



Robert Wood Johnson Foundation  
CLINICAL SCHOLARS

*Partnership for Wellness:*  
**Addressing Stress and Violence  
in Southwest Philadelphia**

**A report of the Robert Wood Johnson  
Clinical Scholars Program at the  
University of Pennsylvania  
School of Medicine  
2008-2010 Cohort**

**In collaboration with**

**THE HEALTH ANNEX**

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## Executive Summary

This report represents the collaborative work between the Robert Wood Johnson (RWJ) Foundation Clinical Scholars at the University of Pennsylvania and the Health Annex in Philadelphia, Pennsylvania. The Clinical Scholars Program is a national post-graduate training program for physicians who wish to enhance their skills in community care, research, and leadership. In 2007, a group of RWJ Clinical Scholars partnered with the Philadelphia Area Research Community Coalition (PARCC) to evaluate the gun-violence epidemic in West and Southwest Philadelphia and suggest interventions to confront it. This report represents the work of a second group of RWJ Clinical Scholars building upon the previous efforts in Southwest Philadelphia by partnering with the Health Annex, a federally qualified health center serving the Southwest Philadelphia community with a wide range of physical and mental health services including non-traditional outreach and community supports. The main objectives were to:

- Explore the means and mechanisms by which people manage and cope with stress that results from violence, and how stress may contribute to aggressive or violent behavior.
- Identify existing resources, both at the community and service delivery level that may help people who have experienced violence and resulting stress.
- Design a service delivery model that would integrate mental wellness resources (ranging from grassroots preventive approaches to center based treatment approaches) to support those affected by stress that results from violence. The hope would be that this model could be integrated into the city mental health system.

This report represents the culmination of in-depth, round-table discussions with community members, religious and lay leaders who are intimately and professionally affected by personal and community violence-associated stress. The scholars also sought the advice of civic leaders and public employees who are responsible or closely involved with the delivery of health, social, and/or recreational services to members of the Southwest Philadelphia community.

### *The Partnership for Wellness:*

The contents of the report culminate with a specific proposal, timeline, and identification of funding sources for a pilot program to integrate, strengthen and unify available resources to improve this community's ability to cope with violence-related stress. This pilot program would integrate services offered at the Health Annex into a matrix of social supports currently present in the neighborhood. The proposal outlines potential steps that the Health Annex and its chosen partner could take to integrate mental health and wellness into the community, enhance community coping, and streamline services for those who need traditional mental health care.

The proposal provides a conceptual model of the *Partnership for Wellness* which involves:

- A collaboration between the Health Annex and other community non-profit organization
- Selection and implementation of educational or training program(s) that provide elements of behavioral health support in non-traditional settings
- Creation of sanctuary spaces at the Health Annex and partner sites for development of wellness and stress management programs that can enhance community coping

In sum, this report represents an attempt to connect, integrate, and strengthen resources in a community which is stressed by violence in many ways. The pilot partnership project is designed to be expansive and modifiable so that it has the potential to be useful to as many types of communities as possible. The authors hope that this report, in whole or in part, may help any of the dedicated community caregivers we met during this project further their mission to make their neighborhoods safer, healthier, and less stressful.

## Charge and Participants

The following charge was elaborated by our community partner, the Health Annex, with the course directors and advisers:

*1) To explore the means and mechanisms by which people manage and cope with stress that results from violence, and how stress may contribute to aggressive or violent behavior. The focus of the efforts was West and Southwest Philadelphia with the hope that at least some portion of what is proposed could be replicated in other parts of the city.*

*2) To identify existing resources, both at the community and service delivery level, that may help people who have experienced violence and resulting stress.*

*3) To design a service delivery model that would integrate mental wellness resources (ranging from grassroots preventive approaches to center based treatment approaches) to support those affected by violence. The hope would be that this model could be integrated into the city mental health system.*

Acknowledging the significant breadth and depth of this charge, we sought to conduct a thorough, focused, and feasible analysis of available resources and current needs – as related to violence-associated stress – of the Southwest Philadelphia community and its constituents. We pursued a three-pronged approach to this charge: first, we conducted in-depth, round-table discussions with community members who are both intimately and professionally affected by personal and community violence-associated stress. Next, we sought the expertise and opinions of professional, religious, and lay community members who currently engage in the delivery of both formal and informal behavioral health care and community support. Last, we engaged civic leaders and public employees who are responsible or closely involved with the delivery of health, social, and/or recreational services to members of the Southwest Philadelphia community. In sum, these meetings informed the structure of this plan to help strengthen and unify resources in order to open channels so that this violence-plagued community can access proven methods of stress reduction.

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The Robert Wood Johnson Clinical Scholars Program (RWJCSP) aims to integrate Scholars' clinical expertise with training in leadership skills, program development, and research methods to help find solutions for the challenges faced by the U.S. healthcare and public health systems. The University of Pennsylvania is one of four national training sites for the two-year program. Katrina Armstrong, MD, MSCE and Joshua Metlay, MD, PhD are the co-directors at Penn. The Scholars in the 2008-10 cohort are: J. Jane Shin Jue, MD (internal medicine), Zachary Meisel MD, MPH (emergency medicine), Mark Neuman, MD (anesthesia), Matthew Press, MD (internal medicine), Anje Van Berckelaer, MD (family medicine), Glenda Wrenn, MD (psychiatry), and Charmaine Smith Wright, MD (internal medicine and pediatrics). Joel Fein, MD, MPH, and Lucy Wolf Tuton, PhD, are the faculty advisors for the 2008 RWJFCSP summer project. Mark Garcia Christie, Tara Hayden, MHSA, Nicole Thomas, MBA, Lorraine Thomas, and Donald Schwartz, MD, MPH served as project advisors.

## **Community Leaders, Advisors, and Experts Interviewed**

Wesley Wilson Bey  
Josephine Blow  
Victoria Cargill  
Patrick L. Cheston  
Emily Carlson  
Lois Clayton  
Carey Davis  
Christopher Deussing  
Helen Divers  
Edith Dixon  
Melanie Eddy  
Healelei Faliko  
Latoya Fulks  
Zoneas Gainey  
Keith Gant  
Cassandra Graves  
Dr. John T Groce  
Terry Guerra  
Tom Henry  
Robin Holts  
Chanita Hughes Halbert  
Henry Hutchinson  
Voffee Jabateh  
Jerry Johnson

Richard Johnson  
Stephan Johnson  
Amy Johnston  
Pat Leidy  
Giridhar Mallya  
Sharon McCollum  
Jerry McVeigh  
Pam Mack-Brooks  
Shanell Mason  
Nigell  
Edna Reddick  
Ernest Robinson  
Kareema Robishaw  
Frank Rottier  
Eugene Sherlock  
Patricia Stewart  
Ebony Taylor  
Darnell Thomas  
Joseph Woodlock  
Gregory Washington  
Officer Joseph Young  
Giselle Wilkins

## Background

The burden of violent crime has had a profound impact on the life of the Southwest Philadelphia community. In 2007, there were 392 homicides in Philadelphia, a disproportionate percentage of which occurred in high-crime neighborhoods, including Southwest Philadelphia. In part through targeted efforts of the Philadelphia Police Department, the city-wide homicide rate has declined by twenty percent over the first half of 2008. Still, the problem of violent crime persists, with devastating consequences for communities like Southwest Philadelphia.

In 2007, physicians from the Robert Wood Johnson Clinical Scholars Program (RWJCSP) at the University of Pennsylvania School of Medicine, in collaboration with the Philadelphia Area Research Community Coalition (PARCC) issued a report on the social impact of violence in West and Southwest Philadelphia. This report, informed by academic research and key informant interviews, describes the problems of violence and stress as involved in a cyclic interplay. Violence creates stress, and stress erodes community stability, leading to further violence.

Violence impairs the coping mechanisms that allow communities to deal with stress. In contrast to stressed communities, healthy communities enhance the coping mechanisms of their members through “collective efficacy,” which the report identifies as “a mutual trust among neighbors and a willingness to intervene for the common good.” The 2007 RWJCSP describes the erosion of community efficacy in Southwest and West Philadelphia by violence. The shared experience of violent crime erodes community efficacy at two levels: first, through the individuals who are directly involved in or touched by a specific violent incident and, second, through the community at large, which lives with the day-to-day fear and uncertainty that violent crime begets.

The ethnographer Elijah Anderson’s studies of urban neighborhoods with high rates of crime and violence provide insight into how entire communities – including people who avoid criminal activity – are stressed by violence. In *Code of the Street*, Anderson identifies how a community’s collective sense of safety is connected to stress. Once external influences, such as those of the police, are unable to provide a safe environment, individuals are forced to take on “personal responsibility for one’s safety.” The process of needing to “handle themselves” in a street-oriented environment begets community stress.

Individual connections to family or other community members have the potential to alter the stress-violence cycle. These connections may arise through multiple routes. For Anderson,

*Youths who emerge from street-oriented families but develop a decency orientation almost always learn those values in another setting--in school, in a youth group, in church. Often it is the result of their involvement with a caring “old head.”*  
(Anderson, 1994).

For the youth of Southwest Philadelphia, this “old head” or adult role model could be found in a relationship with a block captain, a clergy member, a coach, a school teacher, or a tutor. For members of communities like Southwest Philadelphia, exiting the cycle of violence and stress will depend on both an increase in public safety and the development of a “decency orientation” through mentorship and other resources present in the community.

The 2007 RWJCSP report identifies several mental health resources located in West and Southwest Philadelphia; however, use of these resources by community members is limited by several barriers. The stigma of mental health services deters some individuals living in the community from seeking help. Community members often lack the information or resources necessary to obtain services. Emergency

and outpatient behavioral health resources are overcrowded, and mental health services are often not available through schools, where they most easily might be accessed by area youth.

## **Voices from the Community**

Over the course of four weeks, we held interviews to elicit community members' perspectives on stress and violence as well as information about existing community strengths and resources with respect to this issue. The interviews took place at the Health Annex, at community facilities, and in homes. Those interviewed included civic association leaders, representatives of various faiths, volunteers and paid staff from organizations providing services to the community, and informal community leaders. Several common themes arose in the course of these discussions.

It quickly became clear that the reality of community violence is complex, affecting and affected by many factors including poverty, education, unemployment, racism, gun availability, drugs, affordable housing, changes in family demographics, childcare and parenting, police presence and civic engagement. Solving the issue of violence was neither practical nor within the scope of our study and proposal. However, hearing the community and understanding their daily lives and concerns was crucial. Some described their community as having “pockets of bad activity,” referring to certain blocks or areas known for their violence. Others reported feeling “burdened under the constant threat of violence.” A youth counselor told of one student “going to school to get away from stresses at home.” He described high school students' problems as “hardcore... life in jail is a reality for them, life in the streets is a reality for them.” Another counselor observed that in homeless men “a lack of resources and being deprived of basic necessities – food, clothing, shelter – results in resorting to violence as a last option.” In terms of the mental health of the community, counselors in the area shared a sense that “Southwest appears sicker” than other communities. They reported that individuals seem to seek care at a more advanced stage when their symptoms are more severe and their lives are dysfunctional. Some of the barriers to seeking care, counselors said, may be related to stigma around mental health. There was also the sense that “tending to survival” was itself a barrier to seeking mental health services. Even those who did seek help would often find an over-burdened system with long waits.

