



Healing the Hurt: Trauma-Informed Approaches to the Health of Boys and Young Men of Color

Prepared by:



SCHOOL OF PUBLIC HEALTH
CENTER FOR NONVIOLENCE AND SOCIAL JUSTICE



DREXEL UNIVERSITY
COLLEGE OF MEDICINE
DEPARTMENT OF EMERGENCY MEDICINE

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SCHOOL OF PUBLIC HEALTH
AND COMMUNITY LEADERSHIP

DREXEL UNIVERSITY
COLLEGE OF MEDICINE
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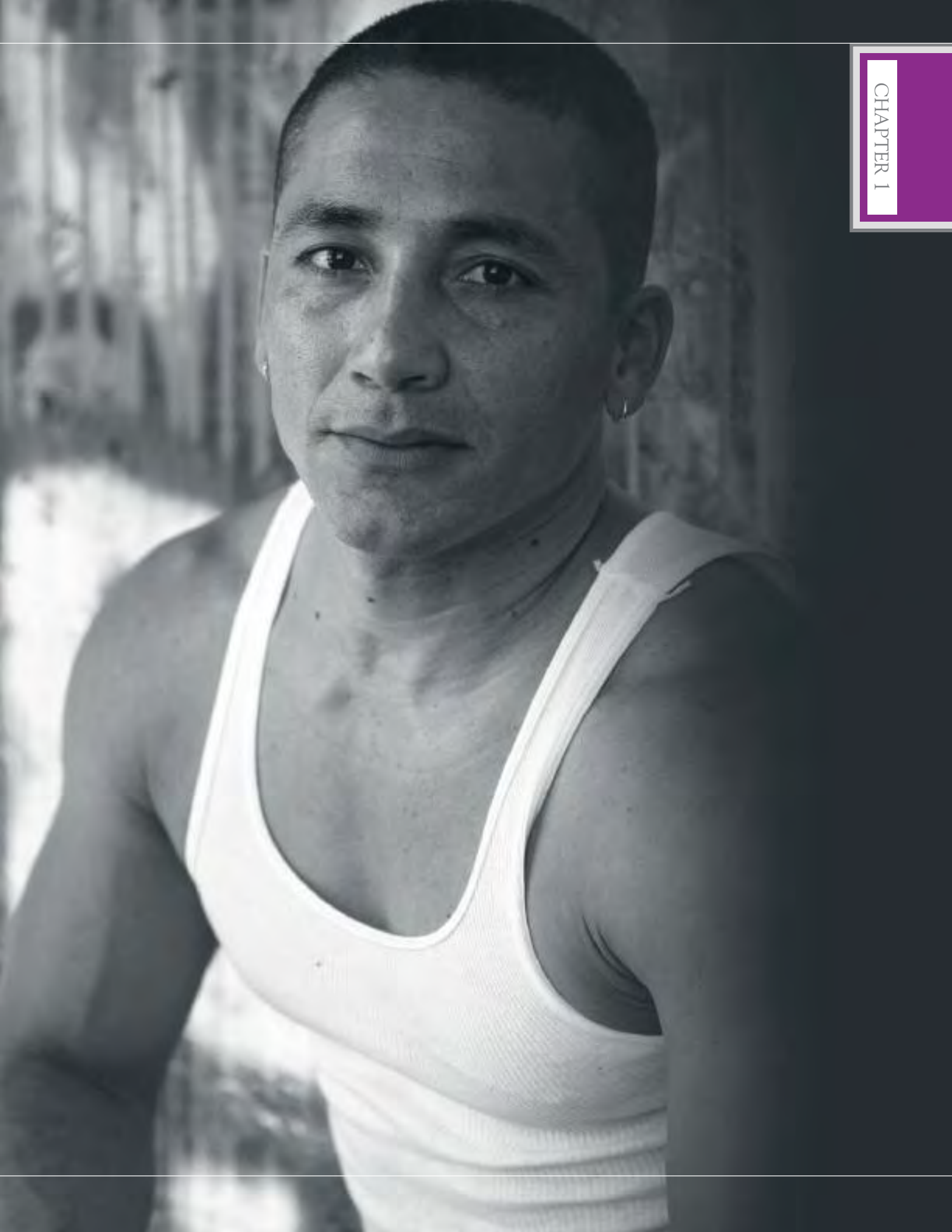
Overview

*This paper was commissioned by The California Endowment to inform their **Building Healthy Communities** strategic plan. The purpose of this paper is to promote understanding of the role of trauma and adversity in the lives of Latino and African American boys and young men and to examine trauma-informed approaches to improving their health.*

The project is founded on the understanding that trauma and adversity have a direct impact on health. We also understand that African-American and Latino young men are disproportionately affected by various forms of trauma and adversity including violence, poverty, incarceration, lack of access to health care, marginalization and low social status.

The project has two main goals:

- To identify, analyze and synthesize existing knowledge about the health status of boys and men of color across disciplines, and interpret it through the lens of trauma.
- To identify promising trauma-informed models and approaches to addressing the health needs of boys and young men of color.





Defining Trauma

We refer to trauma from a psychological perspective to describe experiences that are emotionally painful and distressing and that overwhelm an individual's capacity to cope. Although there has been some debate about how to define a traumatic event, most definitions agree that when internal and external resources are inadequate to cope with external threat, the experience is one of trauma. The powerlessness that a person experiences is a primary trait of traumatization (Van der Kolk 2005).

Trauma has sometimes been defined solely in reference to circumstances that are outside normal human experience. This definition does not fully encompass the experiences of the young boys and men of color who are the focus of this project. For them, traumatic experiences may become an almost routine part of everyday existence. Besides violence, assault, and other traumatic events, African American and Latino males often experience more subtle and insidious forms of trauma. Their exposure to discrimination, racism, oppression, and poverty is pervasive. When experienced chronically, these events have a cumulative impact that

What Is Trauma?

- *experiences or situations that are emotionally painful and distressing, and that overwhelm an individual's ability to cope*
- *chronic adversity (e.g., discrimination, racism, oppression, poverty)*

Supporting Data

African American Males:

- *disproportionately experience violence;*
- *are 5 times more likely to be incarcerated than Whites;*
- *have high incidence of chronic disease;*
- *have highest unemployment rate.*

Latino Males:

- *are most likely to live in extreme poverty;*
- *have lowest rates of high school completion;*
- *in CA, over 40% earn <200% of Poverty Line;*
- *have highest rates of uninsured.*

(Davis 2009)



can be fundamentally life-altering. Such traumas are directly related to chronic fear and anxiety, with serious long-term effects on health and other life outcomes for males of color.

Yet to be fully developed is an understanding of the multiple ways in which repetitive and multigenerational exposure to violence, oppression, neglect, discrimination, criminalization and poverty can impact individuals and entire communities.

This work focuses on boys and young men of color who have experienced and are still experiencing such forms of structural and systemic violence. A term related to trauma is “adversity,” which helps to clarify what people of color experience in the United States. It includes not just experiences outside usual human experience, but those that have become all too much a part of everyday existence.

Trauma Theory

“Trauma theory” is a relatively recent concept that emerged in the health care environment during the 1970s, mostly in connection with studies of Vietnam veterans and other survivor groups (Holocaust survivors, abused women and children, disaster survivors, refugees, victims of sexual assault) (www.sanctuaryweb.com). “Post-traumatic

stress disorder” was added as a new category in the American Psychiatric Association official manual of mental disorders in 1980.

