they] know too much too young".

Repeated exposure to the toxic stress of the interpersonal environment can lead to vicarious trauma among community leaders and service providers alike, who absorb parts of the traumatic stories that residents share with them as part of their helping role. Vicarious trauma then adds to the load that neighbourhood leaders are already carrying from their personal histories, or from their own direct experiences with neighbourhood traumas.[25]

For many respondents, the effects of toxic chronic stress were equally harmful to their wellbeing as traumatic neighbourhood incidents. However, given the context for this study, we focus on individuals' reactions to acute

neighbourhood traumas in the sections below, and include interviewees' insights related to the impact of chronic stressors where possible.

Responses and Reactions to Neighbourhood Trauma

People's reactions to traumatic neighbourhood events are complex. Some people may seem very controlled on the outside, but inside they are filled with turmoil. Other reactions are easier to see because people's behaviours change following an incident. We asked people to share both how they are feeling, and how they behave, after a traumatic neighbourhood incident. People reported a range of feelings immediately after, including anger, shock, fear, anxiety, sadness, grief and loss. Using Figure 1 above, we can group their emotional reactions first in two ways: those who saw themselves as having experienced an incident as *traumatizing*; and those who acknowledged that traumatic incidents occur in their neighbourhood, but they themselves do not feel that they have been traumatized.

Among residents, the vast majority (16/20) fall into the first group, and experienced neighbourhood incidents as traumatizing. For the more 'serious' types of incidents (e.g. shooting), many described feelings of anxiety and being on alert (11/20), and disrupted sleep. For parents of young families, they noticed more arguing among their children as a result of staying indoors. By contrast, only four of the twenty said that they did not feel traumatized by neighbourhood incidents, and as such didn't really react: "*I don't think I really reacted – I wasn't really involved. If [I] had been there, and witnessed it, or was walking down street, it could have been scarier*." A few reported that they didn't have an emotional response beyond feeling compassion for those involved directly (4/20).

Among the 16 who reported experiencing neighbourhood events as traumatic, all had experienced various kinds of personal traumas in their lives (some from childhood, some as adults). Following a neighbourhood incident, the neighbourhood-level trauma brings up, or intensifies, their personal histories of trauma. Typical behavioural reactions to personal trauma and neighbourhood incidents included: wanting to leave the neighbourhood; self-isolating and disconnecting from community involvement; coping through self-soothing (various methods); turning to their faith; and seeking to connect more with neighbours and community.[26] These different coping strategies are briefly described below.

Wanting to move out of the neighbourhood: About one third (6/20) of participants indicated they have requested a transfer to another neighbourhood in the past, or are currently on a waiting list (some for as long as 9 years). Most shared that they expected to find similar challenges in other OCH

neighbourhoods, but were willing to take the chance so that they could get away from their current situation. The reasons for wanting to move varied from person to person, but were all related to the experience of an acute traumatic event (e.g. target of an incident) or toxic stressors (e.g. racism, gossip) experienced in the neighbourhood.

Self-isolating and disconnecting: Self-isolating is a common response to neighbourhood events among respondents (10/20). For several (6/20), this reaction is connected to chronic toxic neighbourhood stressors, and specifically to the challenging interpersonal dynamic. In the words of one respondent, "*I hideaway and lock the doors and don't let anybody in. Lately I have been hurting with all the gossip in the community. The person I trusted the most was the one gossiping. I am going to quit [volunteering] because of the gossip, and I really enjoyed that. I've lost trust and don't share with anyone in the community… I almost feel like crying. Gossip is very damaging.*"

Several respondents (7/20) referred to the cumulative effects of neighbourhood and personal trauma to explain why they withdraw from the neighbourhood, and even from their volunteer responsibilities, after a neighbourhood incident. In the words of one respondent, "*Before I can forget about the last one, another one happens – it all just piles one on top of the other – until finally I feel like, I am done. I am going in my bed and I am not coming out for 2-3 days. I shut it down.*"

Self-soothing: This kind of reaction takes various forms among respondents (6/20), from using alcohol or drugs, food, television or movie watching, and getting outside and connecting with the natural environment. According to one respondent, "*I go to the garden and move my body and I don't come in until my muscles are hurting. I try not to talk to people when it is a bad day; solitude away from people is how I deal with a bad day.*"

Faith: Several respondents spoke at length about the role of Faith in their lives. Their spiritual connection is a touchstone that has allowed them to continue in the face of significant odds (6/20). For example, "*I go to Church on Sundays, I am spiritually working on myself, not that the church is doing it, but just listening to the words [is important…I am] just trying to connect with something larger*". Another respondent shared how her Faith connection has changed how she

manages both the present, and her past: "*I used to get depressed, but since I have found God, I turn to my Faith and that is how I manage [the challenges of living in my neighbourhood]. My Faith is a real source of positive energy in my life and allows me to manage my past in a much healthier way. Before, I would get suicidal; now, no*."