When asked about their needs, residents responded positively to the idea of a place dedicated to mental wellbeing and stress relief, and (as might be expected) were receptive to a more positive framing of the problem: “What are the existing resources addressing mental wellbeing and stress, and how can we reinforce them?” With regard to existing safe and healthy spaces, community members had varying responses. Some felt that the only true sanctuary was inside the home. Indeed, at a police town hall meeting residents complained of harassment and rowdy behavior preventing people from spending time outdoors, including their own stoops and sidewalks. Others mentioned recreation centers as positive places for young people to spend time, though some complained that there were in general too few activities for older teens, particularly for boys. One young man identified the recreation center as a positive place (though not always safe) not only because it provided activity but also because this activity (basketball) helped him form an identity (the basketball guy) that protected him from the violence on the street. In contrast, public schools were viewed as places with a great need for resources and a potential source of stress, rather than places that could themselves serve as resources or safe zones. An abundance of programmed activities after school or in summertime was generally viewed as desirable to keep youths positively occupied. Some of these include block parties, “family fun days” hosted by police or parks, and fairs.

It was quite apparent that residents and community leaders in Southwest Philadelphia have responded to their own needs in a variety of ways. Among the people we interviewed, there are many who by virtue of their employment, volunteer work, or simply their position in the neighborhood as a trusted adult, provide

psychosocial support and often connect people to available resources. These community caregivers all expressed a sense of being occasionally overburdened by their responsibilities and of having too little information or insufficient skills to address the problems brought to them. One community leader, not trained to dispense mental health advice, mentioned the importance of “staying in his lane” when it came to referring those with problems he felt were outside the scope of his knowledge. In addition, although most caregivers reported having social networks, family, or faith resources to reinforce and recharge their energy, they generally felt their resources (in knowledge, time, and skills) were not sufficient to the task before them. One leader mentioned that “those who listen to other people’s problems need a place to go with theirs.”

In conclusion, though the interviews revealed disparate views on some subjects, there was general consensus that violence in Southwest Philadelphia contributes to stress and decreases mental wellbeing, that there are some relative but sparse “safe zones” in the neighborhoods, and that more activities for young people and families would foster more safety and security in the neighborhoods. Furthermore, a recurrent theme in the interviews revealed considerable caregiver stress on the part of those community members who serve their fellow residents as informal advisors and social supports.

### **The Health Annex: History and Context**

The Health Annex is a federally qualified health center serving the Southwest Philadelphia community with a wide range of physical and mental health services. Multidisciplinary and nurse-managed, the health center initially opened at the F. J. Myers Recreation Center in 1995 as a collaborative effort of the Department of Health and Human Services and the University of Pennsylvania School of Nursing. On the day it opened, May 12, 1995, the Philadelphia Daily News reported, “In the Kingsessing-Paschall neighborhood, residents will be the first in the city to get primary health care and recreation at the same place”(Russ 1995). From the beginning, the Health Annex was innovative, integrated, and invested in the community.

Emphasizing a spirit of community development and intervention, objectives of the center were to: 1) promote health and wellness, 2) identify health and illness needs, and 3) deliver family and community based primary care. At the time of its opening, the zip code of Myers Recreation Center had the second highest number of AIDS cases in Philadelphia, and 35% of patients seen at the Health Annex received uncompensated care. Despite having only three examination rooms and 2300 square feet of space at Myers Recreation Center, in 2000 the Health Annex received the U.S. Department of Health and Human Services' Health Resources and Services Administration Community Service Excellence Award. The director of Academic Nursing Practices Lois Evans said, “The Annex not only provides care in the center, but in the neighborhood as well, wherever people live, learn and play”(Mo 2000).

In recent years, the Health Annex steadily outgrew its space and looked to expand its facilities and expertise. New space was found only a few blocks away from Myers Recreation Center and by February 2008, the Health Annex opened its doors at 6120 Woodland Avenue. The now 12,000-square-foot federally qualified health center at the Woodland Shopping Plaza is operated by the Family Practice and Counseling Network, which received a \$250,000 state grant from the Pennsylvania Redevelopment Assistance Capital Program for the project. Currently, the nurse-managed Health Annex provides primary care services, behavioral health care, dental care, social services, family planning, HIV care, cancer support, and breast cancer education in an area that desperately needs these services. In 2005, residents of zip code 19142, where the center is located, had a 17.3% unemployment rate and an adolescent fertility rate of 56 births per 1000 girls (Community Report Card SW Philadelphia).

Current behavioral health services at the Health Annex are staffed by three full-time licensed clinical social workers, one part time psychotherapist, and two part-time psychiatrists. The department has a holistic approach to mental health and reports that many of its patients have a range of unmet social service needs related to poverty and inequity in addition to mental illness. The behavioral health providers also agree that the patients they see from Southwest Philadelphia are sicker and take longer to come into first-time therapy. The department has a long waiting list and is in the process of hiring another full-time social worker to handle the patient load. Mental health care is also being integrated into primary care, so that a social worker can see patients with behavioral health needs during primary care visits, with positive results. Longtime patients who had previously been reluctant to seek behavioral health care are now increasingly seeking out services.

### *Context*

The Health Annex is one of six community health centers in Southwest Philadelphia, and the only health center in Southwest Philadelphia operated by the Family Practice and Counseling Network. Until its move to Woodland Avenue in February 2008, it was also the smallest community health center in size and number of full-time staff, and the only health center without evening hours. The closest community health center is Woodland Avenue Health Center at 5100 Woodland Avenue, which is operated by Greater Philadelphia Health Action with 9 full time staff. The two centers are unrelated, and the extent of patient overlap between them is unknown. Anecdotally, staff report little “doctor shopping;” people tend to use the health center most convenient to where they live. However, a survey has shown that among people living within 5 miles of a community health center, 50% are unaware that it is there (Mallya 7/30/08). As the Health Annex recently changed locations, it is difficult to assess utilization patterns based on 6 months of operation in its current location. This site is in a medium health center access area of Southwest Philadelphia (distance-weighted number of community health centers per block group), and abuts a low access area with no community health centers (Eastwick-Elm neighborhood) immediately to its south. (G. Mallya, personal communication)

Of the 75,709 people who now live in the Southwest Philadelphia Health Annex target service area, 73% are of African descent, 19% Caucasian, 2% Hispanic, and 5% Asian. 12% of residents in this area (census tracts 54-75) speak a language other than English at home and 52% live below 200% of the Federal Poverty Index. In 2007, the Health Annex followed 1714 patients, of which 54.0% had Medicaid, and 30.8% were uninsured, including 37.7% of those over 19. With such a large percentage of uncompensated care, the Health Annex's financing strategies include obtaining grant funding, increasing managed care and mental health volume, and increasing family planning and fee for service volume.

Further details on the Health Annex's status as a Federally Qualified Health Center, its financing, and physical location can be found in Appendix A.

In addition to the six community health centers in Southwest Philadelphia, the area is served by Mercy Hospital. There are three recreation centers, four branches of the Free Library, two public high schools, five middle schools, and 16 elementary schools. There are also an array of community organizations, service-focused nonprofits, and over two dozen places of worship.

Southwest Philadelphia encompasses the zip codes 19142 and 19153, and the southern part of 19143. It is served by the 12<sup>th</sup> Police District, and is represented in City Council by Councilwoman Jannie Blackwell. The Health Annex is located in the 1<sup>st</sup> U. S. Congressional district, the 8<sup>th</sup> Pennsylvania Senate district and the 188<sup>th</sup> Pennsylvania legislative district.

## **The Importance of Coping**

*Mental wellness* is broadly defined as the means of responding to the circumstances of life in a manner that promotes healthy functioning. Wellness models (Myers, Sweeny and Witmer 2000) suggest five mental wellness factors: essence or spirituality, work and leisure, friendship, love and self-direction; and twelve characteristics of healthy mental functioning—sense of worth, sense of control, realistic beliefs, coping and emotional awareness, problem solving and creativity, stress management, sense of humor, nutrition and exercise, self care, gender identity, and cultural identity.

*Mental health* has been defined as the absence of mental disorder as well as the level of emotional or cognitive well-being. Both mental health and wellness exist on a spectrum, and the effects of stress due to violence can be variable. For example, closeness and degree of exposure to violence predict more severe responses, such as depression or post-traumatic-stress-disorder (PTSD), but lower levels of exposure to violence (living in a violent neighborhood, watching a news report on a violent act in the area) may contribute to other responses best characterized as impaired well-being such as substance abuse, irritability, fear of going outside, or quitting a job.

Thus, exposure to violence is a threat to both mental wellness and mental health, with higher levels of exposure predicting increased threat to *mental health*, and lower levels of exposure representing a threat to *mental wellness* which may manifest as increased stress. In the face of additional external stressors, additional violence-related stress may overwhelm coping resources and manifest as impaired mental health.

Responses to external stressors are fundamentally linked to outcomes. Posttraumatic responses can be best understood on a continuum through the following states: no response, normal stress reaction, psychological or behavioral syndrome and psychological disorder (Bonnano 2004). Of the people who experience a distressing reaction to an event, some will recover with minimal assistance, some will benefit from support and stress management, and others will require more intensive treatment. It is normal to see variations in stress reactions to an episode of gun violence (or other trauma) among victims, responders, and relatives. Survivors (victims) may experience feelings of shock, uncertainty, helplessness, isolation, guilt, fear, anxiety, self-blame, and/or blame directed at others. In contrast, responders to the trauma tend to experience feelings of frustration, powerlessness, fear, insecurity and guilt. Relatives of both survivors and the deceased may experience any of these feelings as intensely as the victims themselves. Even among those with the most severe reactions (such as the 60% of women who experience severe PTSD following sexual assault), many will recover over time (only 30% will go on to develop chronic PTSD). This suggests that coping plays a central role in mediating the effects of traumatic stressors.

The process of determining ‘who needs what’ in terms of mental resources is challenging, in part due to our limited understanding of how to reliably predict who will benefit from various levels of intervention in the immediate aftermath of trauma. Moreover, those who are at high risk for developing chronic distress reactions or posttraumatic stress disorder do not always have the information and resources required to get more intensive treatment if they need it. Stigma exacerbates this phenomenon. In the case of individuals personally affected by trauma, this may result in their being denied supportive services that would be helpful. The general population living in traumatic environments is often left to rely on familiar coping strategies that have helped in other stressful situations. When these strategies no longer help or are severely strained, formal services may be needed. But the formal mental health treatment system may not be easily accessible (wait lists for specialized care, insurance problems) or may conflict with other needs (work/child care). Furthermore, due to lack of easily accessible ‘family’ resources and time constraints, supporting the needs of one stress-affected member like a child may undermine efforts to address the needs of other members such as a parent. In many cases it is difficult to engage all members of the family

and relevant endogenous supports when a person is *externally* identified as 'needing mental health services.' This poses a significant threat to successfully supporting affected persons or enabling them to increase healthy posttraumatic responses. It also highlights the need to raise group awareness to encourage appropriate natural referral networks.