Trauma theory represents a fundamental shift in thinking from the supposition that those who have experienced psychological trauma are either “sick” or deficient in moral character to the reframe that they are “injured” and in need of healing. Such shifts are made possible in the context of a supportive political movement. To a significant extent, “trauma theory” attained credibility because Vietnam Veterans refused to be silent about their experiences and because the antiwar movement had an air of legitimacy not previously known. The nation’s defeat in Vietnam “made it possible to recognize psychological trauma as a lasting and inevitable legacy of war” (Herman 1992). Concurrently, as the women’s movement gained strength in the 70s, work with victims of domestic violence and sexual assault also gained legitimacy as professionals first acknowledged that the symptoms of this group were similar to those of combat veterans.





Understanding the Effects of Trauma Across the Life Course

Brain Development In Children

The human brain develops from the bottom up, or rather from the simplest functions to the most complex. The brainstem houses the most basic functions needed for survival (heart rate, body temperature, and blood pressure). From there, the mid-brain develops, controlling the functions of sleep, appetite, digestion, and arousal. Next to develop is the limbic brain, the seat of emotions and memory. The last to develop is the cortex, which houses the highest functions of the brain—abstract thinking, reasoning, and other complex thought processes needed for problem solving, judgment, impulse control, and emotional regulation.

It is important to note that the lower, more primitive parts of the brain are less plastic (able to re-wire and change). Plasticity increases as you move up through the higher functions of the brain, with the cortex being the most adaptive to change and re-wiring.

When a child is born, the spinal cord and the brainstem are almost fully developed and serve the newborn in his or her sole mission to survive. Otherwise, the brain of the newborn is very primitive and highly underdeveloped from the midbrain through the cortex. The brain is designed for continued growth of these higher functions through touch, movement, and interaction—experiences that all serve to wire the

brain for growth and more advanced functioning. The quality of this brain development is directly linked to the quality of these early childhood experiences, and the window of time between birth and age three is critical to forming the basic mental processes that children rely upon for their lifetime (Eliot 1999).

We now have a wide body of research indicating that the brains of children who are exposed to chronic trauma and stress and wired differently than children whose experiences have been more secure (National Scientific Council on the Developing Child 2007). Two key developmental processes are adversely affected by exposure to trauma—neurodevelopment (the physical and biological growth of the brain) and psychosocial development (personality development, capacity for relationships, development of moral values and social conduct).

When experiencing stress or threat, the brain’s “fight or flight” response is activated through increased production of the hormone cortisol. While cortisol production can be protective in emergencies, in situations of chronic stress its level is toxic and can damage or kill neurons in critical regions of the brain. Especially damaging is the experience of stressors that occur in an unpredictable fashion (e.g., community violence, domestic violence). In extreme cases, chronic exposure to trauma causes a state of hyperarousal or dissociation. Hyperarousal is characterized by an elevated heart rate, slightly elevated body temperature, and constant anxiety. Dissociation involves an internalized response in which the child shuts down, detaches, or “freezes” as a maladaptive way of managing overwhelming emotions and/or situations. The younger the child is, the more likely he or she will respond with dissociation. Children are more susceptible to post-traumatic stress because in most situations they are helpless and incapable of either “fight or flight.” Through the repeated experience of overwhelming stress, children may abandon the notion that they can impact the course of their lives in a positive way. The result is a state of learned helplessness. When trauma or neglect happens early in life and is left untreated, the injuries sustained reverberate to all ensuing developmental stages (Bremner 2002; Van der Kolk 1996; McEwen and Magarinos 1997).

Brain Development in Adolescents

There is a body of evidence that shows us that the adolescent brain is far from complete and that the human brain does not achieve maturation until one's early twenties. During adolescence, the brain goes through a critical period of pruning and reorganizing. Functions that are being used and stimulated regularly are strengthened and functions that are not used and stimulated are pruned away.

This massive remodeling occurs in the cortex, the highest functioning part of the brain that is needed for good judgment, planning, and other essential functions of adulthood. Teenage behavior can be better understood in the context of what is going on in the adolescent brain. Asking teens to manage more than one task at a time can overwhelm them, as they are just developing the brain functions needed to prioritize issues, sort through problems, and set goals for the future. Because the cortex is under construction, teens use more primitive parts of the brain (limbic) to manage their emotions, and thus are more likely to react versus think and to operate from their gut response versus reasoning. They are more likely to misinterpret body language and are generally more vulnerable to stress at this time. They also require more sleep because of the work their brain is doing to facilitate all this growth and change (Chamberlain 2009).

While this brain reconstruction is happening, adolescents are also experiencing puberty. They are developing sexually before their brain is mature, and thus are most vulnerable to making poor choices about sex and relationships.

Relative to the entire lifespan, adolescence is a stressful time just by virtue of what is occurring in the brain. Levels of dopamine (the "feel good" hormone) and serotonin (which helps to control impulsive behavior) fluctuate in the adolescent brain. These chemical changes make adolescents more prone to risky behaviors, compounded by the fact that they are primarily working from the limbic system and not the cortex. The likelihood of using alcohol and drugs at this time is heightened. Drugs are even more enticing because they cause high dopamine levels. Compounding these risk factors is the normal adolescent developmental need to identify, belong to and fit in with a peer group and to separate from their parents as they transition to adulthood.



“Adolescents are especially vulnerable to the effects of trauma and trauma can have a significant impact on their development...Struggling with the effects of a traumatic event during adolescence can lead to social isolation, declining school performance, behavioral problems, and other issues that can impact both current quality of life and future functioning” (Eckes and Liss Radunovich October 2007).

Controversies Inherent in the Biological View of Brain Science

The expanding knowledge about the effect of early childhood adversity on brain development and early childhood enhancement on that same process has contributed a great deal to our understanding of the effect of trauma on children. Increasingly, researchers look to brains scans, genetic information and other markers of deprivation to make the case for early intervention. In the midst of this exploding knowledge, several important cautions are necessary. There is a danger that a focus on biological processes in early life could lead to a deterministic and nihilistic view of the potential for children who grow up in poverty or who suffer early childhood trauma or other forms of adversity. For this reason, it is important that the evidence about brain development is clearly articulated by individuals who grasp these deep concepts. For example, while it appears that the first three years of life are critical for the development of pathways that lead to basic functions such as vision and hearing, it is also clear that the regions that govern the higher functions of the brain, including most cognitive, social and emotional capacities are undergoing development far beyond the early childhood years. Without this perspective one might conclude that children who emerge from these early years without sufficient nurturing and stimulation will fail to achieve their full potential. The Center of the Developing Child at Harvard University has stated it this way:

Although a great deal of brain architecture is shaped during the first three years, claims that the window of opportunity for brain development closes on a child's third birthday are completely unfounded. . .For most functions, the window of opportunity remains open well beyond age three (NCDC 2007).

Efforts aiming to enhance and enrich the early life of children should not assume that lacking such enhancement will doom children to inferior function or potential.

Nearly 2/3 of ACE Study participants reported at least one ACE, and more than one in five reported three or more. The higher the ACE score, the greater the likelihood of chronic disease in adulthood.

(Felitti, Anda et al. 1998)

Effects of Trauma into Adulthood

The relationship between traumatic childhood experiences and physical and emotional health outcomes in adult life is at the core of the landmark Adverse Childhood Experiences (ACE) Study, a collaborative effort of the Centers for Disease Control and Prevention and the Kaiser Health Plan's Department of Preventative Medicine in San Diego, CA. The ACE Study involved the cooperation of over 17,000 middle-aged (average age was 57), middle class Americans who agreed to help researchers study the following nine categories of childhood abuse and household dysfunction:

- recurrent physical abuse;
- recurrent emotional abuse;
- contact sexual abuse;
- an alcohol and/or drug abuser in the household;
- an incarcerated household member;
- a household member who is chronically depressed, mentally ill, institutionalized, or suicidal;
- mother is treated violently;
- one or no parents;
- emotional or physical neglect.



