Chapter

Violence: A Prescription of Hope for a Vulnerable Population

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Abstract

Violence is a preventable disease that has long term effects on health. In the United States, violence has become an epidemic that disproportionately affects the African American community. Risk factors that contribute to the perpetration of youth violence include a combination of individual, relationship, community, and societal factors. Individual risk factors include a personal history of victimization of violence, high emotional stress, and exposure to violence and conflict. Family risk factors include low parental education, low income, poor family functioning and low parental involvement. Community risk factors include diminished economic opportunities, high concentration of poor residents, and socially disorganized neighborhoods – all of which are prevalent in communities with high rates of violence. Preventive strategies aimed at reducing violence need to be collaborative and community based. This multi-city project, A Prescription of Hope, aims to educate community members from Illinois and Missouri on the long- term effects of exposure to violence. The target population for Missouri is Ferguson, a small community with an approximate population of 21,035 (2017); however, it is recognized nationally for the demonstrations and unrest that erupted after the August 9, 2014 shooting death of 18-year-old Michael Brown. Worldwide, an estimated 200,000 homicides occur each year among youth aged 10–29 years, accounting for 43% of all homicide annually.

Keywords: Violence prevention, youth violence, health disparities, faith-based community intervention, youth mentorship

1. Introduction

Exposure to violence has long-term implications for mental, physical, and emotional health and wellbeing. In the U.S., individuals that experience high levels of violence face increased risk of mental health and behavioral disorders such as depression, posttraumatic stress disorder (PTSD), personality and conduct disorders, anxiety, sleep and eating disorders, substance abuse, and suicide and suicide attempts [1]. Injuries and violence are the leading causes of death among children, adolescents, and young adults in the U.S., and disproportionately affect young people of color [2]. The epidemic of gun violence in the United States claims thousands of lives every year [3]. During 2015–2016, the U.S. Centers for Disease Control and Prevention (CDC) reported a total of 27,394 firearm homicides, including 3,224 (12%) among persons aged 10–19 years [3].

Across the U.S., systemic inequities make some communities more vulnerable to violence than others. Studies show males, ethnic minorities, and urban residents

are at increased risk for witnessing violence [4]. At the societal level, high levels of income inequality, structural disadvantage and racism contribute to the perpetration of multiple forms of violence [1]. African Americans and Hispanics are more likely to be victims of violent crimes than are Caucasians, and African Americans are disproportionately victims of homicide compared with Caucasians or Hispanics [5]. Those from low-income households are also much more likely than others to experience violent crime [5].

Addressing violence at the community level is often complicated by a lack of trust between at-risk members of the community and the criminal justice system. The U.S. has a much higher rate of police homicide compared to other high-income countries, with an estimated 1,000 civilians killed annually [6]. Studies have shown police officers are likely to use more force with African American civilians than Caucasians, and African Americans are three times as likely to have their cars searched by a police officer during a stop [7]. Biased policing harms historically disadvantaged groups, and disproportionately subjects racial and ethnic minorities to suspicion, surveillance, and intrusion that can have deadly consequences [7].

In recent years, several high-profile police killings of unarmed Black men have put a media spotlight on police brutality and racialized policing. The killing of 18-year-old Michael Brown in Ferguson, Missouri on August 9, 2014 set off a wave of national protests and demonstrations against police brutality. The militaristic police response included the dispatch of rooftop snipers, police dogs and military vehicles, and tear gas that was widely used on protestors. Ineffective communication and coordination across the 50 law enforcement agencies involved in the protest response exacerbated the already weak relations between the Ferguson and St. Louis communities and the local police.

The violence during the Ferguson protest occurred in a "sociopolitical context of long-standing racial, economic, and societal disparities" [7]. Historically, these disparities have contributed to the high violence and crime rates in Ferguson and beyond. Missouri is among the states with the highest firearm mortality rates [8]. Data gathered by the Mayor's Office in 2012 showed that the city's firearm death for youth was more than three times the national rate, and the St. Louis metro area was ninth in the nation for the number of youth murdered by guns [9]. Almost half (46%) of all victims are under age 25 while over half (51%) of all suspects are believed to be under age 25 [9].