*Posttraumatic coping* is a significant factor that can decrease the risk for chronic distress reactions (Bonnano 2004), and is an important step on the pathway to healing and wellness. It is defined by the mechanisms and means of coping following a traumatic event. Coping behaviors are largely affected by the cognitive processing surrounding the trauma based on previous experiences and/or new learning (Haden 2006). There are two major kinds of coping categories: problem-focused and emotional coping (Carver & Scheier, 1994; Folkman & Lazarus, 1985). A person is more likely to engage in problem-focused coping when they feel the situation is changeable, and this is associated with less psychological distress (Carver, Scheier, Weintraub 1985). Emotional coping falls roughly into two styles: active (venting distress, reframing the stressors impact) and avoidant (denial, self-distraction to avoid the distress without problem-focus behavior). Generally, active emotional coping along with problem-focused coping is more adaptive than avoidant styles although this is not consistently true for all groups across types of trauma (Holahan & Moos 1987, Schutzwahl, Maercker, & Manz 1999, Jones & Ollendick, 2002).

Social support (both perceived and real) is a well-documented factor associated with better posttraumatic outcomes. Perceived lack of social support is a risk factor accounting for up to 40% of variance of posttraumatic symptom severity (Brenner 2000). In other words, merely establishing the sense that help will be there when needed is essential to any effort to strengthen an individual's resilience to trauma. This finding is especially relevant to the issue of community violence. A person can perceive social support from family, friends, neighbors, co-workers, community leaders, or institutions. In sum, people who engage in interpersonal coping with social supports do better (Haden et al 2007, Scarpa et al 2006).

This review of the psychiatric and psychological literature supports the notion that mental health support of community coping efforts is a potentially critical mechanism to relieve the stress associated with community violence. We propose that mental health institutions and practitioners can play a key role in assisting communities affected by violence not only by enhancing the treatment of the population affected by psychological disorders, but also by supporting community coping efforts through education, consultation, and basic psychological training for existing community social support systems and individuals. In this proposal, we address both mechanisms through an integrative partnership between mental health and community support institutions.

### **Community Coping Resources**

A wide variety of resources may contribute to a community's ability to address stress or provide respite and recovery from violence – and in some cases reduce the violence at the source of the stress. Social disorganization theory proposes a variety of extrinsic and intrinsic factors that place a community on a spectrum of ability to organize to achieve its ends. With respect to the reduction of crime and delinquency, these intrinsic factors include the community's ability to supervise teenage peer groups, its strong local friendship networks, and its degree of participation in formal and voluntary organizations (Sampson 1989). Physical spaces such as parks and gardens, institutions such as the Police Athletic League or recreation centers, and community caregivers such as clergy, teachers, coaches or trusted neighborhood elders all contribute to the social fabric allowing a community to address violence. Specific examples that demonstrate the impact of these elements on community coping and cohesion include:

### *Recreation Centers*

A well known example of community cohesion against youth truancy in the form of recreation is seen in the Chicago Area Project (CAP). Early 20th century sociologist Clifford Shaw put into action his ideas on how to deal with and prevent delinquency by founding and directing the CAP. Viewing delinquency as a product of social learning, his remedy was to develop youth welfare organizations to alter the local social environment and therefore the expectations to which the youth responded. These organizations share many similarities with today's recreation centers. Shaw saw recreation as a means to a greater end. It was a means of "associating youngsters with constructive activities that would relate them to the conventional life of their community," thereby drawing them out of isolation and into the larger community and culture and also drawing them away from delinquency and anti-social behavior (Burgess 1937). Though the philosophy of the CAP had a threefold approach, (1) recreation, (2) communal self-renewal, and (3) mediation, the largest portion of its energies and programming revolved around recreation, partly because it elicited the greatest enthusiasm from the community. Beyond the extensive activities available, the extent of community involvement in the formation and daily operations of the recreation center was perhaps most central to its success. The staff and volunteers at the centers were community members, playing an important role as adult supervision. They took their responsibility to parents and children very seriously. They were an important bridge to reaching and affecting those already involved with the police. The recreation center also became a symbol of the community's determination to take back the neighborhood from delinquency. It was a catalyst for a new spirit in the community of confidence and order (Schlossman 1983). Indeed, interesting lessons drawn from the CAP, relevant to this report are (1) the important function of recreation in a community; (2) the galvanizing and symbolic role a community organization (in this case the recreation center) can play in the community; and (3) the strength and efficacy of having staff and volunteers of such a community organization being from the community itself.

Although formal recreation activities and recreation centers might seem to support a community's ability to effectively respond to violence, researchers disagree about their role in reducing crime and violence. While some theorize that organized recreation may reduce crime by providing alternatives to delinquency (Peterson 2000, Sherman *et al.* 1997), others posit that recreation sites may increase crime by providing opportunity for rival groups to intersect in time and space (Sherman *et al.* 1997). Nonetheless, residents of Southwest Philadelphia make extensive use of their neighborhood recreation centers (community interviews and site visits July 2008). It follows that interventions aimed at reducing stress in this venue need to address 'turf issues' that may limit access, and evaluate its potential to inadvertently facilitate crime.

### *Gardens*

Community gardeners feel that gardening reduces stress. In one focus group study, respondents expressed a sense of release from stress by working in a community garden. The garden was also seen as building attachment to and connections within the community (Wakefield 2007). The persistence and collaboration required to convert abandoned land to a community garden helps build the social networks and protected space that in the long run are reflective of community health (Schmelzkopf 1995) and may therefore also improve resilience at a community, rather than strictly individual level.

### *Art*

Community art has been described in social science literature as having the capacity to build community cohesion, to improve social outcomes in communities (such as reduction in crime), and to organize community members around social issues (Lowe 2001). The Philadelphia Mural Arts Program, originally arising from the Philadelphia Anti-Graffiti Network, is a program devoted to creating community art as a catalyst to community healing. "Sometimes designing and producing a local mural begins a process of social connection that previously did not exist." (Golden.2002). Residents of neighborhoods participating in murals have responded positively: "Really, it wasn't about art, it was about the fact that kids were

doing something productive for their community.” (Golden 2002). The Peace Wall of the Philadelphia Mural Arts Program (MAP) (Grays Ferry, 29th and Wharton), was designed to address longstanding racial tensions and a history of recent racial violence in the community. The established MAP practice of holding community meetings to plan the mural, though often contentious, resulted in a series of murals in the neighborhood that eventually came to be seen as focal points for “self-pride in the neighborhood” and features that “light up the community”. In other parts of the city, the Pennsylvania Horticultural Society and the MAP have collaborated to transform dreary spaces into neighborhood gardens with associated murals. The notion of giving people “access to beauty” serves as a powerful motivator to communities involved in public art. Because of the community discussion built into the mural-making process, the potential exists to address the issues of stress and violence both in discussion and in the art itself, while at the same time creating a space devoted to a positive response to these stressors.

### **Selecting Community Partners: Collaboration Between Nonprofit Organizations**

In the *Partnership for Wellness*, we propose a model in which the Health Annex collaborates with another non-profit organization active in Southwest Philadelphia. Collaboration would draw the strengths of both organizations into a symbiotic relationship. The goals of collaboration are to (1) to integrate mental health and wellness into the community; (2) to enhance community coping; and (3) to streamline mental health services. This unique proposal of a partnership seeks to work around barriers of stigma; to broaden the reach of the Health Annex; and also to create non-traditional ways of raising awareness about and engaging the community around stress-related mental health issues. The partnership would allow both the Health Annex and its partner to reach beyond their own contingencies. It has the potential to integrate mental health into the community beyond the traditional sphere of a health center. More people could be served, utilizing the access points and outreach abilities of both organizations. Selecting the right community partner is integral to the success of the program. Oster (1995) and Kearns (2000) offer models of collaboration between non-profit organizations. Specifically, Kevin Kearns (2000) elaborates some of the following principles as essential to successful collaboration: (1) complementary missions between organizations; (2) ability to contribute something of genuine value; (3) high level of mutual trust and respect between organizations; (4) agreed-upon mechanisms to resolve conflict and adapt the collaboration to changing circumstances; (5) presence of strong leadership that continually endorses the collaboration and provides resources to support it; and (6) ability to draw upon a history of collaboration. Sharon Oster (1995) provides another more managerial perspective, summarizing six characteristics that encourage cooperation between organizations: shared values, low gains from competition, ability to credibly commit, repeated interaction, ease of monitoring, and other shared lines of business activity. With these characteristics in mind, the Health Annex should create a search committee to carefully evaluate potential partners. The linkage through the partnership is the key to the proposal. Through such a partnership the Health Annex could strengthen its ability to effectively address the community's need for improved supports for mental and emotional wellness.

## **Grant Proposal**

### **I. Organizational Information**

#### **A. The Health Annex: History and Mission**

Over ten years ago when the Health Annex opened at Myers Recreation Center, it was noted that care was provided to the residents of Southwest Philadelphia not only at the center, but in the neighborhood as well, “wherever people live, learn, and play” (see Background, Health Annex). Emphasizing a spirit of community development and intervention, the mission of the center was to: 1) promote health and wellness, 2) identify health and illness needs, and 3) deliver family and community based primary care. Increasing access to mental wellness and mental health services in the community provides the foundation for our proposal. Renewing the reality of physical placement of health services in a neighborhood partner site to enhance community coping would honor the Health Annex’s past success and herald a new era of innovative community care.

#### **B. Current programs, activities, service statistics and strengths/accomplishments**

In February, 2008, the Health Annex moved from Myers Recreation Center to 6120 Woodland Avenue. Four times its original size, the now 12,000-square-foot federally qualified health center at the Woodland Shopping Plaza is operated by the Family Practice and Counseling Network. Currently, the nurse-managed Health Annex provides primary care services, behavioral health care, dental care, social services, family planning, HIV care, cancer support, and breast cancer education in a medically underserved area that desperately needs these services. Of the 75,709 people who live in the Southwest Philadelphia Health Annex target service area, 73% are of African descent, 19% Caucasian, 2% Hispanic, and 5% Asian. 12% of residents in this area (census tracts 54-75) speak a language other than English at home and 52% live below 200% of the Federal Poverty Index. In 2007, the Health Annex followed 1714 patients, of whom 54.0% had Medicaid, and 30.8% were uninsured, including 37.7% of those over 19. With such a large percentage of uncompensated care, the Health Annex's financing strategies include obtaining grant funding, increasing managed care and mental health volume, and increasing family planning and fee for service volume. Its behavioral health department has expanded to five rooms, three full time licensed social workers, one part time psychotherapist, and two part time psychiatrists. They are in the process of hiring an additional social worker to handle the patient load, and the department benefits from its on-site integration into a primary care visit if need arises. Still, the behavioral health department notes that the mental health patients they see from Southwest Philadelphia are sicker, take longer to come into first-time therapy, and experience an increased amount of stress due to poverty and violence when compared to the rest of Philadelphia. Every day, the Health Annex targets the poorest people in its service area while maintaining a high standard of quality medical care.