Each participant received an ACE score in the range of 0-9 reflecting the number of the above experiences he/she can claim (e.g., a score of 3 indicates that that participant experienced 3 of the above ACEs).

The study claims two major findings. The first of these is that **ACEs are much more common than anticipated or recognized**, even in the middle class population that participated in the study, all of whom received health care via a large HMO. It is reasonable to presume that the prevalence of ACEs is significantly higher among young African American and Latino males—many of whom live with chronic stress and do not have a regular source of healthcare.

The study's second major finding is that **ACEs have a powerful correlation to health outcomes later in life**. As the ACE score increases, so does the risk of an array of social and health problems such as: social, emotional and cognitive impairment; adoption of health-risk behaviors; disease, disability and social problems; and early death. ACEs have a strong influence on adolescent health, teen pregnancy, smoking, substance abuse, sexual behavior, the risk of revictimization, performance in the work force, and the stability of relationships, among other health determinants. The higher the ACE score, the greater the risk of heart disease, lung disease, liver disease, suicide, HIV and STDs, and other risks for the leading causes of death (Felitti, Anda et al. 1998).



Trauma as a Social Determinant of Health

Available demographic data show that men of color are disproportionately impacted by adverse social factors including poverty, lack of education, lack of social support, and lack of access to social capital. They are also disproportionately affected by other environmental issues, including living in unsafe neighborhoods with unstable economic and physical infrastructure. Attempts to address the health of boys and men of color must consider the impact that these social determinants have on health.

From a trauma-informed perspective, constant exposure to such negative factors in daily life constitutes a form of trauma. Michael Marmot, who has written extensively about the social determinants of health, argues that while material deprivation due to poverty may in itself predispose one to disease (e.g., through lack of access to healthy foods or exposure to toxic environmental elements), a major way that poverty exerts its effect is through chronic stress (Marmot 2004).

Marmot and others have studied the effect not only of poverty but also of social position and inequality. His work would suggest that men of color, because of their position at the margins of U.S. society, suffer the most damaging effects. Men of color are lower on the social hierarchy than any other group. This, in turn, limits their ability to have a sense of empowerment and control over their lives. Constant bombardment with racism, discrimination, and lack of opportunity further this disempowerment. Marmot and others would argue that it is this adverse social position that creates conditions of chronic stress in the body. Chronic stress is

Social Determinants of Health:

Societal conditions (e.g., income, education, access to services, availability of services, discrimination) that affect the health outcomes of individuals.

characterized by ongoing activation of the “fight or flight” system that is normally activated only under acute self-protective stress. Over time, this hyperactivation can lead to a range of chronic physical disease and behavioral maladaptations. Marmot’s work has shown that even among employed workers, occupying a lower position in the social hierarchy is related to higher rates of death from cardiovascular disease (Marmot 2004).

Marmot’s work also showed that social engagement—the ability to participate as a full member of society and the self-esteem that goes with that—is also critical to positive health outcomes. This has particular relevance for the health of boys and men of color. As we begin to consider the effects of stress on these men, we come to the conclusion that simply addressing poverty and education (for example) in the short run is not enough. Ultimately, through trauma-informed approaches, we can address the adverse effects of chronic stress that come from the social position of this population. Critical to any intervention that addresses the health of men of color is to improve the systems that serve them and with which they interact. If denied opportunity by those systems, the health of this population will be further limited.

Understanding Masculinity

In attempting to understand the health of men of color, it is important to examine masculinity, both in its biological and social contexts. Levels of the hormone testosterone increase after puberty to amounts that are 20 times higher than in the prepubescent male. The presence of testosterone is clearly related to aggressiveness and violence, although the social context in which men live can largely either mitigate or exacerbate these biological effects. Clearly, the presence of testosterone predisposes adult males to a number of diseases including cardiovascular disease, stroke and some forms of cancer, which, like prostate cancer, are sensitive to the presence of this hormone.

Perhaps more significant than the biological effects of maleness is the meaning of masculinity in American society. Masculinity is associated with such qualities as aggressiveness, strength, independence, emotional distance, self-control, and hypersexuality. Boys are quickly socialized to understand the meaning of manhood both implicitly and explicitly based on images of masculinity in the media and in their day-to-day lives. In neighborhoods where parents feel that their children are likely to be assaulted or bullied, parents may teach their children that fighting back is part of being a man.

Studies have shown that men who hold traditional notions of what it means to be a man, like the ones just described, are more likely to engage in high-risk behavior. These studies also find that African American men are more likely to hold these traditional ideas of masculinity. This tendency towards high-risk behavior accounts in part for the higher rates of accident-related illness among men. Men of color who see themselves as powerless may be more likely to try to assert their manhood through risky behaviors (Courtenay 2000; Courtenay and Keeling 2000). Courtenay and others argue that risk-taking behavior provides a way for marginalized males to prove themselves as men since they lack more productive ways to show power.

The powerful messages about what it means to be a man constrain the ways in which men can talk about their trauma. Early in life, most boys are taught to be emotionally unexpressive, self-reliant and to behave in stereotypically “masculine” ways. When they then face trauma in such forms as childhood physical abuse, childhood sexual abuse, witnessing violence against their mothers, seeing violence in their communities or being victims of community violence, they feel ashamed to display their pain or to seek comfort (Mejia 2005). The powerful overt and subliminal messages of masculinity make it difficult for men to acknowledge trauma and seek help. Many men perceive that they will be viewed as weak or “unmanly” if they acknowledge their physical and emotional pain. Unable to express their pain in a healthy way, men may turn to alcohol or other drugs as self treatment. Other men externalize their pain by committing acts of violence in their communities or against their intimate partners. Thus the trauma experienced by boys and young men of color is often intertwined with their struggle with masculinity.

“Throughout boyhood, adolescence and adulthood, ideas about masculinity have an effect on how and when males access health care.”



Throughout boyhood, adolescence and adulthood, ideas about masculinity have an effect on how and when males access health care. The social notions of masculinity often portray getting health care as weak and unmanly. This notion is also relevant to behavioral health services, as men often believe that any acknowledgment of depression or anxiety is a sign of weakness.

Men may fall out of the health care system because they hold unconstructive ideas about manhood or deny that illness will happen to them. Lack of employment and health insurance also serve as barriers. When men do find their way into medical settings, they often find providers who are unsympathetic or unfamiliar with the issues they face. Boys and adolescents may receive health coverage under the State Children’s Health Insurance Plan (SCHIP), but after the age of 18, many young men find themselves no longer eligible for such coverage.

Race, Ethnicity, Language and Culture

When we look at the health of African American men, we have to confront the issue of what race actually means. Race is a social construction and has no specific biological or genetic correlate. When we use race in clinical or epidemiological studies, it overwhelmingly is serving as a proxy for some other variable like poverty or discrimination. Our focus on boys and young men of color is a reflection of the fact that health and social statistics confirm that their health and well-being is worse than that of other groups in California and in the U.S.

Similarly, as we examine the issues that affect Latino men, we encounter the meaning of ethnicity. The term Latino is a broad term that includes people with a variety of countries of origin and cultural traditions. Certainly, in California, the Latino population includes people from Mexico, Central America, Puerto Rico and other countries. Added to this diversity of national origins is the striking diversity among generations, with many recent immigrants as well as families that have been in the U.S. for many generations. By focusing on Latino men, we are recognizing that health and social statistics indicate that they lag behind other groups in terms of health status and educational attainment, and that they suffer disproportionately from preventable problems such as violence and HIV. More profoundly, these men find themselves

and their families effectively cut off from important economic and social opportunities. A key organizing principle of this report is the effect of trauma on men of color.

