

Responding to Trauma, Violence and  
Bereavement Overload in the Lives of Young  
African American Men:

*Trauma-informed Approaches to Health Care*

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## Introduction

We begin this chapter by discussing some of the devastating results of living in America's urban war zones – the inner cities – and the toll this takes particularly on young black men. Currently, most victims of youth violence are young men of color. Black men, however, are sorely underrepresented among providers of care, especially physicians and this under representation deepens the sense of mistrust in young men who already believe that the deck is stacked against them. We have a special interest in this issue because both authors of this chapter are African-American physicians. For us, the war that is being waged at home – so slowly but insidiously destructive – is like a slow rolling disaster with no end in site.

We have both been involved in trying to intervene in the lives of trauma survivors at two key points of contact: medical emergency rooms and primary care clinics. In this chapter we describe two programmatic efforts within the healthcare system to provide a higher level of care for young men in inner city who are victims of violence and who are largely African-American.

The Thomas Jefferson University Hospital Community Violence Prevention Program represents a coalition of providers focused on emergency department-based interventions that have the potential to address trauma and loss more effectively for an urban population. The Young Men's Health Clinic at Boston City Hospital is a primary care based intervention that is designed to provide holistic health care for young man who aged out of adolescent care and who are utilizing adult health care.

We conclude the chapter by discussing some of the key lessons learned in implementing these programs. We believe that it is possible to transform existing health care services by providing a trauma-informed healing perspective that will benefit not only the young man who are seen themselves but also the communities that they come from. It is our hope that by addressing the past and on-going traumatic and bereavement experiences of these young men, that we may make them better able to avoid passing their trauma along to their children.

## Living in a War Zone

The streets of Philadelphia, one of the nation's largest cities, have become an urban war zone. In one particularly brutal neighborhood, the word "Iraq" is spray painted on vacant buildings<sup>[1]</sup> In a seven month period in 2006, 1, 192 people were shot, 242 of them were killed and 142 of these shooting victims were children and teenagers<sup>[2]</sup> In the same period, victims of gun violence in Philadelphia equaled 54% of all American military deaths in Iraq<sup>[3]</sup> Homicides

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<sup>[1]</sup> Moran, *Living, dying in Phila.'s 'Iraq' - A mother is shot to death, and a community is torn.*

<sup>[2]</sup> Baer, *As bullets fly, bodies drop, where's Street?*

<sup>[3]</sup>Haile, Lowy and Pennington. *Lethal Lou's: Profile of a Rogue Gun Dealer – Lou's Loan of Upper Darby, Pennsylvania.*

claimed 406 victims in Philadelphia in 2006 – the deadliest toll since 1997’s 418<sup>[4]</sup>. Over the past two years, the murder rate among people age 18 to 24 is 30% higher than the rate for all victims and overall they make up a third of all homicides in Philadelphia<sup>[5]</sup>. Since 2004, 102 children seventeen years old or younger, have been murdered in Philadelphia<sup>[6]</sup>. Some 88% of all victims in all age categories are male<sup>[7]</sup>.

These numbers, however, only represent the most graphic exposure to violence. What lies hidden behind the statistics of victimization is the enormity of “co-victimization” – every witness to violence, every family member or friend that loses a loved one, is also victimized. And in the process of this devastation, entire communities are affected. As noticed by those who have studied collective trauma, *“Competency in coping can be overwhelmed and weakened in groups that have experienced an accumulation of losses and are still dealing with unresolved past traumas. Bereavement overload, often observed in individuals who have suffered many losses within a circumscribed period of time, can numb a community and interfere with efforts to respond to a current crisis”*<sup>[8]</sup>.

### *Being Young, Black and Male*

Young African-American men in particular are often victims of violence. National data show that African-American men are more likely to report that they have been victimized through violence. Homicide is the leading cause of death for African-American males between the ages of 15 and 34. In addition, African-American males have the highest rate of so-called legal intervention homicide, or death at the hands of law enforcement officials, also known as “suicide by cop”<sup>[9]</sup>. As Geoffrey Canada has noted, *“It takes years of preparation to be willing to commit murder, to be willing to kill or die for a corner, a color, or a leather jacket. Many of the children of America are conditioned early to kill and more frighteningly, to die, for what to an outsider might seem a trivial cause”*<sup>[10]</sup>.

And what lies behind violent victimization is the impact of chronic, grinding, unrelenting chronic sources of stress and loss. As a group, young black men in the inner city experience trauma and loss throughout their lives. The chronic, institutional stresses of poverty and racism are examples of social forces that can be termed traumatogenic in that they breed interpersonal traumatic acts<sup>[11]</sup>. Young black men historically have been victims of trauma through discrimination, lack of access to jobs, high rates of imprisonment and brutalization at the hands of the police. Difficult life conditions give rise to a

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<sup>[4]</sup> Weischselbaum, *A Quest to save youth at risk*.

<sup>[5]</sup> Ibid

<sup>[6]</sup> Ibid

<sup>[7]</sup> Ibid

<sup>[8]</sup> Zinner and Williams, *Summary and Incorporation: A Reference Frame for Community Recovery and Restoration*

<sup>[9]</sup> Poussaint and Alexander, *Lay My Burden Down*

<sup>[10]</sup> Canada, *Fist Stick Knife Gun*

<sup>[11]</sup> Bloom and Reichert, *Bearing Witness*

constellation of cultural circumstances which make the transmission of interpersonal violence normative<sup>[12]</sup>. Poverty has been found to have a primary influence on how well parents manage family life<sup>[13]</sup>. Family poverty inhibits parental processes of family control, for example, increasing the likelihood of childhood acting out<sup>[14]</sup>. In discussing the causes of the rising violence in Philadelphia among youth, Richard Gelles, Dean of the School of Social Policy and Practice at the University of Pennsylvania, suggested that one cause of the rise in youth violence could be the welfare reforms of 1996 – which he helped to write. The city “*may be at the front end of a wave because Philadelphia set a 24 month limit for welfare benefits while the rest of the country set a 60-month limit....We turned a blind eye to the fact that many of them [welfare recipients] were single parents. It’s not a bad idea putting people to work – except that if you’re going to put moms to work, it’s really a good idea to have daycare and it’s really a good idea to have healthcare. We didn’t do that. We created a situation where there’s nobody home*” and without anyone to watch over them, children are being raised by the streets<sup>[15]</sup>.

Because of a high rate of violence among African-American men, many have lost friends or family members to violence or to imprisonment. Many young men have grown up without fathers, and as a result they cannot access the advice, role modeling and mentorship that they would expect. Further, they are deprived of the future economic benefits of having two wage earners in the home and this has a marked effect on their economic security.