Connecting with community: Several respondents talked about their need to reach out for support right after an incident, and pointed to the positive effects a traumatic incident can have on the community immediately after (10/20). They talked about how residents come together to process and make sense of the event (e.g. participating in a memorial; seeking comfort at the Community House; more informal socializing with neighbours). In other situations, residents pull together to help those most directly affected (e.g. collecting donations of food, clothing, other necessities). Some step forward to take on a volunteer role within the community following an incident. One respondent talked about how opening her door to neighbourhood children has been a way for her to connect with others: "I build confidence in myself and my children by sharing my smile, myself, by opening my door to others."

In summary, respondents shared a range of different ways of coping with traumatic neighbourhood events that are commonly reported in research on trauma and resilience. Some of these ways of coping are healthier than others.[27] There is a clear difference in the impact of chronic toxic stressors compared to critical neighbourhood incidents on respondents' behaviours in their neighbourhoods. Specifically, chronic toxic stressors are cumulative, systemic, ongoing, and offer little in the way of a 'rallying point' or opportunity for residents to come together to connect.[28] In fact, their effect is quite the opposite, breaking down social connections and pushing neighbours apart. Traumatic incidents have the opposite effect, at least in the immediate term: they give residents a reason to come together, to find common ground, and to take positive action in the face of tragedy.[29] One respondent summed it up this way: "There are some who go inside and don't interact with others – they become isolated. Others, like me, stay connected to the wider community and manage the situation together, drawing strength from one another. In some cases events bring people out of their homes to the Community House, and then together they can mourn and deal with things."

What Helps to Explain Reactions

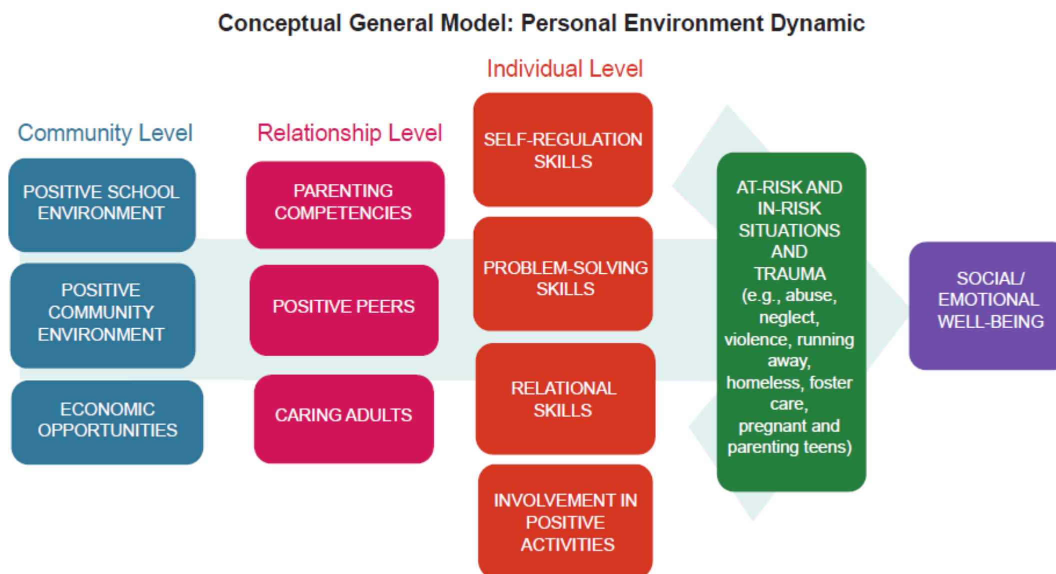
Participants often explained their reactions in relation to the type of traumatic incident (e.g. shooting, fire), whether there was a loss of life, and the extent to which they were directly involved in the incident. To understand the effect of traumatic neighbourhood events on how respondents behave with their family, neighbours, service providers or others, we also need to take a look 'below the

surface' of the water. In our study, we look at respondents' personal history of trauma; if they had access to protective factors[30] (e.g. strong social connections, access to health and social services, faith…); and whether the trauma is ongoing and cumulative.[31] Together these factors affect how someone reacts, how intense their reaction is, and how long it lasts.
There is a large body of research that explores the importance of protective factors. As expected, respondents with more of these protective factors in their lives tended to report a more moderate reaction to traumatic neighbourhood events, including not experiencing the event as traumatizing, as well as healthier coping.[32] These are discussed below.

Protective Factors

Trauma and resiliency research explores why people exposed to similar risks (or traumas) have different responses, with some showing resilience, and others following a more vulnerable path.[33] These protective factors are "conditions or attributes of individuals, families, communities, or the larger society that reduce or eliminate risk and promote healthy development and well-being of children and families."[34] Depending on the context, these factors can compensate for, or moderate, the negative effects of risks or traumas. These factors can be grouped into the individual level[35] (like genetic make-up, cognitive ability, sense of agency/autonomy); factors related to relationships (like competent parenting, caring interactions among family members, positive peers); and factors in the environment (like access to positive school or work environment, community supports, meaningful paid or volunteer work).[36] One way of grouping these protective factors is shown in Figure 3 below.