A key pathway for trauma is the impact of racism and discrimination on the health and development of boys and men of color. Increasingly, the public health literature has moved toward defining how racism functions to affect health, particularly among those who are poorest and most cut off from meaningful opportunity.

Dr. Camara Jones has presented a framework for understanding the levels at which racism functions. She describes three levels of racism: institutional, personally mediated and internalized. This framework is useful in thinking about the broader social effects of racism and discrimination on the health of people of color. In her framework, she defines institutional racism as “differential access to the goods and services of a society based upon race.” In a sense, this is the discrimination and racism that are embedded in social structures, irrespective of the attitudes and views of the leaders of those institutions. Next, she defines personally-mediated racism as either prejudice—*judging* another individual’s abilities on the basis of race—or discrimination—*acting and behaving* differently toward individuals on the basis of race. Finally, she defines internalized racism as the way in which members of the stigmatized group begin to accept the negative messages about themselves that they see in the world and to reflect that negativity in their behavior (Jones 2000).

When we apply this framework to men of color, it has important implications for the social determinants of health. Institutionalized racism in employment structures, the criminal justice system, and the healthcare and educational systems results in men of color being systematically excluded from opportunity. To the extent that long-standing policies and historical discrimination have denied men of color and their families access to jobs and education, these men have less social capital. For example, because their family members have not been part of long-standing employment or educational traditions, they fail to benefit from seniority or legacy preferences. This perspective has real implications for policy level interventions for men of color. Systems that have not examined their own institutional racism will not be able to account for the reality that these men are underrepresented and underserved.



Personally mediated racism, in the form of prejudice and discrimination, is complex and related to institutional racism. Popular notions of racism maintain that there are certain people who are overtly racist and others who are not. More recent evidence has suggested that implicit unconscious bias on the part of individuals can have a dramatic effect on the lives of people of color (Kang 2005). Researchers at the Massachusetts Institute of Technology and University of Chicago conducted a study where they assigned either traditionally black-sounding names or traditionally white-sounding names to a set of hypothetical identical resumes. They found that the resumes that had the black-sounding names were far less likely to receive positive responses than those with white-sounding names. Similarly, we know that African-American and Latino men nationwide are more likely to be stopped by the police and are more likely to be searched if they are stopped. While some would attribute this to overt racism on the part of the police officer, more recent evidence suggests that subtle and unconscious bias can lead to actions that appear discriminatory in the aggregate, even if the individual who is performing the discriminatory act is not aware of it.

Internalized racism in this context is also important. African-American and Latino men are highly stigmatized in the media as criminals, aggressive, lazy and hypersexualized. Such negative stereotypes constrain how these men think about their masculinity and have a dramatic effect on how they envision their futures and potential for opportunity.

Popular culture has identified certain stereotypes as culturally relevant to Latino men. Often Latino men are portrayed as illiterate, hyper-masculine and possessive of exotic characteristics. To the extent that these images affect how these men are seen as they present themselves for education or employment, they create a low glass ceiling that hinders their potential opportunity. To the extent that Latinos accept these negative images as children, these depictions will shape how they see their horizon of possibilities. If men of color never see positive depictions of themselves achieving success or assuming leadership positions in their communities, then they won't see these options as viable.



Effects of Trauma on Health and Human Service Systems

Frequently we think of service delivery to vulnerable clients in an abstract way, as if human emotions and human life experiences play little if any role in that “delivery” of services. In reality, services are delivered by people and the people who deliver these services are, at any point in time, experiencing stressful events in their own lives. A majority of them—given large epidemiological studies—will experience at least one traumatic event in their lifetime.

As a result of widespread exposure to acute and chronic stressors, there are organizational processes that run in parallel to the destructive processes in the lives of the clients that these organizations serve. These parallel processes in individual organizations can interfere significantly with the ability of the current systems to address the actual needs of clients—in this case, boys and young men of color, most of whom are likely to have also been exposed to childhood adversity and adult trauma (Kessler, Sonnega et al. 1995; Goodman, Rosenberg et al. 1997; Bloom 2002; Edwards, Holden et al. 2003).

We know from epidemiological studies, like the ACE Study, that large segments of the population have had significant encounters with maltreatment, dysfunction, loss and violence as children and as adults (Felitti, Anda et al. 1998). These are the very same vulnerable human beings who come together to form organizations. Although there is an extensive body of knowledge in the organizational development and business management literature about the impact of stress on individuals and organizations, this impact has not yet been well described in the literature pertaining to social service or mental health service delivery (Bloom 2006). Yet the sources of stress within organizations that serve the health, mental health, and social service

Defining “Trauma-Informed”

“When a human service program takes the step to become trauma-informed, every part of its organization, management, and service delivery system is assessed and potentially modified to include a basic understanding of how trauma impacts the life of an individual seeking services. Trauma-informed organizations, programs, and services are based on an understanding of the vulnerabilities or triggers of trauma survivors that traditional service delivery approaches may exacerbate, so that these services and programs can be more supportive and avoid re-traumatization.”

—National Center for Trauma-Informed Care, <http://mentalhealth.samhsa.gov/ncitc/trauma.asp>

needs of boys and young men of color are extensive. Numerous reports have declared that such systems, especially the mental health system, are now in a state of chronic crisis (Bazon Center for Mental Health Law 2001; Appelbaum 2002; President’s New Freedom Commission on Mental Health 2003). The summarized version of these reports claims that *“the overall infrastructure is under stress, and access to all levels of behavioral health care is affected”* (National Association of Psychiatric Health Systems 2003).

Just as the lives of people exposed to repetitive and chronic trauma, abuse, and maltreatment become organized around traumatic experience, so too can entire systems become organized around the recurrent and severe stresses that accompany delivering services to clients. This is especially true when there is vast social denial about the origins of so many mental health, violence, substance abuse, and social problems (Bentovim 1992). As a result, parallel processes occur among traumatized clients, stressed staff, frustrated administrators and pressured organizations. Service delivery can often mimic the traumatic experiences that have proven so harmful to the clients served.

This largely unconscious process sets up an interactive dynamic with results that are uncanny and disturbing. The clients bring their past history of traumatic experience into the mental health and social service sectors, consciously aware of certain specific

goals but unconsciously struggling to defend against the pain, terror and losses of the past. They are greeted by individual service providers, subject to their own personal life experiences, who are more-or-less deeply embedded in entire systems that are under significant stress.

Parallel Processes Between Clients and Service Providers

For many institutions the end result of this complex, interactive, and largely unconscious process is that the clients—in this case, boys and young men of color—enter our systems of care feeling unsafe and often engaging in behaviors that are dangerous to themselves or others. They are likely to have difficulty managing anger and aggression. They may feel hopeless and act helpless, even when they can make choices that will effectively change their situations, while at the same time this chronic learned helplessness may drive them to exert methods of control that become pathological. They are likely to be chronically hyperaroused and although they try to control their bodies and their minds, the methods used—such as substance use—are often problematic. They may have significant memory problems and may be chronically dissociating their memories and/or feelings, even under minor stress. They are likely therefore to have fragmented mental functions. These clients are not likely to have learned very effective communication skills, nor can they easily engage in conflict management because of chronic difficulties with emotional management. They often feel overwhelmed, confused and depressed and have poor self-esteem. They may not know how to make and sustain healthy relationships nor is it likely that they know how to grieve for all that has been lost. Instead they have an increased vulnerability to revictimization or the victimization of others and in doing so, may repetitively reenact their past terror and loss.