The citizens and police officers involved in the protests had an extensive history of prior trauma exposure, increasing the risk for negative mental health outcomes [10]. Exposure to violence has a unique impact on youth, who are in critical stages of physical, emotional and mental development. Youth exposed to community violence exhibit increased rates of aggression and high-risk behavior, with the neighborhood having a significant influence on violent behaviors [11]. Neighborhood disorganization in conjunction with individual level exposure to violence has a measurable effect on trauma symptoms among youth [12]. Exposure to trauma is also linked to increased risk of PTSD, which manifests differently in youth and adults [13]. Research on PTSD among youth indicates that there can be long-term biological alterations produced by exposure to trauma, including increased heart rate, elevated or lower cortisol levels, and chronic sleep disturbance [4].

2. Wicked problem impact project (WPIP) description

Violence and trauma are separate yet connected complex problems with complicated risk factors. The interconnectedness of the two presents even greater challenges and is confounded by several variables. Many treatment programs

and interventions targeting youth offer effective interventions, but often fail to consider the community context [11]. Initial formative research and interactions with the community illustrated a lack of role models and indicated a population of youth with no fear of death and dying. Our team wondered why this was occurring. What caused the disconnect? We wanted to look at ways to tackle bridging the gap between the community and law enforcement. From this early formative discovery, we agreed that a faith-based program with an emphasis on mentorship would be beneficial to this particular population. Engaging with the community in the planning and implementation of this project ensures that the project will appropriately address the needs of the community and be impactful long after conclusion of the project.

This project, A Prescription of Hope, was developed with the intent to promote awareness by educating community members on the effects of violence on health and was initially led by a two-person team consisting of a public health nurse (TS) and a pharmacist. It was also informed by the understanding that social support is a protective factor for youth exposed to trauma and violence. Studies show social resources, including relational support, neighborhood cohesion, and neighborhood satisfaction contribute to mental health resistance and resilience following trauma exposure [14]. Youth mentoring, after-school programs, and the involvement of community faith-based organizations have been proven to be valuable sources of support for youth in communities impacted by violence. This project intended to capitalize on those findings and implement similar strategies in local at-risk communities in Ferguson, Missouri.

3. Methods

3.1 Motivation

Initial inspiration for this project stemmed from the tragic death of Michael Brown, an 18-year old African American male who died in a police shooting at the hands of a 28-year old white officer in Ferguson, Missouri. As a nurse (author TS), a native of St. Louis, and a mother of three African American boys, the incident impacted me on a personal level. I had the unfortunate experience of viewing this young man's body lie in a street very familiar to me for up to four hours. I felt helpless and could not erase the memories of what I had witnessed. As with many who live in the city of Ferguson, this situation began to negatively impact my daily work, my communication with other people, my sleep, my eating habits, and more. Reflecting on my own response to the event, I began to think of the young adults reliving the trauma daily, and the residual effects that this incident would have on the community.

The idea for this project emerged through connecting with my colleague, Dr. Lachell Wardell. We had a shared vision for community-based models of healing the trauma being suffered by the local population--wounds that were magnified by the daily re-traumatizing exposures portrayed in the media. Our vision for our Clinical Scholars Wicked Problem Impact Project encompassed solutions to assist the youth in coping with the aftermath of the riots and violence and implement ways to prevent future generations from becoming victims or perpetrators of violence.

Knowing that no single approach could solve the myriad problems facing the community, we narrowed our focus and set our sights to target our priority objectives. Our priority objectives were faith-based (Faith, Love, Hope, and Resilience), meaning showing love to one another, promoting hope, and fostering examples of resiliency. The education component of the project was designed to include

peer-to-peer engagement, scenario-based skits that promote healthy life skills, and addressing anger management, conflict resolution and coping skills. We named this project A Prescription of Hope.

3.2 Planning

Planning process for our project encompassed four primary components: formative research, the development of an advisory board, engagement of community stakeholders, and networking and building partnerships. At the end of the first year of implementation, the project leads decided to diversify our focus through a project phase we called "A Tale of Two Cities", with one arm active in the Ferguson community and the other active in the Chicago, Illinois area. This chapter focuses solely on the Ferguson branch of A Prescription of Hope.

3.2.1 Formative research

Parents and youth were recruited through local schools and Believers Temple Word Fellowship Church (BTWF) in St. Louis. We made announcements to the BTWF congregation about the program, and got permission to distribute flyers to members and leave them in the lobby. Believers Temple has a building separate from the main sanctuary for youth, where we were able to speak to youth directly about the program. We were also granted permission from elementary, middle and high schools in the Ferguson school district to send flyers about the program home with students.