Under such conditions, it is not surprising that unchecked aggression is more frequently exhibited in children from poverty families<sup>[16]</sup>. Other at-risk factors for violence are also associated with economic and race stressors. The “single common pathway to high-risk adolescent behavior” has been found to be early academic failure<sup>[17]</sup>. Yet a child’s chances for success in school has been found to be powerfully affected by early childhood experiences of poverty<sup>[18]</sup>. Anderson has vividly documented the manner in which the “*inclination to violence springs from the circumstances of life among the ghetto poor - the lack of jobs that pay a living wage, the stigma of race, the fallout from rampant drug use and drug trafficking, and the resulting alienation and lack of hope for the future*”<sup>[19]</sup>.

Most significantly, the cumulative effect of violence in the home and on the streets impairs the establishment of interpersonal trust, a central outcome of the human attachment process that ideally endows citizens with a sense of

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[12] Staub, *Cultural-societal roots of violence*.

[13] Garrett et al, *Poverty Experiences of Young Children and the Quality of Their Home*

[14] Sampson and Laub, *Urban Poverty and the Family Context of Delinquency: A New Look at Structure and Process in a Classic Study*.

[15] Vaidya, *What’s Behind a New Wave of Crime*

[16] Tolan and Henry, *Patterns of Psychopathology among Urban Poor Children: Comorbidity and Aggression Effects*.

[17] Tuakli-Williams and Carrillo, *The Impact of Psychosocial Stressors on African-American and Latino Preschoolers*

[18] Brooks-Gunn, *The Effects of Poverty on Children*

[19] Anderson, *Living hard by the code of the streets*

investment in their community<sup>[20]</sup>. The constant background of violence for poor urban youth creates, by contrast, a "culture of disengagement"<sup>[21]</sup>. At this point in the culture, with black males threatened from a convergence of powerful trends, the manner in which a child internalizes the content of negative messages through distorting self-image provides an additional explanation for the culture of violence swirling through urban communities.

### *Post-Traumatic Stress and African American Youth*

It then follows from the catastrophic levels of violence that young black men have high rates of trauma exposure. Yet the medical and mental health literature has not documented clearly the rates of acute stress and post-traumatic stress that occur in these young men, in part because of the problem of definition. Geoffrey Canada has pointed out that, "for the handgun generation there is no post-traumatic stress syndrome because there is no 'post'. We need a new term to describe what happens to people who never get out from under war conditions, maybe 'continuous traumatic stress syndrome'"<sup>[22]</sup>. Breslau and colleagues have documented high rates of post-traumatic stress among inner-city youth<sup>[23]</sup>.

Research findings on the incidence of posttraumatic stress disorder in the African American community are, however disturbing. In the early 1990s, researchers surveyed 7-18 year olds who were participating in a summer program near Washington, D.C. Twenty-two percent of the children reported symptoms of PTSD. The researchers also reported that 70% of the children were victims of violence and of those studied, 85% had witnessed at least one violent attack and over 43% had witnessed a murder. In the study, the greater the exposure to violence, the greater the likelihood of PTSD symptoms<sup>[24]</sup>. Also in the early 1990's, another study screened over a thousand children in the Chicago area and found that 75% of the boys and 70% of the girls had seen someone get shot, stabbed, robbed, or killed and linked these experiences to deterioration in cognitive performance and both behavioral and emotional dysfunction<sup>[25]</sup>.

More recently, Rich and Grey documented that 2/3 African-American males hospitalized for violent injury fulfilled criteria for post-traumatic stress disorder when surveyed a month or more after their injuries<sup>[26]</sup>. Even those men who did not meet full criteria for PTSD showed evidence of hypervigilance on the PTSD Symptom Scale. While these studies alone do not paint a full picture, it

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<sup>[20]</sup> Bloom and Reichert, *Bearing Witness*

<sup>[21]</sup> Berman, *The effects of living with violence*

<sup>[22]</sup> Canada, *Fist, Stick, Knife, Gun*

<sup>[23]</sup> Breslau, Andreski and Peterson, *Traumatic Events and Posttraumatic Stress Disorder in an Urban Population of Young Adults.*; Breslau and Davis, *Posttraumatic Stress Disorder in an Urban Population of Young Adults*

<sup>[24]</sup> Allen, *PTSD Among African Americans*, p. 215-216.

<sup>[25]</sup> *Ibid*, p.216

<sup>[26]</sup> Rich and Grey, *Pathways to recurrent trauma among young black men*

follows that young black men having experienced trauma and loss in so many areas of their lives would show the short-term and long-term effects of trauma.

Several studies show that victims of violence are more likely to be re-victimized<sup>[27]</sup>. Rich and Grey, using qualitative methods suggested the trauma that results from violent injury sets in motion a cascade that makes another episode of violence more likely to happen<sup>[28]</sup>. They found that young men who live in the inner city and who do not trust the police may feel the need to arm themselves after they have been injured believing that they will protect themselves. They also found that these young men believe that if they fail to retaliate when they are victimized, others in their community will see them as weak and will seek to victimize them as well. While these ideas are prevalent in the community among victims of violence, they are exacerbated by active symptoms of post-traumatic stress that lead them to over-interpret any signs of danger as a real clear threat to their safety.

And are these young victims likely to receive adequate mental health treatment? An abundance of reports highlight the present dysfunction of the mental health system as a whole. According to multiple reports looking at the present state of the mental health system, separate health, mental health and substance abuse service delivery systems and funding sources, differences among clinicians in practice orientation and training, and various consumer concerns are just some of the barriers that must be overcome to deliver effective integrated care. According to the President's New Freedom Commission on Mental Health, *"The mental health services system defies easy description.... Taken as a whole, the system is supposed to function in a coordinated manner; it is supposed to deliver the best possible treatments, services, and supports-but it often falls short"*<sup>[29]</sup>. As the Bazelon Center for Mental Health Law points out, *"Fragmented care remains the norm for individuals with serious mental disorders. The delivery systems for mental health, substance abuse and physical health care are separate, often with different financing arrangements and policy-setting"*<sup>[30]</sup>.