Likewise, in chronically stressed organizations, individual staff members—many of whom have a past history of exposure to traumatic and abusive experiences—may not feel particularly safe with their clients, with management, or even with each other. They are chronically frustrated and angry and their feelings may be vented on the clients and emerge as escalations in punitive measures and counteraggressive behavior. They feel helpless in the face of the enormity of the problems confronting them, their own individual problems, and the pressures for better performance from

“When these young men and boys react in ways that reflect their histories of trauma, these reactions are only taken as confirmation of this disparagement.”



management. As they become increasingly stressed, the measures they take to “treat” the clients may backfire and they become hopeless about the capacity of either the clients or the organization to change. The escalating levels of uncertainty, danger and threat that seem to originate on the one hand from the clients, and on the other hand from “the system,” create in the staff a chronic level of hyperarousal as the environment becomes increasingly crisis-oriented.

Members of the staff who are most disturbed by the hyperarousal and rising levels of anxiety institute more control measures resulting in an increase in aggression, dependence on both physical and biological restraints, and punitive measures directed at clients and each other. Communication breaks down among staff, interpersonal conflicts increase and are not resolved. Team functioning becomes increasingly fragmented. As this happens, staff members are likely to feel overwhelmed, confused, and depressed, while emotional exhaustion, cynicism, and a loss of personal effectiveness lead to demoralization and burnout.

It is not unusual to hear mental health professionals and other social service employees wonder how it is possible that their organizations can be so dysfunctional when, taken individually, most of their colleagues seem reasonable, caring and committed. Efforts to create change often appear to confound the very process of change, and as that happens, staff demoralization escalates. It is possible then to see the parallel processes just described at the organizational level.

The combined stresses and trauma of boys and young men of color who use these systems and the systems themselves often lead to a collective sense of hopelessness and helplessness. In many systems, including the health care system, these boys and young men are referred to with terms that suggest that the providers view them as barely human. When these young men and boys react in ways that reflect their histories of trauma, these reactions are only taken as confirmation of this disparagement.



Applying Trauma Knowledge to Community Prevention and Systems Change Efforts

What follows is a look at key prevention efforts and health and human service systems that serve boys and young men of color and recommendations for applying trauma knowledge to these efforts and systems. Violence prevention and parenting education efforts, which may occur within various health and human services systems as well as in schools, are discussed as critically important services that must be infused with trauma-informed practice. The systems change sections that follow include health care, foster care and child welfare, and the justice system.

Methods

To gather the necessary background and to inform our recommendations, staff from the Center for Nonviolence and Social Justice interviewed California-based experts in the fields of trauma, juvenile justice, child welfare, violence prevention and intervention, health care, and fatherhood support (see expert bios in the **Appendix**). Excerpts that illustrate the key themes that emerged from these invaluable interviews are included in each section that follows. Also included are the following: background information; guiding principles; key evidence from the current literature; descriptions of model programs, including California-based models; and conclusions and recommendations for the application of trauma-informed knowledge to each effort or system.

Violence Prevention

Background

Nationally, among 10 to 24 year-olds, homicide is the leading cause of death for African Americans, the second leading cause of death for Hispanics and Asian/Pacific Islanders, and the third leading cause of death for American Indians and Alaska Natives. Among 10 to 24 year-olds, 86% (4,901) of homicide victims were male in 2006. In 2006, more than 720,000 young people ages 10 to 24 were treated in emergency departments for injuries sustained from violence (CDC 2008).

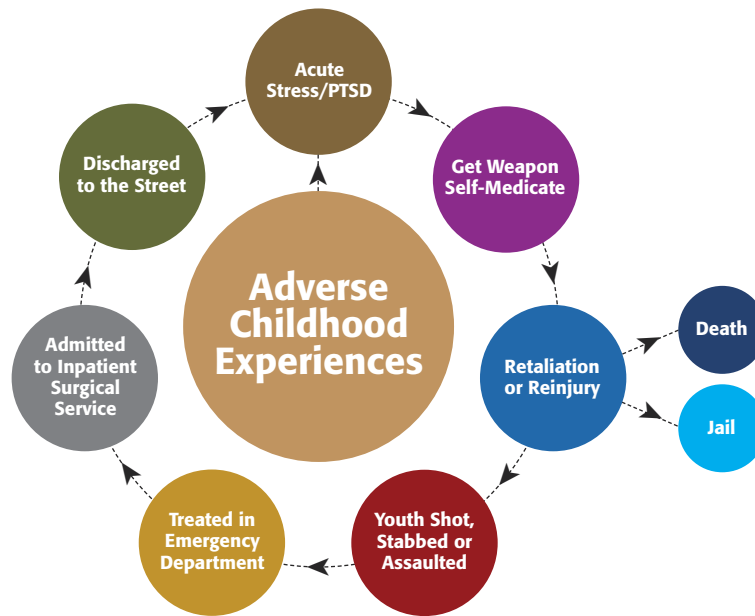
In California, boys and men of color are two times more likely than white boys and men to have witnessed domestic violence and to have been exposed to other forms of violence. African-American children and youth are nearly three times as likely to witness a shooting, bombing or riot. Similarly, Latino children and youth are just over two times more likely to witness a shooting, bombing or riot than white children and youth. In addition, the odds of an African-American child or youth of having someone close to them murdered are 7.8 times higher than a white child or youth; a Latino child's odds are 7.4 times higher than a white child or youth (Finkelhor, Ormrod et al. 2005).

A child's exposure to violence can have consequences for his development. Children exposed to violence are more likely to have internalizing and externalizing behavior problems (Peled 1995).

Children who witness violence are at increased risk for becoming victims themselves, suffering from PTSD, abusing alcohol or drugs, running away from home or engaging in criminal activity (McAlister-Groves September 2002). Young African-American men have a firearms-related death rate 10.1 times that of young white men; young Latino men have a rate that is 3.3 times greater. Forty-four percent of patients with a penetrating injury suffer another penetrating injury within the following five years (Sims, Bivins et al. 1989).

The diagram on the next page illustrates this cycle of violence. A young man is shot, stabbed and/or assaulted. If thought to be severe enough, he is brought to the emergency department. Depending on the extent of the injury, he might be discharged back into the hostile environment from where he came or he is admitted to the trauma

The Cycle of Violence



inpatient service. The young man is eventually discharged. Currently there are not many facilities equipped to deal with the social and emotional effects the young man is experiencing. He is not prepared for nor may he be aware that he could experience acute stress or post-traumatic stress symptoms. Contributing to the trauma may be multiple adverse childhood experiences that heighten his anxiety, paranoia and disdain. He gets a weapon and he smokes marijuana to alleviate some of his fears. In his fog he stumbles into the person or groups of people that harmed him. He retaliates. He is then headed for reinjury, jail or death. The cycle illustrated above is not uncommon to boys and young men of color. Unfortunately it is also not uncommon that there is no intervention to capture these young men and boys. Most often, the young men are left to deal with the impact of the violent incident on their own.



“... trauma-informed practice could help traumatized individuals choose change over a path of retaliative violence, reinjury, jail, or death.”

It is imperative that attention be paid to the various points of entry for boys and young men of color. Boys and men often use the emergency department as a source of primary care and are seen there for nonfatal intentional injuries. Public health practitioners might argue that intervening in the emergency department is a form of tertiary care; however, in addressing trauma, these boys and men of color who die largely from violence would benefit from assessment and direction for healing past and current emotional wounds.

The various entry points to capture boys and young men are opportunities to address the multiple levels of trauma that impact their daily living. In noting emergency departments, primary care settings and the justice system, trauma-informed practice could help traumatized individuals choose change over a path of retaliative violence, reinjury, jail, or death.