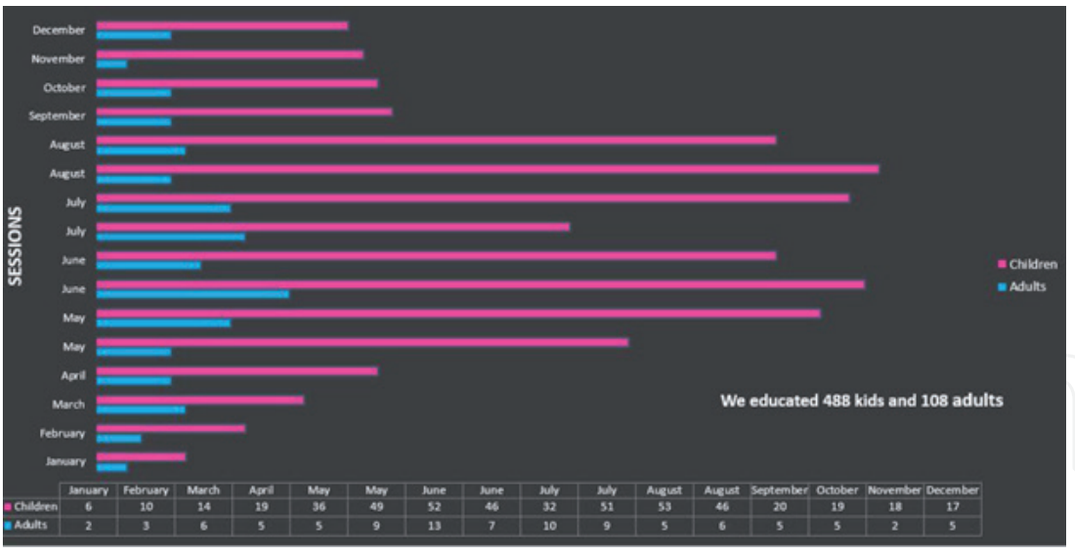
We targeted youth between the ages of 10–18, initially focusing just on youth who lived in Ferguson, but later expanding to include neighboring communities. We requested that participants commit to a minimum of 75% of sessions over the 12-week project period.

Once we had recruited participants, we gathered formative data through interviewing parents (n = 108) who volunteered to share concerns regarding their child's behavior, friends, and issues at school or in the community. These interviews helped to gage parents' beliefs and immediate needs, guided what resources were needed, and built trust between parents and program directors. After receiving parental consent for all youth participants, we further surveyed each child that attended the educational and mentoring sessions at the start of the program (n = 478). The Developmental Assets Profile (DAP) served as our survey tool. This assessment consists of 58 questions that aim to measure the internal strengths and external supports that influence a youth's success in school and in life [15]. Data collected through the DAP assessment showed us which children were being affected directly or indirectly by violence and allowed us to tailor direct support to those in need.

The program was implemented through monthly sessions, with multiple "cohorts" participating in the program over a year. In the summer, we held two sessions per month which yielded increased participation (**Figure 1**). Small groups were 10 participants with one mentor/facilitator. Participants were divided based on the number of youths that were present at any given session.

The program included the implementation of a 12-week curriculum, which was developed to be interactive and engaging. A total of eight adult volunteer facilitators led group activities with the youth, which included scenario-based games, role plays, speaker presentations, field trips, and other activities.

The curriculum centered on the four core values of faith, love, hope and resilience, with each module involving unique peer-to-peer activities in group settings. For the faith module, we explored belief systems, moral systems, perceptions of right and wrong, and making good, conscious choices. In the love module, we



	January	February	March	April	May	May	June	June	July	July	August	August	September	October	November	December
Children	6	10	14	19	36	49	52	46	32	51	53	46	20	19	18	17
Adults	2	3	6	5	5	9	13	7	10	9	5	6	5	5	2	5

Figure 1.
Youth mental health screenings.

facilitated activities and conversations that centered on compassion, giving back to the community and working together. This module included a field trip to a homeless shelter where the youth participants volunteered. In the hope module, we created vision boards, did affirmations and positive self-talk work, and conducted self-esteem and confidence building exercises. In the final module, resilience, we focused on conflict management, coping, building strengths, and strategies for putting the components into the curriculum into action. We surveyed participants in the beginning, halfway through, and at the conclusion of the curriculum to assess what they learned and how their perspectives changed. The content of the curriculum stayed the same throughout; the only change made over the course of implementation was moving some participants into different groups based on their needs and availability.