And as multiple investigators have pointed out, the services for young people are in even worse disarray than those for adults, with children stuck for days and even months in emergency rooms waiting residential programs<sup>[31]</sup>. This is particularly a problem for underserved children and young adults. Unfortunately, the mental health system has not kept pace with the diverse needs of racial and ethnic minorities, often under-serving or inappropriately serving them. Specifically, the system has neglected to incorporate respect or understanding of the histories, traditions, beliefs, languages, and value systems of culturally diverse groups. Misunderstanding and misinterpreting behaviors have led to tragic consequences, including inappropriately placing minorities in the criminal and juvenile justice systems. For example, these populations: are

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<sup>[27]</sup> Sims et al, *Urban trauma: a chronic recurrent disease*

<sup>[28]</sup> Ibid

<sup>[29]</sup> President's New Freedom Commission, *Interim Report*

<sup>[30]</sup> Bazelon Center, *Get It Together*

<sup>[31]</sup> Bazelon, *Disintegrating Systems*

less likely to have access to available mental health services, are less likely to receive needed mental health care, often receive poorer quality care, and are significantly under-represented in mental health research. However, additional barriers prevent racial and ethnic minorities from seeking services, including: mistrust and fear of treatment; different cultural ideas about illnesses and health; differences in help-seeking behaviors, language, and communication patterns; racism; varying rates of being uninsured; and discrimination by individuals and institutions<sup>[32]</sup>.

### *Young African American Men Incarcerated*

African-American men also have rates of incarceration, probation and parole that are much higher than white men. For every 100,000 Black juveniles living in the United States, more than 750 are in custody in a juvenile facility<sup>[33]</sup>. One in three Black men ages 20-29 has either been in prison or is on parole<sup>[34]</sup>. African Americans currently constitute 12% of the national population but 44% of the prison population, which means 5% of Black America is behind bars. Even worse, 10.1% of all black men between the ages of 18 and 29 are in prison.

In the Philadelphia prison system current figures show that 70% of the incarcerated population is Black<sup>[35]</sup>. The number of juveniles arrested for murder and gun possession in 2006 was twice the figure for 2002<sup>[36]</sup>. One out of every 15 Philadelphia residents is under court supervision – a total of about 97,000 people, 5700 of whom are under 18<sup>[37]</sup>. In 2006, 646 kids were arrested for illegally carrying a gun compared with 319 in 2002. And 26 juveniles were charged with murder in 2006, up from 13 in 2002<sup>[38]</sup>. According to a report studying the causes of the violence problems in Philadelphia, handguns are easy to come by and are often used to settle disputes, both big and small; youth believe they have an almost non-existent support system of adults and feel they live in a city with limited messages of recovery for those who have “fallen” and limited access to meaningful assistance to get their lives on the right track<sup>[39]</sup>. As Alvin Poussaint and Amy Alexander point out in their study on the mental health crisis among African-Americans:

*The young black male who takes up a firearm and engages an opponent in a confrontation... has made a decision to put his life on the line. Consciously or not, such a youth sees violence carried out in the name of “respect” as an acceptable way of dying. Often faced with the message that their lives are not valued in American*

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[32] United States Public Health Service, *Mental Health: Culture, Race, and Ethnicity*

[33] Miller, *Young lives lost*.

[34] Ibid

[35] Ibid

[36] Weichselbaum *Youth-crime system broken*.

[37] Ibid

[38] Ibid

[39] *Blueprint for a Safer Philadelphia, Focus Group Research Summary*

*society, young blacks many internalize their despair – or externalize it. The hard-living man or woman*<sup>[40]</sup>

Adding to this problem, health and mental health services delivered within correctional facilities are often inadequate to deal with the stress and trauma that these young men have experienced and the conditions of imprisonment may themselves be traumatic<sup>[41]</sup>. Reports have demonstrated that children entering juvenile detention facilities, particularly those with mental illnesses are unlikely to get adequate treatment. According to a report requested by Senators Waxman and Collins, about 15,000 children with mental illnesses were improperly incarcerated in detention centers in 2003 because of a lack of access to treatment, and 7% of all children in detention centers remain incarcerated because of a lack of access to treatment. In addition, the report found that 117 detention centers incarcerated children with mental illnesses younger than age 11. The report also found that 66% of detention centers said they incarcerated children with mental illnesses "because there was no place else for them to go," Some witnesses who testified at the hearing said that children with mental illnesses often are incarcerated in detention centers because their parents do not have access to treatment in schools or lack health coverage for such treatment<sup>[42]</sup>.

According to the President's New Freedom Commission, at least 7% of all incarcerated people have a current serious mental illness; the proportion with a less serious form of mental illness is substantially higher. People with serious mental illnesses who come into contact with the criminal justice system are often: poor, uninsured, disproportionately members of minority groups, homeless, and living with co-occurring substance abuse and mental disorders. They are likely to continually recycle through the mental health, substance abuse, and criminal justice systems. *As a shrinking public health care system limits access to services, many poor and racial or ethnic minority youth with serious emotional disorders fall through the cracks into the juvenile justice system. When they are put in jail, people with mental illnesses frequently do not receive appropriate mental health services. Many lose their eligibility for income supports and health insurance benefits that they need to re-enter and re-integrate into the community after they are discharged*<sup>[43]</sup>.

More than 106,000 teens are in custody in juvenile justice facilities across the country<sup>[44]</sup>. Recent research shows a high prevalence of mental disorders in children within the juvenile justice system. A large-scale, four-year, Chicago-based study found that 66% of boys and nearly 75% of girls in juvenile detention have at least one psychiatric disorder. About 50% of these youth abused or were addicted to drugs and more than 40% had either oppositional defiant or conduct disorders. The study also found high rates of depression and dysthymia: 17% of

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[40] Poussaint, *Lay My Burden Down*, p. 14

[41] Kupers, *Mental health in men's prisons*

[42] Kaiser Daily Health Policy Report. "15,000 Children Incarcerated Because of Lack of Mental Health Treatment in 2003"

[43] President's New Freedom Commission, *Achieving the Promise*, p. 32

[44] *Ibid*



boys; 26% of detained girls<sup>[45]</sup>. As youth progressed further into the formal juvenile justice system, rates of mental disorder also increased: 46% of youth on probation met criteria for a serious emotional disorder compared to 67% of youth in a correctional setting<sup>[46]</sup>.

Rape is known to be widespread in men's prisons and often leads to post-traumatic stress disorder which is not usually classified by the correction's department as a "major mental illness". As one author points out, *the male prisoner faces overwhelming obstacles to talking through the trauma or prison rape*<sup>[47]</sup>. Under such circumstances, when young men enter the correctional system, the possibility that they will have any opportunity to work through their previous traumatic experiences and traumatic losses is remote. For young men who have perpetrated violence or been prosecuted for any crime, there is little regard or empathy for the losses that they have experienced throughout their lives that may be significant contributors to their present dysfunctional behavior.

### Health Disparities and Unequal Medical Care

Black men overall also have worse health than their white counterparts. Black men live on at an average of five years less than white men and die at a higher rate from heart disease, stroke, AIDS, and violence. This results in many young African-American men and older African-American men having to bid farewell to friends and family members who have died prematurely or who suffer with chronic illness. There is also substantial data that shows that people of color receive worse health care in the healthcare system. A body of research shows that black patients receive dramatically different care than whites for such diverse conditions as heart disease, stroke, cancer, diabetes, renal transplant, HIV/AIDS, immunizations and asthma. Similar disparities in mental health care have also been uncovered. This poor health, due not only to different rates of disease but also to poorer medical care, leads to loss of economic resources through disability. Even more importantly, the prospect of a foreshortened life expectancy often limits the horizon of possibilities of people who live in the inner city, particularly in neighborhoods of color.