Figure 3: Protective Factors Conceptual Model[37]



Our interviews concentrated on factors at the level of the community or 'environment', and at the relationship level. In terms of community-level resources, very few respondents are employed, with at least half receiving some form of disability benefits. Youth involved in the study were all attending school (college or university) as well as working part -time, and in this sense can be seen to have access to a school environment; we do not know whether it is "positive".[38] A majority of participants are involved as volunteers, and a majority expressed some positive level of community attachment (discussed above). Several (8/20) pointed to the benefits of having participated in community-based workshops and training. For those who also act as neighbourhood leaders, these skill-building opportunities have helped them build confidence, and connect to their community in a positive way. More than one respondent mentioned that Safe People gave them ideas as to how to be personally safer, as well as how to manage conflict among fellow neighbours.

In terms of relational resources, a few respondents (3/20) can be described as socially isolated and having low relational resources, with at most 1-2 people in their lives whom they trust and can rely on. When asked to whom they turn following an incident in the neighbourhood, or when their own personal traumas are bubbling to the surface, this most isolated group said things like "*I cannot turn to anyone for help", "I stick to myself and block everybody out",* or *"I don't have any friends or family here".* One reported having friends and family, but being unable to rely on them for help because "*people are busy, and so am I – working, studying – they are in the same situation I am in.*" Another shared that her family relies on her for financial and other support, she cannot rely on them, a situation that was common to a few respondents (4/20). These respondents show how social connections can be double-edged: while they can provide much-needed help, there are also expectations that this help will be returned. This can be difficult for those who are already having a hard time making ends meet, and adds to their stress.[39]

A majority of respondents (12/20) identified both formal and informal sources of support, and said that they reach out to those people when there is an incident in the community, or when their own personal histories get to be too much. For example, "*I get a lot of strength from my family… I go to [PQCHC worker] if I need something more.*" Finally, a couple of respondents can be described as connectors in their communities. They are strongly connected to residents of different ages and backgrounds throughout their neighbourhoods. These individuals typically grew up with at least one stable, caring adult in their lives, be it a grandparent or other relative, and have many neighbours as friends. Having a caring adult as they were developing is one important protective factor that sets them apart from other respondents.[40] While these residents play

important roles in helping others, they are also quick to point out how well-supported they feel by their neighbours, and by formal service providers.

Other protective factors include individual characteristics. Although we did not use any standardized scales to measure these individual-level resources, responses suggest study participants have a range of capacities. A majority (13/20) can be described as having low to moderate levels of personal autonomy or mastery – or the belief that they can make a difference in their own lives, and in the lives of others.[41] For example, one respondent's comments suggest a sense of inevitability, and lack of capacity to imagine things can be better, let alone make things better: "Nobody is safe. Anything can happen to you at any point in time. I am a realist. Nothing is forever and no one is safe". Another respondent referred to the problem of "learned helplessness" among his neighbours, expressing frustration with the lack of respect that people show for one another, for property, for rules and processes.

By contrast, others displayed stronger levels of personal mastery or autonomy: "I can make a difference", and "I'm not going to stop living". Similarly, another participant's comments illustrate his capacity to take initiative: "When I got involved, I just saw a space and tackled it – I had a vision." Another credits her internal sense of direction to her faith in a higher power: "I believe in God, I love music and dancing. I don't drink and smoke. I always believe that tomorrow is always going to be better than today. [People] need something to believe in. Just to believe, you have to remain strong. It is not that sometimes I don't get down. Sometimes good things come out of bad stuff."

These responses are typical among survivors of trauma, especially in the immediate aftermath of a neighbourhood incident. Residents who normally feel safe are thrust into a sense of vulnerability. When this sense of vulnerability continues over time, people can begin to show the effects of traumatic and toxic stress in their lives, with potentially significant impacts on their health and wellbeing.[42]

Previous Personal Trauma

Several interviewees shared that traumatic incidents in the neighbourhood trigger memories, emotions, or other physical signs of their personal histories of

trauma. Words like "*it all bubbles to the surface*", "*I get flashbacks*", and "*I get nightmares*" were commonly used by these interviewees to describe how traumatic incidents in the neighbourhood stir up experiences from their past. For example,"*I had a very traumatic childhood – anything triggers it when I see cops in area". * And for another respondent, "*After I deal with all of their issues, I get disgusted with everything … They bring up hateful hurtful things about my past; I deal with their ugliness in the moment, and then all the stuff hits me about my past, and I shut down"*. The kinds of personal traumas disclosed by respondents included surviving war, personal sexual and physical abuse, addictions, violent death of family member, racism, migration and separation of family and friends, food insecurity and poverty. A few shared only that they had experienced "unspeakable things". Among interviewees, there was a strong connection between having experienced personal trauma earlier in life, and having difficulties relating to others in the neighbourhood following a traumatic incident.