### **II. Purpose of Grant**

#### **A. Needs and Capabilities**

In 2007, there were 392 homicides in Philadelphia, a disproportionate percentage of which occurred in certain high-crime neighborhoods. As the 2007 RWJCSP report notes (see Background), violence not only directly triggers stress but also compromises the coping mechanisms that allow communities to deal with stress. Over the course of four weeks, we interviewed members of the Southwest Philadelphia community, including civic association leaders, representatives of various faith communities, volunteers and staff from organizations providing services to the community, to assess their perspectives on the issue of stress and violence. In particular, we focused on the perceived existing resources for safety and stress reduction in the community, and the ways in which interviewees thought they could be improved.

The major themes arising from the interviews included:

Resources:

- recreation center, after-school programs, athletic activities, family-oriented activities sponsored by police department, blocks, health centers, etc.
- much coping and stress reduction is practiced and counseled by lay providers, people in the community who are viewed as good resources (referred to elsewhere in this document as “community caregivers” or “lay providers”)
- mental health services available at the Health Annex and other service providers

Obstacles:

- lay providers experience caregiver stress: overburdened and under-trained
- concentration of violence in certain “pockets of bad activity” or dangerous blocks
- schools as a source of stress for some, and an escape from familial stress for others
- safe havens and safe activities: too few in number, too limited in scope
- stigma as potential barrier to accessing formal mental health services
- delays in seeking care until symptoms overwhelm functioning.

## B. Goals and Activities

### 1. Summary

The behavioral health needs of Southwest Philadelphia are many and complex; currently, community members find support through a multitude of formal and informal community resources, including behavioral health counseling as provided by the Health Annex.

There remains a great need for additional support, particularly for community members who deal with ongoing stress on a daily basis. The Health Annex could strengthen coping mechanisms that now provide much of the available support for community-level mental wellness through collaboration with an existing community organization. In the *Partnership for Wellness*, we envision a model in which the Health Annex collaborates with another community organization active in Southwest Philadelphia. The collaboration would increase wellness in the community through the following aims:

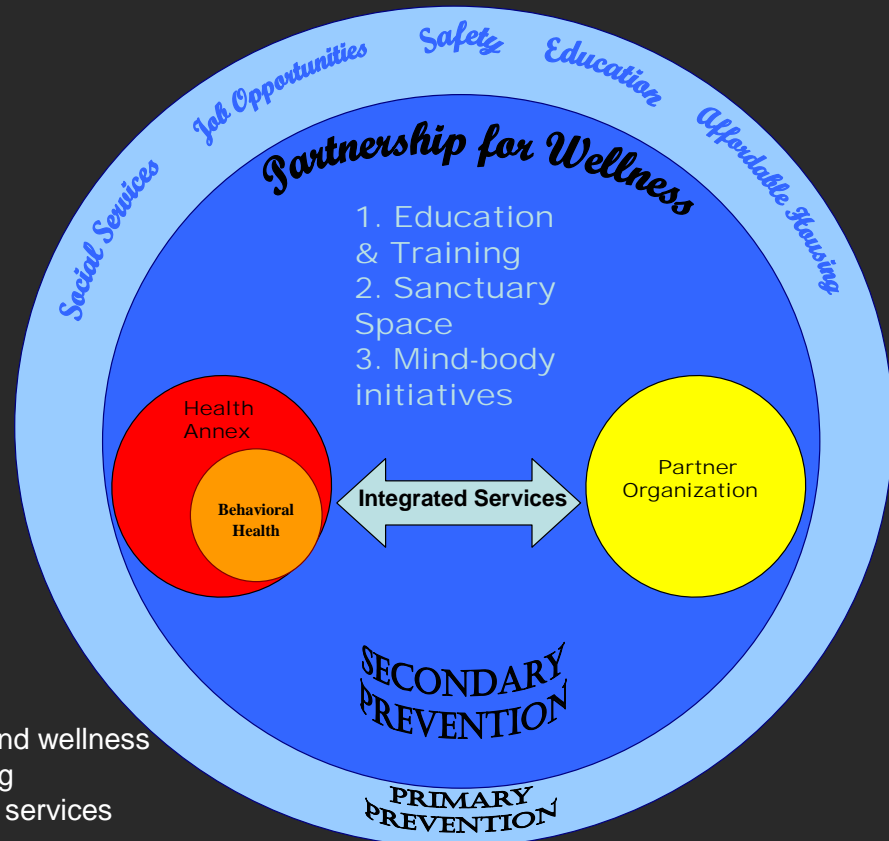
- 1) To integrate mental health and wellness into the community
- 2) To enhance community coping
- 3) To streamline mental health services

We envision this collaboration as a step toward integrating services offered at the health annex into a matrix of social supports currently present in the Southwest Philadelphia Community. This unique proposal of a partnership seeks to work around barriers of stigma; to broaden the reach of the Health Annex; and also to create non-traditional ways of raising awareness about and engaging the community around stress-related mental health issues. The methods through which the *Partnership for Wellness* will achieve its goals include

- (1) education and training of the community;
- (2) creation of a sanctuary space; and
- (3) programmatic mind-body and stress management initiatives.

Through such a partnership the Health Annex could strengthen its ability to effectively address the community's need for improved supports for mental and emotional wellness. With a successful *Partnership for Wellness*, a model for further collaboration with other organizations and community stakeholders could be developed and piloted. Below is a representational schematic of the *Partnership for Wellness*.

# COMMUNITY



Aims:

1. Integrate MH and wellness
2. Enhance coping
3. Streamline MH services

## 2. Pilot Program Description

### a. Collaboration with a Community Partner

Developing a working collaboration between the Health Annex and an established community organization in Southwest Philadelphia would be mutually beneficial. Potential community partner organizations could be as varied as schools, art programs, libraries, churches, recreation centers, or community centers (See Appendix B for an annotated list of selected potential candidate organizations). Regardless of the community organization chosen, the overriding goal would be to increase mental wellness in the community. In order to enhance community coping, some aspects of mental health and wellness expertise will need to be decentralized to create a community knowledge base which serves to standardize some of the informal knowledge-sharing that currently occurs among community residents. When the Health Annex offers its resources to educate and train a network of lay providers, be they recreation center staff, community organizers, clergy, or recognized neighborhood confidants, these individuals can then package and disseminate coping strategies to the community and increase the capacity of the local organizations, churches, and groups to which they belong. The lay providers would be Southwest Philadelphia residents themselves, so they can better translate knowledge about stress and coping into steps that people can use in their everyday lives. They can also facilitate their continuing education and support each other as caregivers in the community. In return, the Health Annex extends its reach into the community raising its visibility as a physical and mental health provider, and facilitates the process of appropriate behavioral health referral back to its skilled staff.

Developing such an important partnership is an integral part of this proposal, and it will require a detailed process of evaluation of candidate organizations to identify a reasonable, sustainable link of mutual benefit between both entities. Included in Appendix C is a list of characteristics that could be considered in such an evaluation. Development of a final list of characteristics and relative priorities of each will be dependent on the timing, financial status, and current needs of the partner organizations.

**b. Training & education**

**Selecting an Intervention**

There are many evidence-based, evidence-supported, and promising interventions designed to impact stress, violence, and posttraumatic disorders. Each of these interventions contains core elements of basic education of common posttraumatic stress reactions, description of or training in helpful coping responses, and are designed to interface with specific treatments for posttraumatic disorders. We have reviewed and included potential interventions involving mental health providers that by design directly incorporate or provide support to lay providers and/or other community-based social supports of exposed and vulnerable individuals. Selection of an intervention to impact violence and stress that would best fit a model of integrated mental health resources requires further clarification of organizational objectives and capacities of both the Health Annex and selected partner organization. Because these factors can vary widely, we present a number of existing interventions with variable requirements for implementation. This does not exclude the use of other interventions, or the possibility that the Health Annex and partner organization could develop a novel intervention. Availability and feasibility of methods to evaluate the impact of the intervention is an important factor to consider in selection. Another central factor to consider is whether a potential intervention will be complementary to or supportive of existing coping efforts employed by community members.

(See Appendix D for a comparative list of treatment intervention options, and Appendix E for a more detailed description of the New Haven Police Department's Child Development – Community Policing program.)

**c. Sanctuary space and mind-body initiatives**

**1) Sanctuary Space**

The development of a “sanctuary space” devoted to mental wellness would help to advance this program’s goals of integrating mental health and strengthening coping mechanisms in the community. Several of our key informants endorsed the concept of a “sanctuary,” a physical space that not only would be a safe haven from violence but that also would offer respite and rejuvenation from the everyday stress of living in high-crime communities. With close proximity and accessibility to a given neighborhood, the sanctuary space would stand as a true outpost of mental wellness in the community. Additional mental wellness services, including training and education, could be conveniently housed in a physical space—along with coordinating operations for the *Partnership for Wellness* program. The sanctuary space also serves as a visible reminder of the importance of mental wellness and would be a lasting emblem of the collaboration between the Health Annex and its partner in addressing this issue.

The sanctuary space could take a variety of forms and still accomplish these important objectives. One option would be a fully-developed wellness center,

featuring a relaxation room, a mind-body studio, and a classroom for stress management and other educational interventions. The space could offer other relaxing features, such as aromatherapy or soothing music.

Alternatively, the sanctuary space could be one room, or even a single, physical structure that conveys the ideas of mental wellness and community coping. For instance, a garden or mural dedicated to mental wellness would bring members of the community together around this issue and would serve as a physical representation of the *Partnership for Wellness* program. A garden or mural also contributes to the beautification of the area. A mural in particular carries the added benefit of bringing an art education component to the mental wellness and coping services offered through this program.

It is difficult to walk a few blocks in Philadelphia without encountering a mural. This is largely in part to the efforts of the innovative Mural Arts Program (MAP). Behind these impressive works of art are the community stories that they tell. Because of their extensive history of meaningful community engagement, we propose a specific collaboration with the MAP as part of the wellness initiatives by integrating existing programs like art education classes offered to youth, as well as involving and unifying the larger community around the creation of new murals and gardens.

A number of Mural Arts educational programs exist in Southwest Philadelphia and are described in Appendix F. A possible link through wellness services at a partner site (e.g. a recreation center) of the Health Annex could be formed. Investigation into the creation of additional sites for art education in West and Southwest Philadelphia should also be considered. New murals and gardens are ways to foster an outside physical space as a “sanctuary.” Because of the community discussion built into the mural-making process, the potential exists to address the issues of stress and violence both in discussion and in the art itself, while at the same time creating a space devoted to a positive response to these stressors.

See Appendix E for a brief outline of some important steps and principles to creation of a mural and garden.