*Among blacks, depression and symptoms of post-traumatic stress syndrome resulting from regular exposure to violence may also constitute a mental illness that neither they nor clinicians would readily recognize or acknowledge. And it is not far-fetched to argue that many of the pathologies currently bedeviling many in the black community – including high rates of drug and alcohol abuse, health-threatening diets, and violence – are fatalistic life-threatening behaviors that can be viewed as long-term or slow-motion suicide. Individuals experiencing poor health due to overeating, alcohol abuse, or drug abuse often go unchallenged by relatives if they*

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<sup>[45]</sup> Teplin et al, *Psychiatric disorders in youth in juvenile detention*

<sup>[46]</sup> Lyons et al, *Mental Health Service Needs of Juvenile Offenders*

<sup>[47]</sup> Ibid, p.194.

*keep up the appearance of “normalcy”, holding down a job or at least keeping their addiction under wraps. The fact that African-Americans suffer from cirrhosis of the liver, heart ailments, sexually transmitted diseases, and obesity-related illnesses in disproportionately higher numbers than whites may be evidence that some African-Americans turn to food, drugs, alcohol, or even sexual activity as a form of medication to ameliorate stresses resulting from racism, discrimination, and other social pressures [48].*

### Young Men on Bereavement Overload

Every act of violence drags grief along with it. One expert on complicated mourning highlights seven high-risk factors that predispose individuals to complicated mourning. These include: sudden, unexpected death especially when traumatic, violent, mutilating or random; death from an overly lengthy illness; loss of a child; the mourner’s perception of the death as preventable; a premorbid relationship with the deceased that was markedly angry or ambivalent, or dependent; prior or concurrent mourner liabilities such as other losses, stresses or mental health problems; and the mourner’s lack of social support. All of these factors result in greater numbers of people experiencing complicated mourning<sup>[49]</sup>. These are characteristics typical of acts of violence that have become normative in the lives of so many urban youth.

The most obvious losses are those associated with homicide. For the friends and family members of homicide victims, the mourning process may be a slow and arduous one and are sometimes considered as “high risk” deaths, meaning the loss contains elements that put people at risk for complicated mourning, requiring treatment for both PTSD and unresolved loss. As one worker in the field has suggested, “a caregiver can expect to observe more intense and more prolonged reactions and will witness a greater incidence of symptoms of post-traumatic stress, victimization, and compulsive inquiry in subjects adjusting to unnatural vs. natural dying<sup>[50]</sup>. Reactions of family survivors of homicide victims are likely to differ from other forms of bereavement in the depth of horror, rage, and vengefulness; the persistence of anxiety and phobic reactions; and the impediments to the adjustment process posed by continuing involvement with the criminal justice system<sup>[51]</sup>. It is easy to understand how the homicide of one youth can create a seemingly endless cycle of retaliation that involves entire families and entire communities.

Traumatic injury causes problems for the injured party and for those who are witnesses to it. The injured person suffers the loss of whatever bodily function is involved, but may also suffer sustained loss from the impairment in

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<sup>[48]</sup> Poussaint and Alexander, *Lay My Burden Down*, p.126.

<sup>[49]</sup> Rando, *Treatment of Complicated Mourning*,

<sup>[50]</sup> Rynearson, as quoted in Rando, *Treatment of Complicated Mourning*, p.538

<sup>[51]</sup> Rando, *Treatment of Complicated Mourning*, p.539

emotional and cognitive function that often accompany post-traumatic stress symptoms. These losses are likely to be “disenfranchised” when expressions of loss are seen as unmanly, or uncool, or unacceptable because they were brought on by intentional acts<sup>[52]</sup>.

Imprisonment represents a wide variety of losses for those who are incarcerated and for others left behind, beyond the most obvious loss of freedom of movement. For those left behind, the imprisoned family member represents an ambiguous loss, where although not physically present the person remains psychologically present<sup>[53]</sup>.

Loss can compound loss over the course of a lifetime and the resulting numbing, alienation, inability to manage affective arousal, disturbed attachment patterns, oversensitivity, over-reactivity, rigid and compulsive behavior, inability to express feelings, inability to establish or maintain intimacy, tendency to engage in self-defeating and self-destructive behaviors, unmanageable anger, and a preoccupation for revenge are a prescription for the continuing escalation of violence and community disintegration<sup>[54]</sup>. As a society, we have a fundamental moral obligation to help young people find their way out of this trap in any way we can. Interventions at the point of contact in medical settings offer opportunities to provide information, social support, and resources that could make a difference in the lives of young men already at risk.

## Emergency Department Based interventions: Building a Trauma-informed Approach

According to the Centers for Disease Control, in 2004, more than 750,000 young people ages 10 to 24 were treated in emergency departments for injuries sustained due to violence<sup>[55]</sup>. The *2001 Surgeon General's Report on Youth Violence* stated that addressing youth violence must start with identification of those that are at highest risk<sup>[56]</sup>. The report named emergency departments as the ideal place to identify such high risk individuals, and start the healing process. Yet, in general, trauma centers have not adopted this recommendation.

Given that these young men do not have easy access to insurance or to a healthcare provider, they often present to the emergency department for episodic care. This care is related not only to their injuries but to the psychological aftereffects of their trauma. Even though this is well known among emergency medicine providers and health care systems, few of these systems are truly equipped to provide trauma-informed services for this population. It is impossible to calculate the cost of such an oversight but to the degree that it leads to

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<sup>[52]</sup> Doka, *Living With Grief*

<sup>[53]</sup> Boss, *Loss, Trauma and Resilience*.

<sup>[54]</sup> Rando, *Treatment of Complicated Mourning*

<sup>[55]</sup> Centers for Disease Control

<sup>[56]</sup> Satcher, *Youth Violence*

recurrent violence, and untreated post-traumatic stress, this oversight is tragic and costly.

A trauma-informed approach considers the suffering and pain that people have experienced over the course of their lives and recognizes that trauma feeds the cycle of violence and recurrent loss. As Sandra Bloom, a nationally known expert in trauma states, “hurt people hurt people”<sup>[57]</sup>. Emergency department-based trauma-informed interventions, seek to use the healing process as an opportunity to help youth understand the effects of trauma and change their responses to the stimuli in their environment.