By contrast, there were some interviewees who reported that they did not feel that neighbourhood traumatic events brought back personal experiences. Some explained that this was because they didn't have any previous trauma. Others noted that their experiences in the past were so different from the present, they did not feel triggered by neighbourhood incidents. For example, "*For me, I am able to compartmentalize – to feel grief, shock, sadness, concern – but I process it and move on. The shock has never been that great beyond the immediate; it has never really tapped my previous experiences because those were so different*". Others talked about having grown over the course of their lives, in spite of their difficulties and experiences of personal trauma. For one participant, traumatic incidents in the neighbourhood give him "*just an appreciation for how I have grown*", while another stated "*I grew up in poverty and grew up being a strong person. I brought this strength with me. I think this environment is easier than where I come from*". These comments suggest that these respondents have experienced traumas in their past, and in the process, developed personal resiliency that they are able to now draw on in the present.

Personal Trauma

Childhood/ Adulthood

war
poverty
racism
family violence
migration/separation
deaths
personal trauma
food insecurity
substance abuse
...

Indications of Heightened Vulnerability

Among study participants, we can draw some conclusions about those who may experience heightened vulnerability following neighbourhood traumatic events. Their reactions may be harder to see in the community, because they

may tend to isolate and withdraw from friends and community. These people may need different kinds of help, or more intense help, including referral to formal counseling services. This is especially true when someone falls into more than one of these groups:

- those who are socially isolated or disconnected (for example due to language, economic vulnerability);
- people living in apartment style/vertical housing, where residents are faced with many of the acute and chronic traumatic stressors in close proximity to their personal living space;
- people in neighbourhoods with a high concentration of persons with mental health and addictions issues: these individuals are at risk for multiple and ongoing exposure to interpersonal violence in particular;
- people exposed to acute and chronic stressors as children and youth, living in poverty as adults.

Residents' Suggestions for Change

As part of this project we asked participants to identify changes they would like to make in their neighbourhood, and the services or supports they would need to make that change happen. Not surprisingly, factors identified as traumatizing also featured in respondents' suggestions for improvement. The three most frequently identified changes were to:

- address the problems of addictions (e.g. impact of public dealing, litter that accumulates in areas of public use, deaths that result from overdose or violence attached to dealing, using);
- address the toxic interpersonal environment caused by gossip; and to
- improve the responsiveness of support services (namely security, policing, and housing).

Other changes identified by respondents focused on shifting people's attitudes, including getting them to think more positively about their lives, their fellow neighbours, and their community: "I would like to change the atmosphere – stop the whining, stop the complaining." Others highlighted getting people more involved in neighbourhood groups, specifically the Community House: "I want people to come out into the public space: people need to connect as human beings, but people are afraid to."

To make these changes happen in their neighbourhoods, respondents had several ideas, some of which involved building on efforts that are already in place. Their suggestions also mirror research into building resiliency. This research recommends a focus on building healthy attachments to self and others, attachments that are broken down by the effects of toxic and traumatic stress.[43]

Resident suggestions include:

- more community-based programming (fitness, arts – several longer term residents had the impression that there used to be more programs locally but these have been cut over the years)
- more activities for girls (the impression being that boys are well-served)
- more activities focused on young adults
- parenting programs
- periodic community-based employment assistance, ESL, and other employment-support services that are difficult for people to access on their own through public transit
- more opportunities for residents to get involved, make things happen, and take ownership.

The following are examples of the kinds of positive statements that many participants made as they reflected on their neighbourhood. While a small number couldn't think of any improvements short of moving to another neighbourhood, a majority (16/20) made comments like "on balance, this is a good place to live", or "The people here are good, the trouble comes from outsiders". A few (4-5/20) had a vision for where they want their neighbourhood to go, and identified healing from trauma as the key to their success as individuals, and as a community: "We need to focus on the roots: for community to be safer, we need to understand the issues with the parents – drinking etc. Each generation repeats itself if it's not healed."

The belief that there are community strengths that can be built upon was also a common theme. Strengths included individual residents, services and supports, the physical spaces of Community Houses, and Community House Leaders. What is most often missing is hope that they can have a future for themselves and their children.[44] In the words of one respondent, "There are many beautiful people with many skills. People need opportunities, a chance to do activities that are productive and that give them something to reach for, something outside of themselves to strive for. [They] need some acknowledgment of their worth. Recognition that they are capable is very powerful."