Guiding Principles

The various forms of violence need not be divided. Youth violence, intimate partner violence, suicide, child maltreatment and sexual assault are varying degrees of violence, all impacted by previous trauma. Traumatic experience is in the history of the person imposing harm and the person receiving that harm. Health care providers caring for men and boys in emergency settings should:

- build knowledge about the impact of traumatic stress and the range of effective trauma assessment strategies and interventions that exist;
- provide trauma-focused education and skill-building for front-line staff, clinicians, and administrators within and across key service systems in order to change practice;
- utilize skilled workers to navigate the consumer to necessary trauma-informed services after injury;
- enable smooth transitions for the consumer that will not discourage him/her from continuing on a path of healing (Ko July 2007);
- incorporate an understanding of traumatic stress in their encounters with boys, men and their families;

- minimize the potential for trauma during medical care;
- understand the important roles that ideas of masculinity, racism, discrimination and poverty play in the physical and mental health of patients and the way these ideas serve as risks for reinjury.

Evidence Review

The U.S. Surgeon General's report on youth violence conducted an exhaustive review of approaches to youth violence prevention and identified best practices and promising models of youth violence prevention. The evidence presented below focuses more specifically on the relationship between trauma and violence for boys and men of color.

The ACE Study made a huge contribution to our understanding of the impact of trauma and adversity on the lives of people (Felitti, Anda et al. 1998). However, adverse childhood experiences have not been, specifically, studied in boys and men of color in urban environments. Given the health outcomes of boys and men of color, we are almost certain that adversity and trauma play a large role in bringing about those outcomes.

A study done by Dr. Joel Fein and colleagues found that: "... emergency department... clinicians recognize the need for evaluation of youth at risk for violence. They are able to identify violently injured youth, but less often perform risk assessment to guide patients to appropriate follow-up resources" (Fein, Ginsburg et al. 2000).

Dr. Carnell Cooper at the University of Maryland Shock Trauma Medical Center showed that patients enrolled in their violence intervention program were three times less likely to be arrested for a violent crime, two times less likely to be convicted of any crime and four times less likely to be convicted for a violent crime (Cooper, Eslinger et al. 2006). The violence intervention program developed in response to this study, though based in the healthcare setting, has had an impact on the reduction of involvement with the criminal justice and juvenile justice systems.



A prospective study performed at two urban emergency departments suggests that “acute stress symptoms assessed in the emergency department in the immediate aftermath of traumatic injury are useful indicators of risk for later post-traumatic stress” (Fein, Kassam-Adams et al. 2002). This applies not only to acute care settings but also pervades primary care settings.

Bresleau and colleagues found post-traumatic stress syndrome to have a prevalence of 9.2% in Detroit youth enrolled in a health maintenance organization (Breslau, Kessler et al. 1998).

Dr. John Rich, in his work interviewing young men that had been shot, reveals the complexities of the lives of these young men: “... aspects of the code of the street and lack of faith in the police combined with traumatic stress and substance use to accentuate their sense of vulnerability. The young men then react to protect themselves in ways that could increase their risk of reinjury” (Rich, Grey et al. 2005).

Expert Interviews

In talking with experts in the field of violence prevention in California, common themes emerged from their recommendations.

Need for navigation and outreach

“As far as [outreach] service we provide, we provide it anywhere from connecting them with mental health counselors or school counselors, the legal, juvenile hall, the probation officers, helping with doctor appointments...A lot of what we’re doing is case management and trying to hook them up with resources in the community as opposed to just saying ‘here’s a list of places that provide mental health counseling’, or ‘here’s a list of physical health services’. Here, the staff will take them. They will sit with them in the waiting room.” – Emilio Mena

“You also have to have strong people to navigate these young Latino and African American men. Those navigators need to know what it means to be a Latino and/or African American man in a larger universe of poverty and deficit and all these things. But the educative function is one way and the other is a sort of court mandated process.” – Jorja Leap

Exposure to violence

“Our main goal is, if possible, to prevent them from ever being exposed to violence in the first place, and if not, then prevent them from being re-exposed to violence. [I myself met] a counselor of a program that was able to remove me from my neighborhood and show me there was a life other than my neighborhood. The counselor told me that I had been dealing with this in a manner that was self destructive. It was not until the counselor helped me that I was able to connect the dots.” – Emilio Mena

Connectedness

“One of the ways to promote alternatives to violence is by reconnecting them with the school system, whether it’s high school or junior college and using education as a way out of a life of violence and exposing them to other community organizations who are on more of a social justice path of promoting nonviolence and bringing a consciousness and an awareness of the surroundings.” – Emilio Mena

“Bringing young men together, outside of their usual neighborhood settings, to engage them in activities that enable them to work cooperatively, to touch and feel each other and to allow them to put their guards down.” – Jerry Tello

Recreating the cultural nexus for young Latinos and African American youth

“The cornerstone tenet of Barrios Unidos like that of Jerry Tello’s work is that the health and well-being of Latino people and communities is rooted in the application of their values, life principles, and traditions, across all areas of their lives. Poverty, its attendant disparities and dysfunctions, and the trauma that the breakdown of community creates are the fundamental focus of what Barrios Unidos and like programs seek to remedy. There is an undeniable intersect between healing and healthy development that is rooted in cultural identity. Recreating the cultural nexus for young Latinos and African American youth is so critical when you’re working with healing issues of violence and gangs. There is a very unique form of trauma faced by children, youth, and young adults in communities of color. This is especially true for African Americans and Latino children, because, you know, their communities are so fractured, they’re so fragmented. The village of the African proverb no longer exists in many communities. The use of words like ‘dysfunction’ or ‘maladjusted’ are typical when describing the behaviors, attitudes, and anti-social life practices of young people labeled at-risk. Poverty and the environmental trauma that it



“Those things that we call trauma, beyond the physical, to include the social, mental, emotional, and even spiritual are critical to understanding before generically trying to define ‘trauma’.”

creates is exacerbated by the breakdown of community fabric. Those things that we call trauma, beyond the physical, to include the social, mental, emotional, and even spiritual are critical to understanding before generically trying to define ‘trauma’. Those things really tear that community apart.” – Frank Acosta

Understanding the language of respect

“Defining a punk is different in different settings. ‘Don’t be a punk’ means don’t read. ‘Don’t be a punk’ means shoot back. If you have a bunch of gun violence in a neighborhood, that means being strapped. In other neighborhoods it does not mean being strapped. And the brilliance of a good community youth program is they know instantly what that is, and they can influence it.” – James Bell

“Defining respect is very different in what our men and boys of color see, hear and feel. There is a certain threshold that you have to get to with these men and boys. You have to get them to think past tomorrow or count to ten before they blow their tops.” – James Bell

Educating communities about trauma

“Under an educative umbrella, you put these homies into groups and say ‘we’re going to talk about what trauma does’. An example is an ongoing class that takes place here at Homegirl Café. And they’ll say ‘this is what trauma does’ and all of a sudden, you’ll see the lights go on. ‘Oh, you mean that if I saw my dad hit my mom that that did something to me?’ The effective way is not psychotherapy. The next step is to get people to talk about it. ‘...okay, I realize it happened, what does it mean to me?’ This method is overwhelmingly educative, but it can also be court ordered. When they go beat up their girlfriends, which they do, they are then ordered into domestic violence groups... and they can hide behind ‘it’s court ordered’. But they participate a little too actively for it. So I would say educative and court-mandated are the ways to look at this trauma and begin to address it.” – Jorja Leap

Existing Models

California-Based Models

Caught in the Crossfire (Oakland, CA)

The Caught in the Crossfire hospital-based peer intervention program hires young adults who have overcome violence in their own lives to work with youth who are recovering from violent injuries. These highly trained Intervention Specialists offer long-term case management, linkages to community services, mentoring, home visits, and follow-up assistance to violently injured youth. The purpose is to promote positive alternatives to violence and to reduce retaliation, re-injury, and arrest.