Of the 478 youth that were assessed and participated in the educational and mentoring sessions, 307 received referrals for clinical mental health care and 98 of those referred (32%) attended 3 or more appointments with their providers.

3.2.2 Advisory board

A wide array of community-based organizations and local experts collaborated with our efforts to put the A Prescription of Hope project plans into action. These organizations were the BTWF, a youth program called Young People's Leadership Academy (YPLA), a local social worker, a professor from Creighton University, and a psychologist. After the project diversified, the St. Louis branch of the project continued the same partnerships with BTWF Church (Bishop Calvin Scott) and the local social worker. The Advisory Board expanded to include a community member who had lost their son to gun violence and a community-based health center. In addition, the St. Louis Prayer Project Inc., a non-profit founded by author TS joined the advisory board as a youth-focused organization that uses the "Developmental Relationships Framework" to serve as the emphasis of the youth-mentorship program [16].

3.2.3 Community engagement

In addition to implementing the curriculum, A Prescription of Hope collaborated on several projects with local middle and high schools in the community. The social worker we engaged with as one of our advisory board members performs

PTSD assessments on at-risk children that are referred to her by teachers and office staff from school; and refers at-risk children to our program. She has been instrumental in getting children referred for counseling services on an in-patient or outpatient basis. She also works directly with the children's families to connect them to resources, including job skills training and life coaching, and obtain counseling referrals for them.

An important element of our program's success has been our ability to leverage the resources available in our community. The local community-based health center serves as a resource for mental health services and counseling for children referred by our staff and by the social worker. We meet quarterly for updates, and as needed in-between, to discuss the focus of care and plans of action identified to assist the children moving forward. The pastor of the church also supports our program by providing an avenue for our team to share information, post flyers, and participate in church-community based activities that further inform the community about our services.

3.2.4 Networking and building partnerships

Social media has been an important tool for A Prescription of Hope to spread awareness of the impact of violence as related to PTSD among youth through an anti-violence PSA. The video PSA (St. Louis Youth A Prescription for Hope, Violence Prevention) features several of the youth that participated in the program. It was shown at schools, the local community partner health center, and shared on other social media platforms. The video showcases an interview with a high school student sharing a personal story. While his story is dramatic, it represents a role-model success story in that he was later referred for counseling services and is currently doing well and attending college on a fully supported scholarship.

3.3 Project goals

The goals of the first year of A Prescription for Hope were to empower parents, teens, and key stakeholder residents, reduce health disparities by providing sustainable interventions through screening at-risk youth, and advocating for policies that provide after-school care to at-risk children. For year two, we expanded the goals to include developing a curriculum which incorporated mental health, resiliency training, and the effects of violence on health. Our second goal for the year was to launch a campaign of speaking engagements that promote awareness.

Despite the conclusion of the formal Clinical Scholars 3-year experience, A Prescription for Hope continues to work towards educating youth on anti-violence and the impact of PTSD through the curriculum-based program that can be implemented in schools for youth, parents, and school staff. We continue to foster relationships with local organizations, including one that collaborates with police officers. We are also working towards having a scholarship funded after-school community-based facility.

In the long term, A Prescription for Hope would like to have our own facility that can house youth in a structured after-school program. This would provide a safe space for them to come to receive mentorship, love, and participate in recreational activities that would build skills to promote healthy living and successful futures.

4. Outcomes

To date, youth ages 10–18 years of age in the city of St. Louis have benefitted the most from the A Prescription for Hope project. We've been able to show

how faith-based after-school programs that have an emphasis on mentorship with classes focused on conflict resolution, anger management, coping skills, resiliency training, and communication can make a positive difference in at-risk young adults. Furthermore, we directly connected hundreds of youth to mental health services through providing referrals so they could obtain the clinical care they needed.

We recognized youth who were nominated by peers, family members, teachers, church members, etc. monthly who were making positive decisions in their homes, schools, churches, and communities. We included them on our website's blog, on social media platforms, and sent them an award basket filled with a Prayer Project t-shirt, a certificate of achievement, a prayer journal, and a $100 Foot Locker gift certificate.

While the three years of project visioning, planning and implementation resulted in several newly developed collaborations, the development of educational curricula, the launching of faith-based resiliency intervention programs, and clinical referrals for professional care for at-risk youth in need, the most important outcomes are the stories of youth who were impacted. Some anonymized exemplar youth success stories are presented below:

- A high school male who was suffering from severe PTSD and depression as a result of trauma exposure and violence participated in our program. Before participating in the program, he was contemplating quitting school and the football team. As part of A Prescription for Hope services, he and his mother were counseled on trauma and its effects. One year later, he is still attending counseling services, and is now attending a university on a football and academic scholarship.