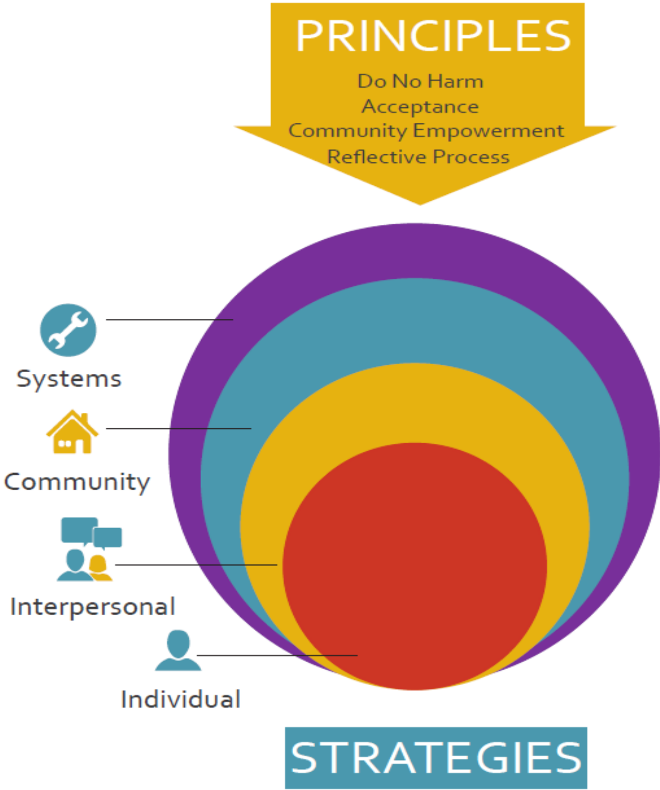
Conclusion and Considerations for Next Steps

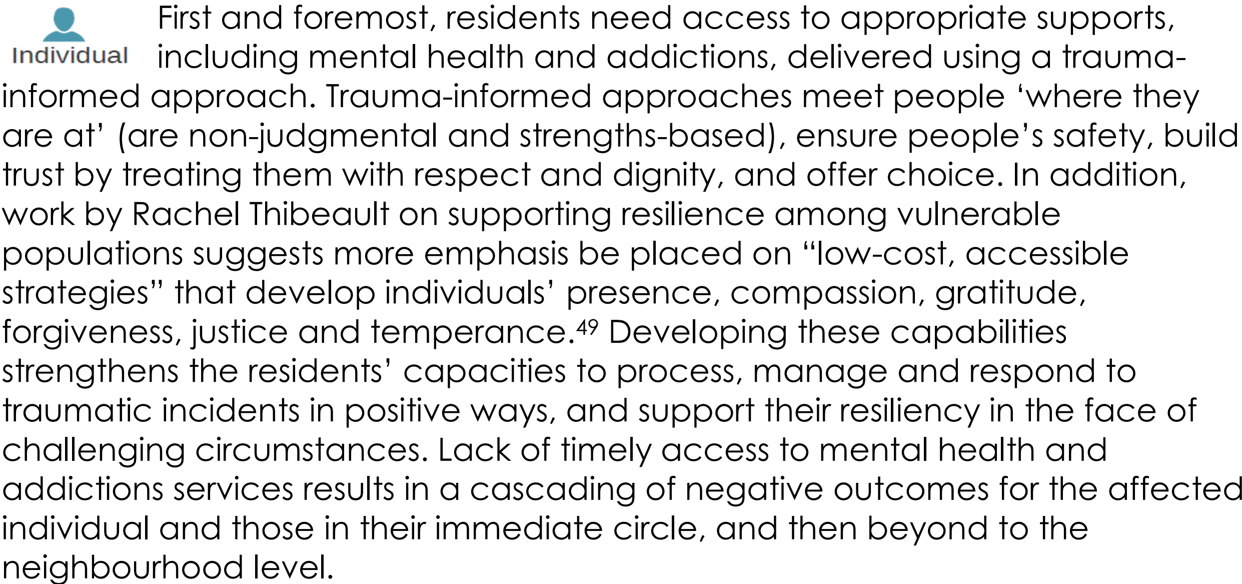
Best practices from post incidents speak to the need for all interventions to be trauma-informed and for stakeholders to work in partnership to identify and provide resources to those most at risk. As discussed, risk factors can be buffered by ensuring pre-existing resources – or protective factors – are in place. This can be done through ongoing trauma-informed community development work. Our research also points to the need for trauma-informed post-incident responses that address acute, immediate individual and neighbourhood needs, especially

targeting those who are most vulnerable and at risk. The post-incident response must draw on community strengths and resources that are part of ongoing community development activities (activities that use a trauma-informed approach). Both ongoing, longer-term community development activities, as well as immediate, short-term post-incident responses, are needed to support residents in trauma-affected neighbourhoods.

Taking a trauma-informed approach does not mean treating trauma directly. It is about creating safe, welcoming and inclusive spaces that acknowledge individuals' special needs. Being trauma-informed means understanding the ongoing impact that trauma may have in shaping people's lives, and in shaping community relationships. Working from this place when responding to acute incidents minimizes the risk of re-traumatization, and helps to ensure that individual needs are met immediately, as well as in the medium and longer-term. Using a modified diagram from *Trauma-Informed Community Building*, we can see the various levels at which the trauma-informed approach works: Individual, Interpersonal, Community, and Systems (see Figure 4 below).[45]
The issue of neighbourhood violence and trauma is complex, and calls for a coordinated, collaborative, multi-partner response.[46] To be successful, the work of residents and local service providers to build individual resiliency and community cohesion needs to be supported by policies and programs at the municipal, provincial and federal levels. Interventions must also be purposeful and targeted, and build capacity at all four levels.[47]