### Emergency Department Provider Narrative

*I had spent the night tending to patients from all walks of life with complaints from a simple cut on the hand to major heart attacks that had to go to the catheterization laboratory for speedy life saving intervention. Near the end of my long 8-hour shift, the alert system rang out in the emergency department: “combative male injury, blunt object to head, vital signs stable, patient is awake and alert, patient is bleeding from head, have security on standby....repeat, combative male injury from blunt object to head, awake and alert have security on hand.”*

*The charge nurse turned and asked me, “Should I call the trauma team?”*

*I responded, “Not yet. Let’s stabilize him and assess his injuries. Then we will go from there.” I asked the charge nurse to ready the emergency department trauma team at the trauma bay. Then I told my senior resident to get set up in the trauma bay. I glanced around the department to ensure that things are on auto-pilot when the paramedics came charging through the trauma bay doors with an African-American youth shouting obscenities while lying on the stretcher. I walked briskly to the trauma stretcher and asked the paramedics what had happened.*

*“He was at the corner store on 12<sup>th</sup> and Walnut and someone tried to rob him. He left the store and when we got to the store there was a trail of blood that led to him about 500 feet around the corner. When we found him he was bleeding from his head. He didn’t want to come, but we finally secured him on the stretcher. He wouldn’t let us put a neck collar on. His vital signs are stable.”*

*“Hello, my name is Dr. Corbin,” I said to the patient as he was being transferred to the emergency department trauma stretcher. “I am going to be one of many doctors taking care of you. Just try to cooperate and things will run smoothly. What is your name?”*

*“Jeffrey,” he responded with a look of anger.*

*At this point, the normal protocol of the emergency department staff is in full gear, my senior resident is at the head of the bed, gowned up and gloved, and calling out his assessment while he evaluates the patient.*

*I said, “Jeffrey, please bear with us. We just want to take care of you.”*

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<sup>[57]</sup> Bloom and Reichert, *Bearing Witness*

*He responded, "I am straight. Get the fuck off of me. I don't need y'all mothafuckers!" Jeffrey started to fight us, trying to sit up and throw punches at the staff. His head was wrapped in blood stained gauze and we were not able to assess the extent of his head injury. The emergency technicians tried to restrain him, because without knowing the extent of his injuries, we all realized that he could die if we could not get close enough to him to evaluate him. We had no idea how much of his behavior was a result of his head injury. Jeffrey continued to yell and fight as we connected him to the cardiac and blood pressure monitor.*

*I continued to ask him, "Jeffrey, will you please work with us? You could be hurt worse then you know."*

*He looked at me directly in my eyes and said softly: "Doc you got to let me go."*

*I told him, "You are hurt. I need to know how bad."*

*My resident said, "He has a really large scalp laceration." At this, Jeffrey started to fight more and began to scream profanities. His heart rate was elevated. This worried me, because I was not yet able to tell whether or not he had suffered an intracranial bleed or if he was just agitated. I progressed to the next more aggressive step.*

*I announced to the team, "We need to intubate him. I cannot tell what is going on and he is not cooperating. He could hurt himself more." At this point we were all following the trauma protocol. My senior resident was excited about this procedure, but I was reluctant because of the way Jeffrey looked at me. I knew that medically it was the to do and the safest way to determine the extent of his injuries. Jeffrey was sedated and paralyzed by the medication the senior resident gave him in order to perform the procedure. We were administering oxygen to him through a bag valve apparatus. According to the monitor he was getting enough oxygen. My resident then tried to intubate him, but was unable to do so.*

*I asked, "Do you see the vocal cords?"*

*He responded, "No, I just can't see them." I told him to take his time as I know this is not an easy procedure, and it is anxiety-provoking. The resident stopped and asked the technician to continue to oxygenate with the bag valve. I traded places with my resident and looked in to Jeffrey's mouth with the laryngoscope.*

*As soon as I did, I saw a small plastic bag lodged into the area above his vocal cords. I thought, "How could he talk without choking?" I used forceps to remove the small bag filled with a whitish substance I assumed was an illicit drug and I was able to insert the endotracheal tube without a problem. We were then able to put him on the mechanical ventilator to breathe for him, ensure proper placement of the tube and continue with our assessment. We found that he had a 10 centimeter scalp wound with a moderate amount of bleeding. His vital signs appeared stable at this point. I ordered the appropriate scans to check for any life threatening injuries. Fortunately for him, minutes later the CAT scan of his head showed that Jeffrey did not show a life threatening intracranial bleed. The police showed up asking about the status of the patient and asked if they could talk to him. I knew I was not obstructing justice in any way when I tell them that*

*the patient is not able to talk because he is intubated and that we have not finished our evaluation of him.*

*Clearly, what I found in Jeffrey's mouth was an illegal substance, but I am obligated to care for his medical problems as the first priority. Now I know why Jeffrey said that I had to let him go. "He needs drug rehabilitation," I think to myself, "no he needs direction. He needs direction and drug treatment."*

*I looked at the registry and found that he had been in our emergency department before for a previous injury and multiple other complaints. In reviewing the chart, I found that Jeffrey had a long history of exposure to violence going back to childhood. It became clear to me that this young African American man had been affected by the impact trauma has had on his life. Sadly, I recognized that nothing else would be done for him after we cleared him medically. I could have argued with the psychiatry department to admit him, but because I see he is deemed a "self-pay" which equals uninsured, and because he is a substance abuser, the likelihood of him being admitted was extremely low.*

*I questioned myself, "Where do I refer this young man? Is he going to follow up with the suggestions that I make for him? Does he even want to follow up? Clearly he is suffering from the impact of his environment and situation, but how does he get redirection?" Jeffrey finally left the emergency room, still alive but just as much at risk for a violent early death as when he entered.*

The scenario depicted above is not an unusual one. In Philadelphia, and across the country, emergency providers are confronted with young victims of violence who present with complex stories and complex needs. While the young man above was involved in the illicit drug economy, he also came in with significant trauma and a history of substantial violence in the past. Emergency providers are daily faced with men, women, and children with histories of similar exposure to violence. Providers would like to make a difference but often lack the time and resources to do so.

### *Jefferson Community Violence Prevention Program*

It was in response to frustration over patients like Jeffrey that the Jefferson Community Violence Prevention Program at Thomas Jefferson University Hospital (TJUH) was developed as part of a larger initiative known as the Health Care Collaborative. This violence prevention initiative at TJUH began in 1997 through a three-year grant from the William Penn Foundation. The grant was designed to identify young victims of violence who were seen and discharged from the emergency department to provide follow-up referral services that would improve these patients' quality of life and prevent return visits to the emergency department for reinjury or death. Identification of young violence victims was accomplished through medical staff referrals to Jefferson's Department of Pastoral Care and Education.