## **2) Mind-body and stress management initiatives**

Mind-body initiatives, such as yoga and meditation, are additional components of the *Partnership for Wellness* program that would serve to enhance community coping. This type of intervention has been utilized previously to improve coping skills as a part of general stress management as well as for individuals facing the stress of specific medical and psychological challenges. Additionally, mind-body interventions have been employed with varying groups of individuals, including children and informal care-givers (Stuck 2002, Van Puymbroeck 2007). A 2005 study describes the implementation of a Tai Chi and mindfulness-based stress reduction program in a Boston public middle school (Wall 2005). The author reports that students in the program reported experiencing “well-being, calmness, relaxation, improved sleep, less reactivity, increased self-care, self-awareness, and a sense of interconnection or interdependence with nature.” While the program was not specifically designed to address violence-related stress, the author suggests further study of this intervention as part of an antiviolence effort and to promote self-care and conflict resolution.

The implementation of a mind-body initiative as part of a larger mental wellness program would fill a void in Southwest Philadelphia. A current Google map search of “yoga” and “fitness” in Philadelphia reveals a noticeable absence of locations in Southwest Philadelphia, in contrast to other parts of the city. The mind-body initiatives in the *Partnership for Wellness* could take several different forms. One option would be a standing series of classes conducted at the partner organization site, perhaps taught by certified volunteer teachers from Philadelphia-area mind-body centers. Classes could be offered in yoga, guided meditation, tai chi, or other mind-body programs. These classes also could take place in schools, libraries, or other important community locations. Ideally, in a future phase, interested community members could become certified to teach in one or more of these interventions and potentially open a dedicated studio in the community.

Stress management initiatives also serve to enhance community coping. Stress management encompasses the mind-body programs discussed previously but also can include more formalized education and teaching. The idea behind stress management is to equip community members ahead of time with the skills that will help them effectively deal with stressful events. That is, it is a form of primary prevention. A number of studies have shown different stress management interventions to be successful in a variety of populations (Jacobsen 2002, McGregor 2004, Baer 2003). Depending on the type of stress management intervention (e.g., relaxation, cognitive-behavioral, mindfulness-based, or a combination), training can occur in single-class, series of classes, self-administered, or web-based formats. Trained teachers are required for the class-based formats, but the self-administered format utilizes an instructional video and has been shown to be more cost-effective (Jacobsen 2002).

### **3. Targets and Implementation Process**

The primary targets of the *Partnership for Wellness* are community members affected by stress and violence. This group is primarily engaged through existing caregivers such as coaches, clergy, program directors, recreation center staff, volunteers, and informal community confidants. A detailed description of the rationale for using these caregivers is included in Appendix G. Certain components of the model selectively target symptomatic individuals who would benefit from behavioral health services while other features target those responding to stress in an adaptive manner but who are at risk for becoming overwhelmed without additional support. Thus, the model targets individuals across the spectrum of stress response and adaptation.

A secondary target is community caregivers affected by stress and violence. This includes providing support for Health Annex staff, partner organization leadership, and community caregivers themselves. An example intervention that explicitly integrates this concept is the Sanctuary Model which provides organizational support through supervision sessions and formal assessment of caregiver/provider stress.

The process of implementation occurs at three levels: the behavioral health professional, the partner organization, and the community. This may occur in step-wise progression explicit at each level or in a modified progression depending on the intervention. Maintaining periodic contact between the partner organization and Health Annex is required for ensuring adequate follow-up, data collection, and feedback.

In a community-based service delivery model, candidates for direct involvement in the specific program may have differing training, occupations, and exposure to different groups

of constituents. It is important to consider these characteristics when considering individuals as potential partners in the community-care effort. Characteristics have been identified as factors which are likely to be associated with highly effective and committed personnel/volunteers. The Asset-Based Community Development Institute (ABCD Institute, 2005. *Community Building Workbook*) identified the following important individual characteristics which may help promote effective programs:

1. Expertise/ ability to teach
2. Individual traits
  - a. Ideas
  - b. Energy
  - c. Enthusiasm
3. Technical Training
4. Networks of connections
5. Knowledge of constituent community
6. Leadership/ Authority
7. Access to space and facilities

In any given community, there may be many individuals who fit some or all of these criteria. In the promotion and delivery of behavioral health there may be additional qualities important for these individuals to possess.

Providing staff and volunteers of the partner organization with the skills to recognize and refer people in need of professional care is also part of the implementation process. Mental Health America, a nonprofit in Houston, for example, offers workshops to clergy in recognizing symptoms of mental illness, promoting mental health during times of crisis and addressing the mental health needs of adolescents and homeless communities that might be used as a model (see References for website). Such workshops would initially be arranged for volunteers and staff members at the partner organization (for example tutors, staff, and coaches at a recreation center). These lay providers could be provided with a list of community resources as well as a contact in the Health Annex's behavioral health department for referrals. Referrals for children and adolescents will be organized through contact with their parents.

Finally, clearly defining roles and responsibilities is essential to successful implementation of an integrated model. One way to organize the roles might be through the use of a partnership coordinator who would serve as a liaison between the Health Annex and the partner organization. The coordinator's responsibilities could include providing administrative support to organize meetings and training sessions, and coordinate program activities. Depending on the extent of funding support for additional personnel, the *Partnership for Wellness* could have other dedicated administrative positions, or provide salary support to expand the scope of existing positions in the Health Annex or partner organization. Maintaining community engagement, program development, sharing of specialized information, giving and collecting feedback, monitoring outcomes, are all responsibilities of the *Partnership for Wellness*. Determining the specific distribution of responsibilities is a crucial initial task of establishing an effective collaboration. Therefore, the Health Annex and the partner organization can best determine the optimal distribution of roles. A personnel needs assessment specific to the chosen partnership would be required and additional funding may be necessary.

#### **4. Impact of Activities**

- a. Impact

The combination of collaboration with a community partner, training staff and volunteers in recognition and referral, and establishing a wellness space and stress reduction mind/body activities will have effects that vary with the intervention and community partner selected. Potential impacts on individuals include symptom reduction, acquisition of stress management skills and enhanced social support. Creating an integrative infrastructure and increasing the community knowledge base will have effects at a larger system level.

Different choices of community partners will offer access to different target populations. For example, a recreation center community partner will likely offer access to a target population of youth aged 5-19 and their parents (for younger children), as well as selected adult groups such as senior fitness groups who also use the facility. This potential audience will gain

- 1) access to a space dedicated to mental wellness and stress reduction along with accompanying classes and activities
- 2) increased awareness of stress and its relation to wellbeing
- 3) increased access to and awareness of the need for behavioral health services (for a subset of the audience)
- 4) reduction in overall perceived stress levels

The partner organization and its staff and volunteers are expected to benefit by having

- 1) increased self-care skills with respect to stress,
- 2) a greater capacity to respond to stress and violence-affected community members in positive ways,
- 3) a better understanding of stress and stress reduction, and
- 4) skills in identifying warning signs of serious mental illness and resources for referral

From the Health Annex's perspective, independent of the community partner chosen, the number of referrals to behavioral health services (as well as medical services) should rise. A corollary benefit is likely to be an increased understanding of the prevalence of stress-related mental illness in the Southwest Philadelphia community on the part of the clinicians at the Health Annex.

b. Measurement and Evaluation

The program will be evaluated with respect to its three principal aims. To evaluate the **integration of mental wellness**, self-report surveys should be performed both before and at intervals during and after implementation to assess perceived support and resources as well as satisfaction with programs. In addition, quantitative assessments such as attendance at programs (such as mind-body classes) will be useful in evaluating the number of people reached and in tailoring programs that best fit the community's interests.

The **enhancement of coping** will best be assessed by self-report surveys. A variety of validated survey tools exist, for example, to assess stress levels in different populations (Teacher Stress Inventory, City Stress Inventory). An adaptation of such tools would be essential to evaluating the effectiveness of our intervention. Surveys should also address frequency of interpersonal violence experienced by respondents, for example the number of times the respondent witnessed or personally experienced violence. Given the strong disinclination in our initial interviews of people to report these violent events to police, it would additionally be interesting to compare the data from this kind of survey with police records. In addition, the intervention chosen as part of the core education and training

component will use rating scales with valid psychometric properties. These are incorporated into the specific intervention. Additional short-term and long-term outcome measures can be identified and correlated with the program.

The **streamlining of services** should be evaluated by assessing the number of referrals received via the community partnership in order to assess the effectiveness of the training and intervention. Here again, self-report survey elements will be essential to assess how accessible and acceptable the referrals and the care received are to the community.

c. Sustainability.

The establishment of formal links between the community and the Health Annex provides an opportunity to pool resources currently used for outreach and information dissemination. A successful partnership will generate additional revenues for the Health Annex via increased use of services by the catchment population. The community partner will be equipped to sustain specialized knowledge after the funding period has expired, and the recipients of training will be expected to continue to apply the techniques they have learned in their existing work activities. Successful elements of the program once the *Partnership for Wellness* is established could be maintained through support from local businesses or additional public and private funding sources. In addition to community residents, the City of Philadelphia, the Police Department, the schools, and the business community including nearby universities, all have a stake in reducing violence in Southwest Philadelphia. Once the efficacy of the intervention has been demonstrated, further investment by these stakeholders (who already devote funds to similar programs) may be feasible.

### 3. Sample Timeline

I. Phase I (Year 1)

A. Revision and submission of funding proposal for infrastructural and staffing support

B. Selection of community partner organization and intervention models

1. Community partner selection

- a. Review of proposal and supporting materials
- b. Selection by Health Annex Leadership of project leadership
- c. Formulation of selection criteria for candidate partner
- d. Listing and initial review of potential candidate organizations
- e. Contact by Health Annex Representatives with candidate organizations
- f. Collection of information on candidate organizations: mission, operations, infrastructure, personnel, and capabilities of organization
- g. Selection of partner organization
- h. Review and initial selection of intervention program components

2. Selection of intervention models

- a. Collaboration with partner organization for selection of program elements
- b. Consultation with community members and key stakeholders
- c. Consultation with wellness and behavioral health experts
- d. Review of budgetary needs and personnel requirements
- e. Job postings for new positions, if appropriate

II. Phase II (Year 2-3): Implementation of joint venture elements

A. Training for Health Annex and community partner staff

1. Contact with behavioral health training facilitator

2. Training session for Health Annex and community partner staff
  3. Trial period for model intervention
  4. Continuing review and quality improvement (see Phase III)
  - B. Creation of ‘Sanctuary Space’ at partner organization
    1. Designation of location for sanctuary space
    2. Design and planning of renovations/remodeling needed
    3. Request for proposals for contracting needs, review and selection of bids
    4. Physical development of space
    5. Marketing of sanctuary offerings to community targets
    6. Continuing review of utilization; quality improvement (See Phase II)
  - C. Identification of community leaders and stakeholders for further training and support
    1. Design of optimal recruitment strategies for informal neighborhood leaders; consultation with community organizations, block captain network, business owners, other community stakeholders
    2. Selection of behavioral health training module
    3. Recruitment of community participants
    4. Implementation of community based behavioral health training
    5. Ongoing program evaluation and quality improvement (See Phase III)
- III. Phase III (Ongoing)
- A. Review of program effectiveness
    1. Interviews with community members, Health Annex and community partner clients
    2. Interviews with Health Annex and community partner staff
    3. Monitoring of trends in program utilization and referrals to Health Annex
  - B. Continuing self-evaluation and training for Health Annex and community partner staff
  - C. Consideration of expansion of *Partnership for Wellness* model to additional community organizations

### III. Funding

#### A. Sources

The next steps for establishing a *Partnership for Wellness* would include securing funding to support Phase I goals. One to accomplish this would be through an organizational capacity-building grant.