Figure 4: Trauma-Informed Community Building: A Model for Strengthening Community in Trauma Affected Neighbourhoods[48]





First and foremost, residents need access to appropriate supports, including mental health and addictions, delivered using a trauma-informed approach. Trauma-informed approaches meet people 'where they are at' (are non-judgmental and strengths-based), ensure people's safety, build trust by treating them with respect and dignity, and offer choice. In addition, work by Rachel Thibeault on supporting resilience among vulnerable populations suggests more emphasis be placed on "low-cost, accessible strategies" that develop individuals' presence, compassion, gratitude, forgiveness, justice and temperance.[49] Developing these capabilities strengthens the residents' capacities to process, manage and respond to traumatic incidents in positive ways, and support their resiliency in the face of challenging circumstances. Lack of timely access to mental health and addictions services results in a cascading of negative outcomes for the affected individual and those in their immediate circle, and then beyond to the neighbourhood level.

Residents also need opportunities to develop interpersonal capacities, including to build trust and social connections. Residents impacted by personal trauma may cope by isolating themselves in response to neighbourhood traumatic events – a response that also cuts them off from positive supports that may be available in the community. Creating opportunities for residents to see healthy behaviours being modeled by community leaders; positive peer to peer relationships; and group activities that allow residents to share, make sense of the traumatic event, and to offer and receive support, are all examples of how a trauma-informed approach can be applied following a neighbourhood traumatic event.

Just as individuals need opportunities to make sense of events, and to grow their resiliency, similar opportunities are needed at the neighbourhood or community level. Giving communities ownership and control over how they are perceived, to name their challenges and also identify solutions, is a central aspect of the trauma-informed approach. The stories that a community tells about itself are key to its identity, and to the identity of its members. Creating ways for the community as a whole to come together, to make sense not only of past and current traumatic events or challenges, but also to plan for the future, can support healing following a traumatic incident. Such community-based planning needs to build on strengths; include opportunities for community ownership and leadership; take an incremental (or phased) approach that builds on concrete, specific successes over time; and be sustainable.

Systems and services intended to help can re-traumatize. Trauma-informed best practices emphasize the importance of neighbourhood-level work to address pre-existing risk factors and toxic stressors, and to build individual and community resilience. They also point to the importance of effective post-incident response. CPO's Post-Incident Response Network Framework has many elements that are in keeping with trauma-informed principles. For example, it focuses on developing multi-level partnerships, clear communications, and targeted responses to incidents. The Framework gives communities a template to assist in identifying the range of partners, responsibility areas, and specific actions that are appropriate when responding to an acute neighbourhood incident. The Framework highlights the importance of good communication, including making sure that community voices and priorities are heard, and reflected back to community members, in a timely way. Finally the Framework is also clear about the need for post-incident responders to work with ongoing community development work that work with the community's strengths. The Framework could be applied using the principles of trauma-informed service delivery so that these principles are reflected across the system, and within its component organizations.

Appendix 1: List of Advisory Committee Members

Sharmaarke Abdullahi, Business Consultant, Crime Prevention Ottawa
Steve Clay, Community Development Manager, Ottawa Community Housing Corporation
Robynn Collins, Project Coordinator, UNLOC (United Neighbours/Levers of Change), Community Health Worker, Pinecrest-Queensway Community Health Centre
Tammy Corner, Health Promoter, Pinecrest-Queensway Community Health Centre
Sylvio (Syd) Gravel, M.O.M., Staff Sergeant (ret'd.), Ottawa Police Service, Co-Founder of Robin's Blue Circle, Ottawa Special Advisor, Peer Support Services, Mood Disorders Society of Canada
James Hicks, Researcher, SP Consulting
Gillian Keefe, Coordinator, Community Development Framework
Fran Klodawsky, Professor, Department of Geography and Environmental Studies, Carleton University
Ahmad Luqman, Tenant and Community Workers, Ottawa Community Housing
Dawn Lyons, Interim Program Director of Community Health, Pinecrest-Queensway Community Health Centre
Stephanie Potter, Principal Investigator, SP Consulting
Yacouba Traore, Executive Director, Rideau-Rockliffe Community Resource Centre
Donna Watson-Elliott, Manager Ottawa Police Victim Crisis Unit
Bessa Whitmore, Professor Emerita, School of Social Work, Carleton University