The program was developed in response to concern about increased youth violence in Philadelphia. It envisioned the opportunity to collaborate with other area programs in creating a network of services offering community-based resources for employment, education and personal counseling to at-risk young people. When victims of violence between the ages of 14 and 25 were admitted to the trauma service or seen in the emergency department, a coordinated attempt was made to develop trust and rapport that would extend beyond the hospital stay, and offer support for the future. The program included [\[slb3\]](#) :

**Identification:** Jefferson's Emergency Department medical staff was trained in the risk-assessment protocol developed for this project. Overall, the staff demonstrated a high level of acceptance and willingness to use the protocol to help identify, screen and assess youths they treated in the ED after incidents of violence. To assist in identification, two full-time social workers were hired and trained in the risk-assessment protocol as well. These social workers, stationed in the ED ten hours a day and seven days a week, provided real-time screening at the bedside and referral to Pastoral Care for community follow-up. They were helpful in capturing walk-in patients with less critical injuries who still would benefit from bedside counseling and referral. All staff members received training quarterly and were encouraged to attend violence prevention seminars offered off-campus as well. Monitoring of emergency patients for victims of violence was done by the social workers from noon until midnight, our peak time for trauma cases. From midnight to noon, the ED physicians, nurses and technicians paged pastoral care staff, who evaluated patients in the department. Every morning, the Project Director conducted computer surveillance of the previous 24 hours of emergency department activity to ensure that all youths eligible for the project were captured.

**Screening and Intervention:** Youths who were screened would be stratified into low, moderate and high-risk categories according to safety factors in the youths' lives at the time. High risk was defined by the extent of the injury plus more than two specific or contributing risk factors, such as a plan for retaliation and a history of drug abuse or violence. Moderate risk was more than one specific or contributing high-risk factor. Low risk was a violent event without a previous history of violence, drug use or plans for retaliation. High-risk youths were referred to a community health worker and community resources. Moderate-risk youths were referred to the community liaison for interviews and further interventions as needed. Low-risk youths were referred to the Pastoral Care resident. Emergency Department staff conducted brief screenings of youth at the bedside, and continued to do so for the duration of the project. Assessments of high, moderate or low risks were determined then. Youths at high risk of further injury to themselves or others were referred to the on-call Pastoral Care resident, who saw patients in the ED and contacted the community liaison. The hiring of two community health workers that were assigned only to this project was a vital link between youths and community referral. The

community health worker program provided caring adults who were able to de-escalate conflicts, establish a rapport, and move youths towards more constructive thought processes surrounding the event.

**Assessment:** A member of the emergency department staff or a Pastoral Care resident screened youths at the bedside using the violence risk assessment form. Risk stratification, as described in the preceding paragraph, was determined then. After the level of risk was determined, patients were referred to the community liaison, a community health worker, or the Pastoral Care resident. The community liaison and PAAN (Philadelphia Anti-Drug, Anti-violence Network) mentors met with the project director weekly. Information gathered at these meetings helped in further evaluation and planning of the patients and the program.

**Linking Youth to Interventions:** High-risk youths were referred to community health workers for one-on-one community follow-up, moderate-risk youths to the community liaison and/or pastoral care resident, and low-risk youths to the pastoral care resident. Cases were closed in situations where we were unable to contact a youth, a significant relationship was developed between a youth and a referring agency, or a youth dropped out of the program.

**Unique Project Elements:** Jefferson's Violence Prevention Project was unique in that we utilized faith-based staff as a core ingredient of our front line emergency department assessors. Chaplains were present in the hospital 24 hours a day, seven days a week, and were automatically paged to all trauma codes in the ED. These chaplains were available to both the patient and the family at a time of crisis. Community follow-up was carried out by our full-time pastor and community liaison, who followed youths from the Hospital through transition into the community. The full-time pastor/community liaison's strength was her ability to connect with young people and develop personal relationships via routine visits with families and patients in their homes as the core of follow-up. For patients who were walk-ins, we had two, full-time social workers, who are paid employees of Jefferson's Emergency Department, stationed in the Department from noon until midnight, seven days a week. The social workers worked very closely with the ED staff and with the youths and their families.

Despite demonstrated successes in connecting young victims to community services and widespread acceptance from the Emergency Department providers, the Foundation ended its support of the program in 2003. The Foundation chose to change its funding focus toward children in the first 5 years of life. We remain grateful to the Foundation for the years of support that it provided.

Still, the demise of this program demonstrates the tenuous status of health care based programs that focus on preventing violence. Since health care coverage fails to reimburse for community-based services needed to keep these



young people safe, such programs are dependent on external, so-called “soft” funding for their survival. Nonetheless, the JCVPP stands as a potential model for emergency department intervention for violence and trauma. Efforts are ongoing to resurrect the program at Jefferson and at other hospitals in the Philadelphia area.

[\[slb4\]](#)

## Primary Care Approaches to Young Black Men

### Meet David

*David is a 21-year-old African American man who comes to the clinic for follow-up after he sustained a mild gunshot wound to his upper left arm for which he was hospitalized for less than 24 hours about two weeks ago. He was scheduled for follow-up in the clinic because while he was in the hospital he was discovered to have mild hypertension. When he arrives at to the clinic the nurse notices that he appears anxious and jumpy. Once in the examining room, he reports that he has been having nightmares and flashbacks for which he uses three to four marijuana filled cigars per day. The patient also says that he feels numb and finds himself unable to feel love or fear when he is in situations where those emotions are appropriate.*

*When I ask what happened, he is at first reticent. He tells me that he never told the story to anyone before for fear that he would have to testify against the assailants. However the patient reports that he was at home when two men in masks invaded his home and held him and a friend at gun point. While holding a gun to his head, they repeatedly threatened to kill him.*

*While he is afraid that these men will target him again, he is also afraid to tell the police since he believes that they will force him to testify against the assailants. He believes that this cooperation with the police will make him a target. He has been staying with an aunt who lives several blocks away from the home where he was assaulted. He rarely leaves her house because he is afraid to ride the buses or trains. He would like to move away, to stay with relatives in North Carolina, but he cannot afford to travel. He also has a 2-year old son who lives with his girlfriend. He is also reluctant to leave his son. Because of his fear of leaving the house, he cannot look for jobs.*

### Young Men’s Health Clinic

In 1993, providers at the Boston City Hospital in Boston, Massachusetts founded the Young Men’s Health Clinic. The clinic came about because doctors working in primary care noticed that they were few young men between the ages of 18 and 29 seeking regular primary care in the clinic. Rather, at this urban inner city Hospital serving the largely African-American areas of Roxbury Dorchester and Mattapan, young men sought care only for acute illness. Hospital statistics showed that most of these patients were seen in the

emergency department, sexually transmitted disease clinic, dermatology, orthopedics, or surgical clinic. For orthopedic and surgical clinic, many of these patients were there for follow-up care after a violent injury.