The Philadelphia Foundation ([www.philafound.org](http://www.philafound.org)) is one organization that supports organizational effectiveness grants for capacity-building. This includes proposals to address the areas of Business and Finance, Governance, Leadership, Management/Operations, Mission/Vision/Strategy, Program Delivery and Development, Technology Planning and Implementation, Strategic Relationships and For Risk Capital.

Additional components of the *Partnership for Wellness* model could be funded separately through clinical research grants (as a replication site for a treatment intervention) or community development grants (to support specific wellness initiatives). The 2007 RWJCSP Report provides a detailed summary of existing funding sources with missions relevant to supporting violence prevention and community enhancing programs.

Establishment of physical space at a community location may require capital investment. The Health Annex and community partner could identify existing community resources to meet the requirements for physical space. Already the Health Annex secured the Pennsylvania Redevelopment Assistance Capital Program for its move to Woodland Avenue, and would be in

good position to reapply for further development of partner sites. The Aramark Corporation provides food services, facilities management, and uniform and career apparel to health care institutions, universities and school districts, stadiums and arenas, and businesses around the world. In grant-making through corporate charitable funds and local business support, they contribute annually to local organizations that are making a meaningful impact especially in the way of development of new facilities ([www.aramark.com](http://www.aramark.com)). The CIGNA Foundation also provides a limited number of Targeted Grants for creative initiatives in the area of Health & Wellness, especially for those initiatives that focus on their concern about the connection between a healthy mind and body ([http://www.cigna.com/about\\_us/community/targeted\\_grant.html](http://www.cigna.com/about_us/community/targeted_grant.html)). For a more comprehensive list of grants which focus on community development, health, and wellness, see the 2007 cohort's report, *Addressing Stress and Violence in Southwest Philadelphia*, at <http://www.med.upenn.edu/rwjcp/documents/finalreport.pdf>.

## B. Budget

Phase 1 goals include selection of the community partner and intervention model, and submission of grant application. Below is a budget for selected Phase I goals. Budget costs are based on supplies to complete the task and hours of work necessary per mid-level administrative assistant, or when indicated, other skilled employees. The Task Force would be a volunteer committee comprised of salaried Health Annex leadership and volunteer community leaders and Health Annex Staff.

Task	Job Type (number)	Hours	Cost
Review of proposal and supporting materials; assessment by Health Annex leadership on feasibility, mission congruence, and value of community collaboration.	Health Annex Director,	10	\$400
	Board of Directors (5)	10	\$2000
Formulation of selection criteria for candidate partner organizations by Task Force	Administrative Assistant (1);	10	\$500
	Health Annex outreach specialist (1);	10	\$500
	Task Force	10	0 \$200 (meeting costs)
Listing and initial review of potential candidate organizations serving Southwest Community	Administrative Assistant (1);	10	\$500
	Health Annex outreach specialist (1);	10	\$500
	Task Force	10	0 \$200 (meeting costs)
Contact by Health Annex Representatives with candidate organizations to assess willingness for collaboration	Administrative Assistant (1)	20	\$1000
			\$500 (Outreach phone calls and mailing)
Revision and submission of funding proposal for infrastructural and staffing support for Joint Venture Project	Administrative Assistant (1);	20	\$1000
	Health Annex Financial Leadership (1)	20	\$800
Preliminary meetings with	Administrative Assistant	30	\$1500

candidate organizations; collection of information on mission, operations, infrastructure, personnel, and capabilities of organization; identification of designated contact within partner organization	(1); Task Force	30	0 \$300 (meeting costs)
Consultation with community members and key stakeholders to specify areas of need for focused intervention	Administrative Assistant (1);	10	\$500
	Task Force	10	0 \$100 (meeting costs)
Consultation with wellness and behavioral health experts regarding programming content and execution	Administrative Assistant (1);	10	\$500
	Task Force;	10	0
	Psychiatrist (1);	3	\$300
	Psychologist (1);	3	\$250
	Social Worker (1)	3	\$150
			\$100 (meeting costs)
Contract negotiation with selected community partner	Administrative Assistant (1);	10	\$500
	Legal (1)	3	\$900
TOTAL			\$14,300

## Appendix A

### Health Annex: Financing and Location

**Financial support** for the Health Annex includes the Charitable Medical Care Grant, administered by Independence Blue Cross. This program has recently been expanded and will dedicate up to \$2 million per year through 2010 to help three clinics in Philadelphia – for a total of \$10 million committed to the program. As a federally-qualified health center (FQHC), the Health Annex also receives funding from a grant under Section 330 of the Public Health Services Act. There are some specifications within the law regarding the services that FQHC's have to offer, mainly dental, substance abuse treatment, and mental health or the means to refer people out. Payments are made directly to the FQHC for covered services furnished to Medicare beneficiaries. Services are covered when furnished to a beneficiary at the FQHC, the beneficiary's place of residence, or elsewhere (e.g., at the scene of an accident). Generally, Medicare pays FQHCs (which are considered suppliers of Medicare services) an all-inclusive per visit payment amount based on reasonable costs as reported on its annual cost report. Social work services are not strictly billable. The cost for providing social work is bundled into the cost of providing for an all-inclusive total visit at Health Annex. The beneficiary pays no Part B deductible for FQHC services but is responsible for paying the coinsurance with the exception of FQHC-supplied influenza and pneumococcal vaccines, which are paid at 100 percent. Generally, the coinsurance for FQHC services is 20 percent of the clinic's reasonable and customary charge except for psychological or psychiatric therapeutic services (generally furnished by clinical psychologists and clinical social workers), which are subject to the 62.5 percent outpatient mental health treatment limitation. This limit does not apply to diagnostic services. The application of the outpatient mental health treatment limitation increases the beneficiary's copayment to 50 percent of the clinics's reasonable and customary charge. The FQHC all-inclusive visit rate is calculated, in general, by dividing the FQHC's total allowable cost by the total number of visits for all FQHC patients. The FQHC payment methodology includes two national per-visit upper payment limits—one for urban FQHCs and one for rural FQHCs. The two national FQHC per-visit upper payment limits are increased annually by the Medicare Economic Index applicable to primary care physician services. The Health Annex does attempt to collect the co-insurance from all of its patients, but often collects a lesser amount based on whatever the patient is able to pay at the time. (FQHC Fact Sheet, Lorraine Thomas)

Historically, **financing strategies** of the Health Annex include obtaining grant funding, increasing managed care and mental health volume, as well as increasing family planning and fee-for-service volume. The current situation of Health Annex on Woodland Avenue is an important factor in the Health Annex's business objective, especially when it comes to increasing patient volume. To further detail the physical space that surrounds the Health Annex, it is important to note that Woodland Avenue has two vital cultural and institutional anchors, the historic Church of St. James at 68th Street and the University of the Sciences in Philadelphia at 45th Street, but the corridor currently lacks business anchors with the ability to draw customers. Woodland Avenue does have a rich history as it was part of America's first North-South highway and a once-lively and diverse retail district. (WARP Revitalization Project)

Today, Woodland Avenue has encountered decay as a result of poor public space housekeeping and the passage of time. An ambitious development strategy was undertaken by the **Woodland Avenue Revitalization Project** (WARP) a few years ago recognizing the great potential of Woodland Avenue because it hosts a wide variety of land uses including residential row homes, neighborhood shopping stores, commercial and industrial uses, and a dense eight-block, Core Retail Area from 60th to 68th Streets. There are currently 179 retail businesses located along Woodland Avenue between 45th Street and Island Avenue. A few are scattered amidst housing and other uses, but most (132) are concentrated in the Core Retail Area.



*Vacant storefronts*



*Vacant lots*

Currently, SEPTA is excavating, renewing and paving approximately 4,000 feet of eastbound and westbound tracks on Woodland Avenue from 60th Street to 68th Street. On July 12, 2008 at a meeting of City Lights, a group comprised of 40 community organizations from the SW area and Wayne Presbyterian Church who gather monthly for city network meetings, SEPTA Community Relations Director, Michael Dawkins, assured the community and area businesses that the project was on schedule and would be completed by the end of the summer. This would allow for increased access to businesses and facilities between 60<sup>th</sup> and 68<sup>th</sup> street, including the Health Annex.



*Photo rendering of the Development Strategy for the Woodland Avenue Revitalization Project (WARP)*

All of the recent failures and successes along Woodland Avenue are important in understanding the Health Annex's capacity for further community integration and the social and economic benefits that the Health Annex could acquire from improved accessibility by the Southwest Philadelphia community. Its current location in the retail corridor of Woodland Avenue may also support the establishment of a community outpost in more residential areas that further facilitate outreach and streamline referrals for those who may need care at the Health Annex.

## **Appendix B**

### **Selected Potential Candidate Organizations**

Background: The list below reflects the product of community input and discussion drawn from key informant interviews, community tours, and focus group input. It is not an exhaustive list, but is intended to give Health Annex representatives input into organizations that may be appropriate for a wellness-focused joint venture (such as, the *Partnership for Wellness*). Beyond the three organizations listed here, we encourage the leadership of the Health Annex to consider the following as potential partners in such a venture: religious institutions, including churches and mosques, branches of the City of Philadelphia Free Library, area public schools, the Southwest Philadelphia Community Development Council, and other non-profits such as the Southwest Action Coalition, Men United Against Violence, and Mothers in Charge.

1. *City of Philadelphia Department of Recreation*

The City of Philadelphia Department of Recreation, led by Commissioner Susan Slawson, oversees 163 recreation centers and 79 parks, including 7 recreation centers in the Southwest Philadelphia area. Recreation centers in Philadelphia have been severely affected by violent crime, as centers located in Southwest Philadelphia and other neighborhoods have become the setting for violent attacks, including homicides (Phila. Enquirer 10/3/07, 5/1/07). Despite this, recreation centers in Southwest Philadelphia play a vital role in supporting youth activities and community programming, and offer a potential opportunity for behavioral health intervention.

Our research identified at least two recreation centers in Southwest Philadelphia that could be considered as candidate organizations based on their structural and leadership characteristics: the Kingsessing Recreation Center at 50<sup>th</sup> Street and Kingsessing Avenue, and the Francis J. Myers Recreation Center at 58<sup>th</sup> Street and Chester Avenue.

Both centers are located in close proximity to the Heath Annex, and support a wide range of programming targeted at community members across ages, including after-school programming, sports programs, and adult programming. Programs are supported at each center by a mix of volunteer and paid staff. Both are designated as Teen Centers, receiving special support from the Department of Recreation for programs targeting youth ages 14 to 24. Additionally, both centers have strong historical and interpersonal links with the Health Annex. The Myers Recreation Center served as the original location of the Health Annex prior to December 2007, and members of the Kingsessing Recreation Center's Community Board maintain contact with Health Annex outreach staff through mutual involvement in Southwest Philadelphia grassroots activities.