The Wraparound Project (San Francisco General Hospital, San Francisco, CA)

The San Francisco Wraparound Project's mission is to prevent violent injury and break the cycle of violence in our most vulnerable communities by addressing root causes and risk factors with culturally competent case management and vital community resources. Physical rehabilitation is provided in the aftermath of injury, however, providing services to reduce or eliminate risk factors associated with violent injury are not traditionally offered upon hospital discharge. The Wraparound Project serves as a vital point of entry, provides mentorship and links clients to essential risk-reduction resources in order to reduce injury recidivism and criminal recidivism among the most vulnerable citizens of San Francisco.

National Latino Fatherhood and Family Institute (NLFFI) (Los Angeles, CA)

The National Latino Fatherhood and Family Institute (NLFFI) offers a nationally recognized mentoring program focused on nurturing young fathers as they learn about the growth and development of their children and the responsibilities of parenting. They also offer *El Joven Noble*, a program for young Latino men that seeks to instill positive values, behaviors, cultural identity, and acceptance of personal responsibility through educational and mentoring activities.

This work outlines many of the underlying traditions of Latino culture and blends them with strategies that have been found to encourage and support Latino men as they work to heal their personal pain, and to strengthen and maintain their families. This work is deeply grounded in providing services in the context of the family—*“la familia”*—and endorses for men the notion of *Un Hombre Noble*—a noble



man who keeps his word. “Circulo de hombres” is another culturally-based framework used by the NLFFI in working with males of color. The “circulo” is a gathering that represents a circle of friendship and extended kinship. It is a cultural ceremony that supports males in clarifying their roles and responsibilities and in rebalancing themselves and becoming grounded in their culture. Through this rebalancing, men and boys support and encourage each other in their various roles— “hombres,” fathers, husbands, life partners and community leaders.

The National Latino Fatherhood and Family Institute is a project of the National Compadres Network in collaboration with Bienvenidos, Inc. and Behavioral Assessment, Inc.

Barrios Unidos (Santa Cruz, CA)

Barrios Unidos is a Santa Cruz-based organization that is rooted in the Chicano experience. A central premise of the Barrios Unidos theory of change is the understanding that the identities of Latino and other socioeconomically disadvantaged youth are shaped by political and economic forces that do not always have their best interests at heart. The focus of Barrios Unidos programs is to restore a sense of belonging to young people, their families and communities. Today the work of Barrios Unidos is embodied in three areas: the Cesar E. Chavez School for Social Change (a charter school that seeks to empower youth to become positive role models of social change) community outreach and community economic development. Barrios Unidos has developed in parallel to the work of Jerry Tello (of the National Compadres Network and the National Latino Fatherhood and Family Institute) to promote the healing properties of culture. Barrios Unidos served as one of the key community action projects of the California Wellness Foundation’s Public Health Initiative to Prevent Youth Violence.

Healing Hurt People (Drexel University, Center For Nonviolence and Social Justice, Philadelphia, PA)

Healing Hurt People (HHP) is the cornerstone programmatic component of the Center for Nonviolence and Social Justice. HHP is a community-focused, hospital-based program designed to reduce recidivism among youth aged 12-30. The program is affiliated with the Emergency Department (ED) at Hahnemann University Hospital

and the Drexel University College of Medicine. HHP staff work with youth who are treated in the ED for violence related injuries in an effort to prevent retaliation and continued connection to violence and crime. The staff at HHP serve as mentors to help clients discover more positive paths in life. They link the youth to comprehensive support services such as: substance abuse treatment; post traumatic stress treatment; health care; education; job training and placement; legal assistance; transportation; counseling; and physical rehabilitation.

Conclusions/Recommendations

WE RECOMMEND that a trauma-informed approach to violence prevention that addresses the needs of African American and Latino boys and young men should consider the following:

- Trauma-informed training for professional development of judges, law enforcement, healthcare providers, teachers, social service providers and other providers who encounter youth who are at risk of involvement in violence.
- Trauma-informed training should be infused in the basic education of law, medicine, education, law enforcement, and social services.
- Because victims of violence are especially vulnerable to recurrent violence and retaliation, services should focus on interrupting the cycle of violence. Emergency department and hospital-based interventions have potential to accomplish this.
- Training peer health navigators and mentors in trauma-informed methods and employing them to help youth who are at risk for violence to heal and navigate difficult systems and reconnect to school and work.
- Incorporating a deep understanding of masculinity and the meaning of respect into violence prevention efforts at all levels.
- Enhancing violence prevention curricula with trauma-informed knowledge and principles.

“... the most significant protective factor for children and adolescents who have experienced trauma is a healthy relationship with at least one caring adult.”



- Creating effective trauma-informed violence prevention and male development approaches—especially group-based strategies such as *healing circles* and *trauma-recovery groups*—that are acceptable and accessible to men and boys.
- Building on and bringing to scale existing and related models of cultural healing such as Jerry Tello’s *Joven Noble*, Barrios Unidos and the work of the National Latino Fatherhood and Family Institute to disseminate, replicate and evaluate these trauma-informed models for boys and men of color.

Fatherhood and Family Support

Creating environments in families that build protective factors and promote resilience is critical in mitigating the effects of adversity. Perhaps the most significant protective factor for children and adolescents who have experienced trauma is a healthy relationship with at least one caring adult. “Children’s resilience to trauma is linked to the presence of a healthy parent or adult in their lives” (Margolin and Gordis 1998). This is why a trauma-informed approach to working with parents/caregivers is so vital to both healing and prevention.

For fathers who have known trauma, the ability to parent may be compromised by experiences such as:

- growing up without a father;
- growing up without a positive male role model;
- childhood neglect or abuse;
- growing up without nurturing or positive attachments;
- domestic violence;
- substance abuse;
- living in an unsafe community;
- chronic poverty;
- homelessness;
- discrimination.

For some fathers, caring for a child may trigger their own painful memories of childhood. Fathers may feel ambivalent about their children and unsure of their parenting abilities. If they lacked a nurturing caregiver themselves, they may have no frame of reference for what positive childrearing involves. Overwhelmed with pressures in their own lives, fathers may have lapses in their empathy for their children and difficulty in identifying and attending to their needs. Lack of information about child development and nonphysical discipline strategies can lead to unrealistic expectations of children's behavior and possibly to corporal punishment. Many fathers are not custodial parents, which removes them from the daily lives of their children. Infrequent or irregular contact with their children can impede healthy relationship development. Feelings of shame or guilt can be triggered by periods of absence, lack of confidence in their fathering abilities, or estrangement from their children's mother.

Traditionally, fathers are underrepresented in social services and many parenting programs focus exclusively on mothers and their children. Typically, "fatherhood" programs tend to focus on job training, legal and financial issues, and/or domestic violence and not on the father's role as caregiver in raising and nurturing children. Fatherhood programs are not often designed with relevance to culture, language, or real life circumstances. It is critical that fathers be able to view their contribution as more than simply that of provider or disciplinarian. Economically and socially disadvantaged men of color are further challenged in the role of father by low education and literacy levels and language barriers.

Evidence Review

Studies of parenting education programs that included fathers, compared with those that did not, reported significantly more positive changes in children's behavior and desirable parenting practices (Lundahl 2007).