Appendix 2: Approach and Methodology

Ethics and Risk Management: How we took a Trauma-informed approach

Specific protocols were put in place to minimize the risk of re-traumatization, and to support participants who might feel the need for assistance in the days following the interview. Recruitment was done by a PQCHC staff member. This staff member used a recruitment grid to ensure that an appropriate cross-section of the community (gender, age, cultural and racial diversity) was included in the interviews.[i] Pre-screening conversations were done using a Trauma Screening Questionnaire to ensure that respondents were well-supported and ready to participate. Each respondent was provided with a list of resources at the end of the interview that they could contact if they needed. The next day, PQCHC's System Navigator followed up with each respondent to see how they were feeling, and whether they needed to be connected to any supports. Researchers also debriefed with the PQCHC staff member following each interview: this ensured that the researchers themselves received support,

and also served as an important communication mechanism to share any specific needs or concerns identified by residents in the interview.
In addition, interviewers never asked respondents to describe their personal trauma. Instead, we framed the conversation through events that occurred in the community; explored people's reactions to those as traumatic events; and then asked whether following these neighbourhood level incidents, people noticed feelings, memories, or other reactions attached to earlier life experiences bubbled up to the surface. In this way, interviewers "opened the door" to residents who wanted to share their personal traumas, but left it up to participants to determine if they wanted to walk through. Even among those residents who said that neighbourhood events triggered reactions to their own personal traumas, not every respondent went into detail as to what those traumas were. In the words of one respondent, "I survived unspeakable things earlier in my life", and for some participants, this was a detailed as they wished to be.

Description of Respondents

Description of Four Neighbourhoods: Respondents were drawn from four priority neighbourhoods within the PQCHC catchment area. All identified neighbourhoods had experienced multiple traumatic events within the last 12 months. Neighbourhood selection was designed to obtain a sample of residents who reflect a diversity of lived experiences, including different housing types, family composition (families, singles, seniors), cultural, linguistic, and religious backgrounds, among others.

- Neighbourhood 1: Comprised of 3,4 and 5 bedroom townhouses catering to families. Well-situated near green space, close to shopping and transit. Multi-cultural population.
- Neighbourhood 2: Comprised of 1 bedroom apartments in high-rise style catering to singles or couples. Well-situated near green space, close to shopping and transit.
- Neighbourhood 3: Comprised of 2, 3 and 4 bedroom townhomes catering to families. Situated close to shopping and transit. Multi-cultural population.
- Neighbourhood 4: Comprised of 3, 4 and 5 bedroom townhomes, as well as 2 and 3 bedroom apartment-style units. Situated close to shopping and transit. Multi-cultural population.

Description of Service provider Sample: We interviewed a total of 17 service providers, including three Community House Coordinators; two Community Health Promoters; three Multicultural Case Managers and one System Navigator; three staff from Ottawa Community Housing; three Pathways Staff ; and two staff associated with Safe People and UNLOC projects. Interviews were conducted to give researchers a grounded understanding of the issues in each neighbourhood from multiple perspectives. Interviews with service providers were also used to identify potential areas for exploration with residents, and to get advice and guidance on how best to engage residents. Like the sample of residents, the service providers interviewed reflect a diversity of lived experiences, including different demographic characteristics (age, gender, cultural, linguistic, and religious backgrounds), professions, and lived experiences of trauma (detailed table not shown).

Description of the Resident Sample: A total of 20 interviews were completed across the four neighbourhoods, with close to even representation across all four communities. The demographics of the full sample are briefly summarized in Table 2.

Table 2: Summary Demographic Characteristics, Resident Interviews

Characteristic	Category	N
Gender	Female	15
	Male	5
Age	18-24	4
	25-54	11
	55+	5
New Canadian	1st Generation	6
	2nd Generation	4
	NA	10
Visible Minority	Yes	11
	No	9
Disability	Yes	11
	No	9
Dwelling Type	Apartment	7
	Townhome	12
	Single Family Homes	1
Length of Time in Neighbourhood	Average	9 years
	Range	2-20+ years
Employment Status	Full Time	4
	Part Time	4
	Unemployed	12
	TOTAL	20

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Endnotes

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[1] Crime Prevention Ottawa (2013).
[2] Most recently, like numerous other municipalities, CPO has funded the development of a trauma response protocol to support first responders, and communities, in the aftermath of critical incidents – see Draft Post-Incident Neighbourhood Response Network – Framework produced by Rideau-Rockliffe; in Toronto, see their Community Crisis Response Program City of Toronto (2008).
[3] E.g Benjamin and Crawford-Browne (2010); Stoddard et al. (2013); Samuels-Dennis, Ford-Gilboe, Wilk, Avison, and Ray (2010); Collins et al. (2010).
[4] These are often referred to as resilience studies in Canada, for example the work led by Ungar (2010) at Dalhousie University (2010); and researchers at McGill's ICIHRP (2010).
[5] Known in the population health literature as the social determinants of health: Mustard (1991); Federal Provincial and Territorial Advisory Committee on Population Health (1999). E.g. Ungar (2005a); Ungar (2005b); Center for Substance Abuse Treatment (2014).
[6] For example, the Truth N' Trauma Project at Chicago State University, Harden et al. (2015); Johns et al. (2012).
[7] Wilson, Pence, and Conradi (2013).
[8] For example in St Louis, the Alive and Well St. Louis initiative: http://www.stlrhc.org/work/alive-well-stl/; in San Francisco, Weinstein, Wolin, and Rose (2014) and the National Center for Trauma-informed Care (NCTIC) http://www.nasmhpd.org/content/national-center-trauma-informed-care-nctic-0; Ferencik and Ramirez-Hammond (2010); St Michael's Hospital Centre for Research on Inner City Health: http://www.stmichaelshospital.com/crich/projects/traumainformed/.
[9] See for example Klinic Community Health Centre (2013); Arthur et al. (2013).
[10] See writings by Bloom (2013), Shonkoff et al. (2012), Shonkoff, Boyce, and McEwen (2009), Moskowitz, Vittinghoff, and Schmidt (2013).