#### Contact Information:

##### City of Philadelphia Department of Recreation:

Commissioner Susan Slawson  
One Parkway  
1515 Arch St. 10<sup>th</sup> Floor  
Philadelphia, PA 19102  
(215) 683-3601  
susan.slawson@phila.gov

##### Kingsessing Recreation Center:

Director: Les Quill  
4901 Kingsessing Ave.  
Philadelphia, PA 19143  
(215) 685-2694

##### Francis J. Myers Recreation Center:

Director: Daryl Nelson  
5800 Chester Ave.  
Philadelphia, PA 19143  
(215) 685-2698

#### 2. *The African Cultural Alliance of North America (ACANA)*

Founded in 1999, ACANA is a non-profit organization located at 55<sup>th</sup> street and Chester Avenue providing a range of services to Southwest Philadelphia. Founded with the mission of helping "refugee and immigrant families access health and other social benefits with special focus on women, children, youth and the elderly," ACANA's programming impacts a diverse array of community

members in Southwest Philadelphia, not strictly limited to recent immigrants. Programs include WATREP, an after-school counseling program serving about 55 youths, an adult basic education program focusing on reading and math skills, a course in computer repair and maintenance training for area youths. Through its refugee/asylee program, it provides outreach services, case management, information and referral and life skills workshops to over 180 African immigrants. ACANA additionally participates in health promotion and cultural support within the Southwest Philadelphia community through health fair participation and programming at its center on Chester Avenue. The work of the center is supported by volunteer effort with some staffing support. The center's director is Voffee S. Jabateh, a social worker and community activist.

Contact Information:  
Director: Voffee Jabateh  
5521-23 Chester Ave  
Philadelphia, PA 19143  
(215) 729-8225  
Email: info@acanaus.org

3. *The Police Athletic League*

The Philadelphia Police Athletic League, a non-profit organization oversees 27 centers in Philadelphia, including a Southwest Philadelphia center at 5900 Elmwood Avenue. Programs are supervised by Philadelphia police officers and civilian staff, and include sport, educational and cultural opportunities. PAL Programming includes a college scholarship program for participating community youth, as well as a variety of educational and cultural trips.

Contact Information:  
Officer Darren James  
Police Athletic League of Philadelphia  
2524 E. Clearfield Street  
Philadelphia, PA 19134-5034  
(215) 291-9000 x 160

Southwest Philadelphia PAL  
St. Mary's RC Church  
5900 Elmwood Avenue, 19143  
(215) 727-8181

## **Appendix C**

### **Criteria for the Evaluation of Potential Community Collaborators**

- 1) Willingness to engage as an equal partner in a collaborative relationship with a community organization. This willingness should be shared by leadership, staff, volunteers, and clients of the organization.
- 2) Commitment to the development of wellness among the residents of Southwest Philadelphia, without discrimination against any group of persons on the basis of race, ethnicity, age, gender, income, lifestyle, or ability.
- 3) Clients utilizing the services of the candidate organization should:
  - a) Engage with the candidate organization on a stable, recurring basis over time
  - b) Be of sufficient number, as judged by the Health Annex, to add to the frequency of referrals to the Health Annex (medical and behavioral health)

- c) Be representative of the community served by the Health Annex; this should include, but not be limited to representation of the range of ages, sexes, races, ethnicities, abilities, and lifestyles present in Southwest Philadelphia
- d) If clients of the candidate organization are representative of a particular segment of the population, mechanisms should be available for wider outreach to include segments not immediately served by the organization
- 4) Staff of the candidate organization should:
  - a) Represent a stable pool of resources committed to serving the organization's mission over time
  - b) Have capability, as an organization, to accommodate the person-hours for behavioral health training
  - c) Have the capacity on an individual level to complete a structured training in behavioral health
  - d) Have the capacity on an individual level to provide basic counseling in stress management to clients utilizing the organization's programs
  - e) Have the capacity on an individual level to make judgments regarding the need for behavioral health referral to the Health Annex and to pursue such referral in an appropriate, respectful, and confidential manner
- 5) The material and financial infrastructure of the organization should:
  - a) Be financially solvent with a high likelihood of continued service at the organization's current level of activity over several years
  - b) Include a physical presence in Southwest Philadelphia in reasonable proximity to the Health Annex
  - c) Include a structural meeting place that is clean, safe, and secure. Ideally, the likelihood of need for re-location of the organization during the period of collaboration should be low.

## Appendix D

### Comparison Chart of Interventions for Traumatization and Stress

Name	Treatment Description	Target Population	Key Components	Implementation Requirements	Training Materials	Clinical Evidence?	Research Evidence?
Community Outreach Program- Esperanza (COPE)	Case Management along with Trauma focused CBT, Culturally Modified trauma focused treatment, parent-child interactive therapy(PCIT)	Children 4-18 yrs and their family	Psychoeducation, coping skills training, affective identification and processing, trauma narrative, and risk reduction. Outreach and case management	Sessions held at home, school, or other community site convenient for child or parent. Weekly supervision required upon initial implementation	Readings, treatment manuals, group and individual supervision of 6-10 cases	Y	N
Child Adult Relationship Enhancement (CARE)	Trauma-informed modification of specific PCIT skills for general use by non-clinical adults	Children of all ages and their caregivers	Live coaching. Teaching 3P skills (Praise, Paraphrase, and Point-out-Behavior). Includes trauma education.	Manualized training. Implementation after completion of CARE training (3-6 hrs)	none	Y	N
The Sanctuary Model®	System-wide approach to creating trauma informed culture based on creating nonviolent, democratic, productive community	Children over 4 and adults	Shared language of Safety, Emotion Management, Loss and Future. Development of a core team for implementation. Concrete tools for intervention (community meetings, redflag reviews, psychoeducation in trauma, self-care planning, safety plans, team meetings & treatment planning conferences.	Assessment of performance along 7 Sanctuary commitments. Supervision and training. Consultation. Implementation may take 2-5 years	Staff training Manual, Implementation Guide, Data collection manual.	Y	Y

<b>Name</b>	<b>Treatment Description</b>	<b>Target Population</b>	<b>Key Components</b>	<b>Implementation Requirements</b>	<b>Training Materials</b>	<b>Clinical Evidence?</b>	<b>Research Evidence?</b>
The Safe Harbor Program	Uses a 'safe harbor' room in school as a low stigma, easy access entry point to attract distressed child/youth coping with violence.	Ages 6-21	1) PEARLS: People Empowered about Real Life Situations, trauma education/violence prevention curriculum(10 lessons)2)Individual counseling as needed 3) Parent involvement and staff trainings 4) Structured group activities to strengthen peer relationships 5) School-wide antiviolence campaign	Requires designated space in the school and regularly scheduled clinical and administrative supervision. 6hrs-3 days of training depending on experience level of clinician-in-training	Implementation Manual and PEARLS curriculum with Facilitator's guide	Y	Y
Trauma Systems Therapy				4 types of services must be available to the team: skill-based psychotherapy, home and community based therapy, legal advocacy, and psychopharmacology. These can be assembled creatively out of resources available in the community. Supervision not required, but weekly team meetings provide group supervision.	Training available through individual agency contracts	Y	Y
Multimodality Trauma Treatment	Trauma-focused coping, skills-oriented CBT approach designed as a peer-mediating group intervention.	Children 9-18 yrs exposed to single-incident trauma	Psychoeducation, anxiety management & cognitive training, anger coping, grief management, narrative exposure, affective processing, relapse prevention	Trained clinical supervisors and staff. Established relationship with school. Private rooms to conduct treatment, Determine if school counselor will co-lead group. Flip boards/chalk boards	Manualized treatment. Training involves organizational readiness assessment. 1-2 day skill based training. 4-6 months of expert consultation	Y	Y

<b>Name</b>	<b>Treatment Description</b>	<b>Target Population</b>	<b>Key Components</b>	<b>Implementation Requirements</b>	<b>Training Materials</b>	<b>Clinical Evidence?</b>	<b>Research Evidence?</b>
Group Psychological First Aid	A group of skills identified to limit distress and negative health behaviors taught in a group format	Individuals exposed to potentially traumatic event	Psychoeducation about normal responses to stressful and traumatic events, active listening skills, understanding the importance of maintaining physical health and normal sleep nutrition & rest, understanding when to seek help from professional caregivers.	Specialized training recommended for group format. Can be taught to volunteers and professionals, Valuable if one of the co-leaders is a member of the culture being addressed.	Published 'Field Guide' for individual PFA. Group treatment described in detail in published articles.	Y	Y
Pure Quality Life	Free web-based stress-management system for self-assessments of stress, real-time feedback, cognitive exercises	Consumer driven access	Quality-assured online tool. Stress education. Self-assessment and feedback. Exercises (breathing, relaxing & sleep, emotional control and body awareness, cognitive restructuring). Ability to track progress and compare to normative data	Web Access	All online integrated in program	N/A	Y
Prolonged Exposure for PTSD	Individual CBT designed to treat Posttraumatic Stress Disorder	Adults with PTSD	Psychoeducation, relaxation training, imaginal exposure to traumatic memory and in-vivo exposure to trauma reminders, combined with cognitive processing	Training of clinicians required. (4 day workshop) Counselors can also participate in training. Remote supervision of 4 cases recommended.	Treatment manual. Assessment tools available	Y	Y
The Child Development-Community Policing Program	Collaborative model between law enforcement and child mental health professionals to respond to children and families in the aftermath of crime and violence	Children and families exposed to violence	Child development training for police officers; police "shadowing" experience for clinicians; 24/7 consultation service with mental health clinician provided to police; program conference for police and clinicians to discuss cases	Willingness between organizations to collaborate, specialized training	Manual (including development, implementation, case studies, guidelines for selecting participants, operating a consultation service, and evaluating the program)	Y	Y

## **Appendix E**

### **Community Policing**

Community policing efforts are critical to the reduction of violence and improvement of community trust. In addition, one project described below may serve as a model for a partnership between the Health Annex and the Philadelphia Police, and could fit into the *Partnership for Wellness* framework. The text below is taken from the Office of Juvenile Justice and Delinquency Programs website ([http://ojjdp.ncjrs.org/pubs/gun\\_violence/profile48.html](http://ojjdp.ncjrs.org/pubs/gun_violence/profile48.html)) where more information can be found. Further information can also be found at the Yale Child Study Center website at <http://childstudycenter.yale.edu/services/cdcp.html>.

The Child Development-Community Policing (CD-CP) Program – a collaborative effort of the New Haven Department of Police Services and the Child Study Center at the Yale University School of Medicine – was developed to address the tragic psychological impact of exposure to violence on children. The CD-CP Program brings together police officers and mental health professionals for mutual training, consultation, and support so that they may effectively provide direct interdisciplinary intervention to children and families who are victims, witnesses, or perpetrators of violent crimes.