In speaking with health care providers in these various settings, the primary care physicians learned that these providers did not know where to refer these men for further care. In general, these providers were well-meaning, but unaware that African-American men suffer from particular chronic diseases at a higher rate and might need referral for longitudinal care.

Initially, the clinic was designed to provide general primary care ranging from routine physicals, episodic treatment of mild medical conditions, screening for hypertension, high cholesterol and diabetes, as well as education about self-examination for testicular cancer, healthy eating and exercise. The initial strategy of the clinic was to invite referrals from clinics throughout the hospital system of young men who were too old to be seen in the adolescent clinic and had no usual source of care. The idea of the clinic was feasible only because Massachusetts had an uncompensated care pool that reimbursed hospitals for the care of uninsured patients. This was particularly important since 80% of the patient seeking care in the clinic had no insurance.

Not far into the course of the clinic, it became clear that while medical issues were important, many of the young man presented with some emotional distress. To better understand what experiences our patients brought to the clinic, we surveyed all new patients over two year period. We found that 34.4% of patients had been shot, stabbed or both at some point in their lives. Overall 45% of patients said that they had been victims of a violent assault (defined as having been shot, stabbed, shot at or beaten up in the past.) Forty-three percent of those with histories of violent injury had experienced more than one type of violent assault.

In addition, many of our patients had experienced other traumatic experiences. Fifty-one percent said that they had seen someone shot or stabbed in the past; 25% reported that they did not feel safe; 14% reported carrying a weapon; 59% reported that they had been arrested in the past; 30% reported that they were incarcerated for more than one day; and 44% reported having been harassed by the police.

We went further to compare those young men who were victims to those who had not been victims. We found marked differences between those who reported past victimization and those who did not. Specifically victims had fewer years of education, were more likely have children and were more likely to be African-American. Victims were also more likely to report such traumatic experiences as having been harassed by the police, not feeling safe, having been arrested, having witnessed past violence, carrying a weapon and having been incarcerated. They were also much more likely to the report past use of heroin, cocaine, marijuana or cigarettes. A multiple logistic regression showed that a combined index of their traumatic experiences accounted for much of the difference between the victims and non-victims. Those men who reported having been incarcerated, carrying a weapon or having witnessed violence were significantly more likely to report that they had also been victims of violent

assault. This evaluation proves that victims of trauma also have a disproportionate burden of other health and social problems. These data reinforced what we felt in our clinical encounters: exposure to trauma is a potent risk factor that is associated with other behaviors that relate to violence.

Many of these young men reported anxiety, difficulty sleeping, and use of large amounts of marijuana and alcohol. On further probing, it also became apparent that many of these young men had experienced some level of trauma in their lives. The traumas that they talked about included being mistreated by the police, sexual abuse as children, witnessing the physical or sexual abuse of their mothers, witnessing violence, loss of friends and family to violent injury and extreme feelings of anger toward fathers who were all too often not with the family. Quickly, we began to make referral to the mental health resources within the system. However this proved to be ineffective. Young man had to wait long periods of time for appointments. When they were seen in the clinic, many young men reported that they only went for one appointment because they found the psychiatric providers to be judgmental and unfamiliar with their needs and circumstances. One young patient reported to his doctor that after his initial visit, he not gone back to the psychiatric clinic. When the provider questioned why, the patient said "I told the psychiatrist that I used to be something of a hoodlum and the psychiatrist asked 'what's that?'" Anecdotes like this one helped up to realize that many of the resources available at that time were not culturally competent and were not well-suited to the extreme social context in which these young man grew up.

In response to this, we worked with the primary care clinic to identify and hire a psychologist with expertise in trauma and with particular interest in holistic treatments like meditation and stress management techniques. This provider saw patient in the same clinic space, with flexible hours that coincided with clinic hours. During the clinic, if a patient needed to be seen urgently for a crisis, often the psychologist was available. In addition, because of the perceived need to treat post-traumatic stress symptoms rapidly, the psychologist allowed the primary care physicians to overbook his schedule if the patient had experienced extreme trauma. This innovation, in response to a recognized need among young black men, made us able to meet the needs of young patients who otherwise would have been alienated from healthcare.

Over time, the providers in the clinic recognized another need. Patients who came to the clinic were unfamiliar with the general workings of the clinic and could be intimidated by the staff there. The providers recruited a health outreach worker, who had been trained in a special program designed to prepare young men of color to be health educators, and have him work in the clinic. This health educator counseled each patient, first greeting him in the waiting room and providing him with information about male reproductive health, condoms, and the functions of the clinic. In addition, the health educator would orient the patient to mental health resources that were available.

In describing resources, the health educator found it useful to use the analogy of living in a war zone. In health educator would describe to the patients that many of their symptoms were like those seen in people returning from war.

With that introduction, many of young men were able to discuss the ways in which their own existence felt to them like being in a war. By representing the mental health services as treatment for stress and trauma, the young patients found it much more acceptable to see the psychologist<sup>[slb5]</sup> <sup>[slb6]</sup>.

The Young Men's Health Clinic continues to serve the needs of young men in Boston. In Boston, since 2004, rates of aggravated assault have increased 23% and homicide has increased 32%. Similar increases are being seen in many cities in the US. This re-emergence of violence combined with increasing numbers of young men re-entering communities after periods of incarceration has meant that the clinic continues to see many young men with dramatic manifestations of trauma. There are challenges that come with trying to provide preventive and behavioral health services in an environment where health care institutions are facing increasing pressure to focus on services that are more generously reimbursed. Still, institutions that have a mission to provide care to the poor and underserved resonate with the conclusions of the Kellogg Foundation sponsored monograph *Poor Man's Plight: Uncovering the Disparities in Men's Health*: "A coordinated response to the health issues facing men of color will help us to reclaim a lost potential for health and productivity and contribute much to our health as a community."

## Lessons Learned

### *A shared trauma-informed framework*

Drawing upon the benefits of hindsight, if we were to create similar programs today we would incorporate a trauma informed framework from the beginning. By placing trauma squarely on the radar screen right alongside the emergency and primary care needs, a trauma informed framework would have shaped the programs from the beginning. To accomplish this, we would make sure that every staff member was fully versed in the ways in which post-traumatic stress and unresolved loss can present in medical care settings. A trauma-informed approach could be more easily reinforced in the health care setting if we were to use a whole-system, trauma-informed approach to the staff as well as the clients. An overarching framework like that described by the Sanctuary Model is a powerful way to bring together an entire institution to deal with the issue of youth violence<sup>[58]</sup>. Although both of the efforts described in this chapter experienced some success, we believe they would have been measurably more effective had they been embraced by larger institutional change. Because the Sanctuary Model values such as committing to a culture of nonviolence and a culture of open communication were not explicitly shared, these efforts were sometimes viewed as fringe efforts to deal with an equally fringe population. To be most successful entire institutions must embrace not only the importance of addressing youth violence but address it from a trauma-informed perspective.