[11] Klinic Community Health Centre (2013).
[12] The full range of responses is very individual, and complex. For more information see e.g. Center for Substance Abuse Treatment (2014).
[13] Klinic Community Health Centre (2013, p. 14).
[14] See British Columbia Centre of Excellence for Women's Health (2011); Poole (2013); Substance Abuse and Mental Health Services Administration (2014); Bloom (2013).
[15] Arthur et al. (2013).
[16] Canadian Centre on Substance Abuse (2014); Poole (2013).
[17] Substance Abuse and Mental Health Services Administration (2014).
[18] Poole (2013, p. 5).
[19] Iceberg Model originally from Goodman (2002); Figure from Monat and Gannon (2015, p. 18).
[20] See for example Social Prosperity Wood Buffalo (2015).
[21] Klinic Community Health Centre (2013); Weinstein et al. (2014); Center for Substance Abuse Treatment (2014)
[22] In part this is a result of our sampling process: PQCHC staff started with residents who they felt would be capable of safely participating in the interview, which naturally drew them to invite residents who also have leadership positions in their respective neighbourhoods.
[23] E.g. Atkinson, Nelson, and Atkinson (2010); Collins et al. (2010).
[24] The National Center for Victims of Crime (2012).
[25] Bloom (2013), Shonkoff et al. (2012), Shonkoff et al. (2009).
[26] In fact, one person might have had some or all of these reactions, depending on how long they have lived in their neighbourhood.
[27] E.g. Hajer and Walsh (2005); Gurwitch, Pfefferbaum, Montgomery, Klomp, and Reissman (2007); Collins et al. (2010); Klinic Community Health Centre (2013); Canadian Centre on Substance Abuse (2014); Thibeault (2015); Ungar (2015).
[28] The National Center for Victims of Crime (2012).
[29] The National Center for Victims of Crime (2012).
[30] In this report, we will use the simplified term 'protective' to talk about highly complex risk-resilience processes. The resilience literature refers to 'promotive and protective' factors to distinguish between factors that can support a person's healthy development *outside of* a traumatic incident, versus those protective factors that interact with risk or trauma to lessen the negative outcome for the individual. For additional reading, see for example Center for the Study of Social Policy (2012);Day and Wanklyn (2012); Zimmerman et al. (2013); Ungar (2015).
[31] E.g. Pearlin (1989); Turner and Lloyd (1995); Public Safety Canada (2008); Stoddard et al. (2013); Samuels-Dennis et al. (2010); Saul (2013); Shamai (2015).
[32] Ungar (2013); Bloom (2013).

[33] See for example Furlong, Sharkey, Quirk, and Dowdy (2011); Child Welfare Information Gateway (2015); Ostaszewski (2012); Zimmerman et al. (2013); Stoddard et al. (2013).
[34] US Department of Health Human Services (2015).
[35] This study didn't use any standardized scales to measure those elements within the "Individual Level"; where possible interviewers refer to respondent statements as evidence of the presence of some of these factors.
[36] See for example Child Welfare Information Gateway (2015); Hui and Barozzino (2013); Bloom (2013).
[37] Child Welfare Information Gateway (2015, p. 4).
[38] Furlong et al. (2011).
[39] Moskowitz et al. (2013).
[40] See for example Ungar (2011) and Bloom (2013) who draw on (among others) the work of Bronfenbrenner (1979) to understand the multidimensionality of the resilience process, in this case specifically the importance of positive attachments.
[41] E.g. Masten and Garmezy (1985); Luthar, Cicchetti, and Becker (2000); Luthar (2006).
[42] E.g. Bloom (2013).
[43] Thibeault (2015); Haskell and Randall (2009); Shonkoff et al. (2012); Ungar (2013).
[44] This knowledge is also core to the healing approaches advocated for use with various at risk populations, from Aboriginal survivors to newcomers to Canada: e.g. Thibeault (2015); Haskell and Randall (2009); HeavyRunner and Marshall (1997); Klinic Community Health Centre (2013); Weinstein et al. (2014).
[45] This section uses the framework described in Weinstein et al. (2014, p. 13) to the specific case of how to apply a trauma-informed approach to the issue of neighbourhood trauma.
[46] Kania and Kramer (2013).
[47] Weinstein et al. (2014).
[48] Adapted from Weinstein et al. (2014, p. 13).
[49] Thibeault (2015).
[l] Brewin et al. (2002).

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