The CD-CP Program consists of interrelated training and consultation components that focus on sharing knowledge and developing ongoing collegial relationships between police officers and mental health professionals. Toward this end, CD-CP sponsors fellowships for police supervisors and clinicians to establish interdisciplinary relationships. In the Child Development Fellowship for Police Supervisors, fellows spend 3 full days in training activities and observations to become familiar with developmental concepts, patterns of psychological disturbance, methods of clinical intervention, and settings for treatment and care. Supervisors also provide basic knowledge about police practices to their mental health colleagues.

Since the CD-CP Program began formal operation in January 1992, 260 officers have completed the 10-week CD-CP seminar, 50 police supervisors have completed the Child Development Fellowship and continue to attend the weekly program conference, and 19 Child Study Center faculty members have completed the Police Fellowship. Moreover, since its inception, the CD-CP consultation service has received more than 700 referrals regarding more than 1,000 children. These consultations concerned children of all ages who have been involved in a variety of violent incidents as victims, witnesses, or perpetrators. Numerous incidents demonstrate the impact that the program has had on children referred to consultation services.

The CD-CP Program serves as a national model for police-mental health partnerships and is being replicated in several cities. Similar programs have been established in Baltimore, MD; Buffalo, NY; Charlotte, NC; Framingham, MA; Nashville, TN; Newark, NJ; Portland, OR; and Italy. The Office of Juvenile Justice and Delinquency Prevention is providing training and technical assistance to these new sites.

In Philadelphia, the West/Southwest Victim Services Program is committed to helping victims of crime in the 12th, 16th, 18th and 19th police districts. The program's Victims' Advocates offer supportive counseling, referrals, assistance with the legal system, crime victim's compensation and protection orders. For more information they can be reached at (215) 748-7780

## **Appendix F**

### **Mural Arts Program**

#### **I. Existing social/educational art programs**

Youth art education programs currently available in West and Southwest Philadelphia include Big Picture located at two sites, 48th and Woodland Playground, and the Shaw Middle School at 5400 Warrington Avenue. Big Picture is a visual arts education program for young people ages 10-18yo that focuses on community and social responsibility. An additional component is a job training-focused session where participants earn a modest stipend. There is also the Mural Corps program located at Sayre High School, at 5800 Walnut Street. This program for 14 to 21 year olds provides job skills by cultivating fine arts training. A collaboration between the City of Philadelphia Department of Human Services and Philadelphia Family Court, E3 (Education, Employment, and Empowerment) Power Centers provide programs for youth coming out of detention centers, long-term placement, or school drop-outs. The Mural Corps is also offered at the E3 Power Centers. Youth are usually referred to the City sponsored after-school programs ArtWorks! and AVRPP (Adolescent Violence Reduction Partnership) sites by the Department of Human Services, and site locations are determined by them

#### **II. Steps to Mural Creation**

Below is a brief outline of some important steps and principles to creation of a mural put forth by the Mural Arts Program in their publication, My Anti-Drug Mural Guidebook.

##### (1) Getting Started

- Finding a mural artist
- Forming a mural team
- Select a Mural Type
- Scout for a Mural Surface
- Secure Your Space
- Obtain Insurance Permits

##### (2) Budgeting your mural project

- Determine cost projection
- Secure funding
- Thank your sponsors

##### (3) Creating the vision

- Develop the team structure
- Find a mural theme
- Develop a mock design
- Get the community involved

##### (4) Painting the mural

- Assign roles and responsibilities
- Determine materials needed
- Prepare surface for work
- Transfer design to surface
- Select paint for the mural and paint
- Cleanup

##### (5) Promoting and dedicating your mural

- Plan details of dedication ceremony
- Determine elements needed for dedication program
- Publicize your event
- Share your success with the community and other city agencies including MAP

## Steps to starting a community garden

### (1) Formal Planning Committee

- What kind of garden--vegetable, flower, trees, a combination?
- Who will the garden serve--kids, seniors, special populations, people who just want an alternative to trash?
- Form committees to accomplish tasks: Funding & Resource Development; Youth Activities; Construction; Communication.
- Approach a sponsor. Churches, schools, citizens groups, private businesses, local parks and recreation departments are all potential supporters. Community Development Block Grants are sometimes available through your municipality.
- Decide on a site and Obtain lease or agreement from owner
- Choose a name for the garden

### (2) Choose a site

- Identify the owner of the land
- Make sure the site gets at least 6 full hours of sunlight daily (for vegetables)
- Do a soil test in the fall for nutrients & heavy metals
- Consider availability of water
- Try and get a lease or agreement which allows the space to be used at least for 3 years
- Consider past uses of the land. Is there any contamination?

### (3) Prepare and develop the site

- Clean the site
- Organize volunteer work crews
- Decide on plot sizes, mark plots clearly with gardeners names
- Include plans for a storage area for tools and other equipment, as well as a compost area
- Have a rainproof bulletin board for announcing garden events and messages
- Lay out garden to place flower or shrub beds around the visible perimeter. This helps to promote good will with non-gardening neighbors, passersby, and municipal authorities.

### (4) Organizational Considerations

- What is your purpose? What are your short and long-term objectives?
- How are decisions to be made? Who chooses leaders and how?
- How will work be shared? Who does what?
- How will you raise money? Membership dues, fund raising, grants, sponsors?
- Are you open to change? Flexibility is important when goals and members change.
- Do you want to be incorporated or act as a club?

### (5) Troubleshooting: Vandalism is a common fear among community gardeners. However, the fear tends to be much greater than the actual incidence. Try these proven methods to deter vandalism:

- Make a sign for the garden. Let people know to whom the garden belongs and that it is a neighborhood project.
- Fences can be of almost any material. They serve as much to mark possession of a property as to prevent entry, since nothing short of razor-wire and landmines will keep a determined vandal from getting in. Short picket fences or turkey wire will keep out dogs and honest people.
- Create a shady meeting area in the garden and spend time there.

- Invite everyone in the neighborhood to participate from the very beginning. Persons excluded from the garden are potential vandals.
- Plant raspberries, roses or other thorny plants along the fence as a barrier to fence climbers.
- Make friends with neighbors whose window overlook the garden. Trade them flowers and vegetables for a protective eye.
- Plant potatoes, other root crops or a less popular vegetable such as kohlrabi along the sidewalk or fence. Plant the purple varieties of cauliflower and beans or the white eggplant to confuse a vandal.
- Plant a "vandal's garden" at the entrance. Mark it with a sign: "If you must take food, please take it from here."

(6) Resources

- Neighborhood Gardens Association, Philadelphia <http://www.ngalandtrust.org>
- Philadelphia Green (Pennsylvania Horticultural Society) <http://www.pennsylvaniahorticulturalsociety.org>
- Urban Community Gardens <http://alexia.lis.uiuc.edu/~sewells/communitygardens.htm>

## **Appendix G**

### **Audience for community training**

#### *Clergy*

Religious leaders have broad consistencies and, by definition, are experts in the delivery of messages that are meant to promote spiritual well being. They are trained in their vocation. They are often highly connected to their constituents and if they are effective religious leaders, they are likely to possess high levels of energy and enthusiasm. Additionally, as a function of their positions, they automatically possess authority and access to various religious spaces and facilities. There is significant evidence that clergy already provide counseling and behavioral health referrals regularly. One potential criticism of the use of clergy for the delivery of behavioral health services to a community is that a given clergyperson's influence may be limited to their congregation, which may or may not be representative of the target community. However, a study of 121 African American church clergy in New Haven, CT showed that clergy average more than 6 hours of active psychological counseling per week and do so both inside and outside their own denominations. (Young 2003)

#### *Tutors*

Paid and volunteer tutors work in both schools and after-school programs. In Philadelphia, many of these programs exist at recreational centers and the Free-Libraries. Tutors may or may not meet all of the above criteria of effective individual characteristics for community enhancement. However, by the nature of their involvement in tutoring, they are likely to possess some combination of teaching ability, enthusiasm, community knowledge, and access to facilities where the tutoring occurs. Additionally, there is evidence to suggest that programs even where untrained high school students are tutors, they may be able to improve the emotional health of both the tutees and the tutors themselves (Rogeness, 1973). This suggests that tutors may be appropriate candidates for a community behavioral health delivery model, despite absences of high levels of training.

#### *Coaches*

There is limited empirical evidence that sports and recreation coaches are specifically suited to the delivery of community based behavioral health services. However, community based participatory research projects, such as the Centerpiece Project of the Philadelphia Violence Prevention Center (ref) have successfully piloted aggression reduction programs in organized settings such as youth football.

Because sports coaches possess expertise, leadership, enthusiasm and access to facilities/spaces, they are likely to be prime candidates to participate in community oriented behavioral health delivery.

### *School Teachers*

The importance of schools as a place to deliver community-based behavioral health education is well recognized. Healthy People 2010 has a specific objective to “increase to proportion of schools that provide school health education to prevent health problems in the violence, suicide, tobacco use and addiction. (Healthy People 2010). Teachers, in particular, have been identified as regular providers of behavioral health advice to their students but also have stated that they feel under-equipped and ill-prepared to do this (Cohall, 2007). Teachers do have direct access to their constituents and certain levels of authority in their relationships with students. Conversely, teachers may be more limited than other service providers due to their relative narrow constituency and significant competing time pressures to provide academic instruction. One example of creating a successful community knowledge base in Southwest Philadelphia was accomplished by the West African Refugee Assistance Program (Children’s Crisis Treatment Center, Philadelphia PA). They established training programs for teachers of West African refugee students to enable these teachers to recognize the unique mental and behavioral health needs of their students, many of whom experienced trauma in their country and during immigration to the US. Through a four-level system of evaluating these trainings, teachers were asked about their reactions and their learning, and the program observed the transfer of teacher knowledge into behavior and the impact of the training on the students’ mental health and appropriate referral. The continuing education of these teachers provided a community of teachers who continued to support one another and to evaluate their own efforts. These teachers built upon the lessons they learned in assisting the West African refugees and collaborated with the West African Refugee Assistance Program to present a more inclusive lesson for all Philadelphia teachers by presenting a workshop entitled “Survival Strategies: Managing Stress and Ways to Take Care of Yourself in the Challenging Work Environment of an Inner-City School”. In this way, the community knowledge base not only became a tool for secondary prevention of posttraumatic stress experienced by the refugee students, but also became a tool for primary prevention of caregiver stress in the greater Philadelphia community of teachers.

## Appendix H

### References and Suggested Readings

Mental Health America [http://www.mhahouston.org/mha\\_houston.cfm?a=cms.c.20.3.0](http://www.mhahouston.org/mha_houston.cfm?a=cms.c.20.3.0)

Among other things, this nonprofit association offers training programs for clergy who work as lay counselors in recognizing warning signs of severe mental illness

National Child Traumatic Stress Network: <http://www.nctsn.org/>

National Center for Children Exposed to Violence: <http://www.ncccev.org/>

National Center for PTSD <http://www.ncptsd.va.gov/ncmain/index.jsp>

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