- A middle school young girl was having behavioral issues in school including fighting, getting suspended, and receiving failing grades. She was also suffering from PTSD due to trauma she suffered from the violent death of her father being killed by his neighbor. She and her brother started receiving counseling services and mentorship through our program and she became an honor roll student. She is now an eighth-grade graduate looking forward to starting high school next school year.

- A twelve-year-old boy was suffering from severe depression due to his father being incarcerated and being left home alone to care for himself every day after school while his mother worked. He was receiving failing grades and was suffering from a mild case of failure to thrive due to low weight. He started receiving mentoring and counseling services and is now participating in after-school sports programs and gets to visit with his dad on a regular basis. They share a healthy relationship and he's looking forward to his father's release from prison soon.

5. Discussion

Community partnered interventions are important tools to helping heal communities traumatized by violence. When these community partnerships are broad and inclusive of many sectors, the outcome is stronger. A Prescription for Hope included faith-based organizations, clinicians, non-profits, academicians, parent voices and youth voices. The diversity of that chorus strengthens and informs approaches, making them richer and extending their impact.

The voices of the youth are essential to creating youth-centered programs that are effective; not only does it empower them to share and engage with others; it also promotes trust among the group. We were able to get to know each other and build meaningful partnerships that allowed us to educate them using non-traditional methods. As a facilitator and mentor many times, the lead author (TS) had the opportunity of observing peer-to-peer interactions which by far were the most rewarding. Listening to them share real-life, transparent stories of traumatic experiences, hopes, and aspirations with others in small group sessions allowed them to let their defenses down. These interactions resulted in their peers showing genuine concern, empathy, and self-expression. It was in these moments that real breakthroughs took place. The youth were able to be vulnerable and it was apparent that the safe space that we were hoping to create had been achieved. The presence of the social worker brought reassurance and offered strategies to prevent the communication from turning to an undesired direction.

The impacts of community-based interventions on youth are positive and dramatic, as indicated by the exemplar stories above. While millions of dollars in federal investment to rebuild schools and communities would be wonderful, it is striking the degree of difference that love, attention, counseling, support, role-modeling and mentoring can make in a child's life, even a child who is dealing with the complexities that result from violence. Surely, these kinds of approaches can be augmented to benefit many children who are at-risk across many communities. Particularly in times of economic contraction or recession, the resources for extensive revitalization might not exist. Yet, this project demonstrates the potential impacts of smaller-scale interventions that are doable at the community level.

Making a difference in communities is more than just having passionate advocates--it is about giving those advocates voice, enhancing their skills, giving them the tools and support to launch impactful programs. While the financial support was not large in comparison to many grant-based programs ($35,000/year), the combination of financial resources and sophisticated skills training augments the ability of passionate advocates to make real differences in communities that need it the most.

6. Leader learning (TS)

My personal experience with the RWJF, Clinical Scholars program over the 3-year period has been nothing short of "Excellence." My learning experience has included a greater respect for diversity among other professionals and peers, personal enrichment in improving my personal life and the life of others, improved self-awareness, and increased self-confidence as a leader in the field of Public Health.

Working with community partners provided me with the opportunity to participate in community projects which enhanced my networking skills with local stakeholders, improved my communication skills, leadership skills, and problem-solving skills. I was able to build long lasting trusting relationships as well as plan for future projects and opportunities.

My experience with the youth has humbled me in ways that are unimaginable. My goals were to educate them and leave a lasting impression, but they were the ones who educated me. I am forever grateful and forever changed. I can only hope that I've done the same for them. I told myself going into this project that if I could help to positively change one child's outcomes then I've done my job. Lastly, I learned that in order to reach youth you have to be willing to give a lot of yourself while expecting nothing in return. Your motives have to be genuine or they will see

through you and you will never gain their trust. Patience and love have to be your strength or you will never reach them. I am stronger and better as a result of every young person I've encountered.

7. Toolkit and other resources

- St. Louis Prayer Project Website
- St. Louis Prayer Project Facebook Page
- St. Louis Prayer Project Instagram

A more comprehensive toolkit can be found at https://clinicalscholarsnli.org/community-impact

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