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<sup>[58]</sup> Bloom, *The Sanctuary Model of Organizational Change*

Such a perspective would transform not only the way is provided to injured patients but to the larger institution as well.

The Sanctuary Model could inform not only the intervention for the patient but also the way in which providers would agree to relate to each other and relate to patients. The cultural dictates and strong principles embodied in the acronym SELF, would help providers identify the needs of traumatized patients and identify the best resources needed<sup>[59]</sup>. It would follow that if an institution embraced addressing youth violence from a trauma-informed perspective then appointed personnel would be responsible for making sure that the best outcomes were achieved. In the programs described above, there were limited number of personnel who supported the programs and most were viewed as pursuing their own passions. Therefore, additional staff was not hired and additional resources did not necessarily follow. This was due in part to the fact that many of the services that we provided to patients (such as mentoring, community health workers, referral and follow-up) are not directly reimbursable. Consequently, there is little incentive for health care institutions to put them in place.

### *Better assessment and screening*

Each of the programs described above did an early assessment that helped to better understand the problems that patients brought to the emergency department and to the primary care clinic. However, these instruments were developed as needs assessments to better understand how to provide services. Better screening instruments that include an assessment of the patient's history of trauma and resulting symptoms would be of great benefit to providers. A sound trauma informed assessment would stimulate a human dialogue between providers and patients that would help both to understand how the patient's past trauma would affect their health. For example, such a history would allow better referral to preventive mental health services and supportive community resources. Looking forward, a strong user-friendly instrument that could be used both in an emergent setting and also in primary care would benefit and speed evaluation of these patients. This is especially important when providers are themselves are under pressure to see more patients in less time.

### *Dedicated staff*

In each case, a designated program coordinator who was charged with the responsibility of coordinating the care of the patient, gathering critical data and engaging the entire department in the work of youth violence would be a valuable and necessary component of any such future projects. This staff member would be responsible for a global assessment prior to the patient seeing the physician. In emergency departments, an injury prevention coordinator,

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<sup>[59]</sup> Bloom, S.E.L.F.: *A Trauma-Informed Psychoeducational Curriculum*

much like the staff person currently in place at Alameda County General Hospital<sup>[slb7]</sup>, would help to understand the needs of a given patient and immediately make referral to community resources.

### *Community Involvement*

The realization that these patients come from underserved communities which are foreign to the most providers in the health care setting means that dramatic participation from community members is critical. This participation can take many forms, but at its best it involves community members from the beginning of the intervention through evaluating the data and the delivery of services. The emergency department program at Jefferson Hospital partnered with a community-based organization known as Philadelphia Anti-Drug, Anti-violence Network (PAAN) and this resulted in a strong community connection. Similarly, in the Young Men's Health Clinic, a trained community health educator was an integral part of the clinic. Programs that envision reproducing either these models would do well to engage community members from the beginning using a community-based participatory model where institutions and communities have an equal stake in making sure that youth violence decreases and that the health of young men improves.

In each setting, the presence of highly trained community members who are employed as staff and who are charged with making referrals, providing support and mentoring to the patient after discharge would be ideal. When these staff members are trained as part of the team in the Sanctuary Model there is a continuity of care that provides for the patient and will also help to immunize the staff against the secondary effects of trauma.

### *Institutional buy-in*

Institutional buy-in from the highest levels of the institution is critical. The highest levels of leadership within the institution must have an understanding of the trauma-informed approach and investing in the success of the program. In this way, programs that are started through the passion of an individual faculty or staff member will not be viewed as fringe and marginalized but will be seen as a part of the institutional mission. Program directors and support this buy-in by collecting strong data that demonstrate the effectiveness, and if possible cost-effectiveness, of such programs.

### *Trauma-informed policy*

At a policy level, trauma-informed services have not received the robust reimbursement that they deserve. Advocacy at the local state and federal level for reimbursement for trauma related services is critical. Coalitions consisting of the leadership of health care institutions, providers, patients affected by violence and affected communities should advocate with leaders at all levels to improve reimbursement for services that relate to trauma. In addition, policy statements that highlight a trauma-informed approach to youth violence should be developed by professional organizations, state and local health departments and public

health researchers. Requirements for training and trauma-informed practice can be incorporated into requests for proposals issued by municipalities or states. In this way, trauma-informed services will become part of the culture and fabric of care provided to victims.

### Diversity

Finally, a lesson learned from these interventions and that can be carried into the future, is that diversity across the providers of care to victims of youth violence is critical. Historically, racism has had a negative impact on health care and mental health care delivery to African-Americans. As Poussaint and Alexander point out:

*Mistrust of the medical establishment that currently contributes to poor mental health in some blacks can be linked to the long history of troubled relations between blacks and the whole American medical community... Bias and racial insensitivity continue to affect patient care at all levels of the medical and psychiatric establishment, and has seeped into the fabric of America's health care apparatus, staining the ground-level service delivery systems with which black Americans must interact<sup>[60]</sup>.*

There continues to be a need for greater diversity among the health care professionals that supports these important initiatives. More specifically, a staff that is well-trained in violence and trauma, will bring various perspectives and cultural sensitivities to patients and communities struggling with youth violence.

## Conclusions and Recommendations

In each of the settings a key focus was to improve the health of patients most of whom are young men and many of whom are African-American. An initial focus of each of the programs was to provide either acute medical care in an emergency setting or continuity of care in a primary care setting. In each case there was a shift in focus from simply treating the medical complaint to trying to achieve a more holistic plan of care.

Each program inductively came to conclude that trauma played a large role in the lives of their patients in these settings. These impressions were confirmed by data gathered from the patients. Each setting adapted its practices in an attempt to better address the trauma these patients were experiencing. Sometimes, the adjustments served to improve the clinical setting for patients and to address some of the patient's needs.

Most importantly, it is social policy that needs to change. As educator and activist Geoffrey Canada has put it:

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<sup>[60]</sup> Poussaint and Alexander, Lay My Burden Down, P 64 and 76

*Part of the problem is that most current policymakers fail to address the problem of the sheer availability of guns. Young people in our inner cities know that there is a war going on' millions have been accidentally or intentionally caught up in the many small battles that make up the war on America's streets. Most young people are interested in surviving the war, but the price they pay is being prepared to kill or be killed almost every day<sup>[61]</sup>.*

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<sup>[61]</sup> Canada, *Fist, Stick Knife Gun*, p. 68



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