The influence of father involvement on child outcomes is significant. The quality of the father/child relationship is the variable that is most consistently associated with positive life outcomes. Research has shown the following (Allen 2002):



- **Cognitive development:** From infancy through school age, children with highly involved fathers are more cognitively competent, are better academic achievers, and are more likely to enjoy school, participate in extracurricular activities, and graduate. They are also less likely to have behavior problems at school. As young adults, they have higher levels of educational and economic achievement.
- **Emotional development and well-being:** Children with involved fathers have a greater tolerance for stress and frustration and are better able to manage their emotions and impulses in an adaptive manner.
- **Social development:** The peer relationships of children with involved fathers are typified by less negativity, less aggression, less conflict, more reciprocity, more generosity and more positive friendship qualities. The strongest predictor of empathic concern in children and adults is high levels of paternal involvement.
- **Decrease in negative outcomes:** Father involvement is associated with decreased delinquent behavior, less substance abuse among adolescents, less truancy, and lower incidence of depression. “Adolescents who strongly identified with their fathers were 80% less likely to have been in jail and 75% less likely to have become unwed parents” (Furstenberg 1993).

Expert Interviews

Some of the themes around parenting that emerged in speaking with California experts include:

Fathers are often absent from the lives of their children and estranged from the children’s mother, and even from the mother’s family. Incarceration also separates fathers from children and sometimes results in parental rights being terminated. The absence of a father or positive male role model can be cyclical/generational. “...in the minds of boys that are raised without those kinds of men in their lives, they have an image of what a man is. Because they haven’t had a reflection otherwise, and the result is that they go around emulating an image that is not accurate or it’s so far out because that’s what’s around them. It is just a self-fulfilling prophecy...they will tell you ‘I want to be there for my child’. They don’t know what it is. And the trauma that goes on when you see these boys who have fathered children and are detached from them and you get them alone and they begin to cop to ‘dude, I’m doing exactly what happened to me’. And that disappointment

is profound. I mean I don't have the skills to, to address that disappointment other than saying, you know, tomorrow's a new day, brother." – Emilio Mena

Teen parenthood is prevalent, and often generational.

"...moms and pops are out of the picture, grandma's over there raising all the children...that's pretty much everywhere...You gotta understand these days grandma's 33 years old." – Emilio Mena

For young men of color, having a child can be a critical turning point or "wake-up call" that makes the concept of "future" relevant for the first time and can inspire men to want to change the course of their lives.

"Men having children is tricky [because] most of them feel out of control... they'll often say I don't know what I'm gonna do... And by the way, it also is what gets some of them to stop. About half of the people I've interviewed when I said what was your tipping point...[it] was having a child." – Jorja Leap

"... the other tie-in of the parenting...as an intervention is that there's a lot of gang research and a lot of criminal logic research that says the two things that pull someone out of being a career criminal are strong family relationships and an education or vocational skill so they can be employed. The strong family, especially for the younger people because I think they tend to think that you don't leave the gang until your early or mid 20s but we see in this parent program 16 and 17 year old boys that are really sort of like 'well I'm a father and I have responsibilities' and I think that we can sort of divert them much younger than people have thought." – Sue Burrell

For young men of color, the act of fathering children, often with various mothers, can be viewed as part of what it is to "be a man."

"...we found out there's a lack of [good] role models, male figures...to be a man these days you have to have a lot of money, you have to have a lot of girlfriends, you have more than one kid with different girls, with different ladies." – Emilio Mena

"...one of the kids that I was talking to a while ago in an interview...I was asking him about what he thought about what could be done for violence prevention and he talked about birth control and he said one way, and he was one of the few young men his age, he was like 20 who hadn't fathered any kids and that was seen as a weakness." – Deanne Calhoun

“... Latino youth are more likely to live with both parents, while African American youth most often live with just one parent.”



Although rates of single parenthood are high for both Latinos and African Americans, Latino youth are more likely to live with both parents, while African American youth most often live with just one parent.

“...we also then track who was the youth living with? We used to have almost no youth who were living with both parents. And now a lot of months we have 30% and it’s almost entirely Latino participants who are living with both the mother and father. I mean which is so to me and I mean and I’m not saying it’s always a functional situation but I mean that’s a huge difference...I still think that’s a huge distinction between African American and Latino [youth]... African American young men are almost always just with one parent.” – Emilio Mena

Cultural traditions are often embodied in and die with the older generations. When the grandparents die, so can the sense of family cohesion and identity.

“...I mean I’m looking at some of the guys that I grew up with who have kids now. There’s no sense of family...I mean there’s no family structure there’s no family culture...it sounds like the breakdown of family...once grandma and grandpa are gone their whole...family bond...no one is there to pick it up and keep that there... keep it part of the family and it’s just lost.” – Emilio Mena

Fathers can carry feelings of shame and guilt that result from circumstances such as: having a child in the juvenile justice or child welfare system, not being able to provide financially, periods of absence or disconnection from the lives of their children, or feeling ineffective because of their own trauma.

“The shame and guilt you feel as a parent whose kid is in the system. See, people don’t think about that part...a lot of times parents overcompensate because they’re carrying this inner shame that they failed in some way [because] their kid is in the system.” – James Bell

Existing Models

California-Based Model

National Latino Fatherhood And Family Institute

(authors: Jerry Tello, Barbara Kappos, Alejandro Moreno, Bobby Verdugo, Hector Perez-Pacheco, Fatima Sanchez, and Claire Donahue)

The National Latino Fatherhood and Family Institute (NLFFI) offers a nationally recognized mentoring program focused on nurturing young fathers as they learn about

the growth and development of their children and their responsibilities of being a father. They also offer *El Joven Noble*, a program for young Latino men which seeks to instill positive values, behaviors, cultural identity, and acceptance of personal responsibility through educational and mentoring activities.

This work outlines many of the underlying traditions of Latino culture and blends them with strategies that have been found to encourage and support Latino men as they work to heal their personal pain, and to strengthen and maintain their families. This work is deeply grounded in providing services in the context of the family—“*la familia*”—and endorses for men the notion of *Un Hombre Noble*—a noble man who keeps his word.

The National Latino Fatherhood and Family Institute is a project of the National Compadres Network in collaboration with Bienvenidos, Inc. and Behavioral Assessment, Inc.

National Parenting Education Models

The Office of Juvenile Justice and Delinquency Prevention (OJJDP) in collaboration with the Substance Abuse and Mental Health Service’s Center for Substance Abuse Prevention conducted a project in 1999 called *Strengthening America’s Families* that identified “best practice” family-focused programs proven most effective in preventing juvenile delinquency and substance abuse. Information about the project, as well as direct links to individual program websites can be found at www.strengtheningfamilies.org. Each curriculum cited focuses on specific risk and protective factors. Among the model programs cited by this project are the following:

- ***The Incredible Years*** by Carolyn Webster-Stratton, MSN, MPH, PhD, www.incredibleyears.com (also cited by California Evidence-Based Clearinghouse for Child Welfare)
- ***Nurturing Parenting Program*** by Stephen Bavolek, PhD, www.nurturingparenting.org (also cited by California Evidence-Based Clearinghouse for Child Welfare)



- **Strengthening Families Program** – www.strengtheningfamiliesprogram.org
- **Parents as Teachers** – www.parentsasteachers.org
- **Strengthening Multi-Ethnic Families and Communities** by Marilyn L. Steele, PhD
- **Effective Black Parenting**, designed by the Center for the Improvement of Child Caring, www.ciccparenting.org

Conclusions/Recommendations

To be effective in working with African American and Latino fathers, parenting education and support programs should consider the following elements:

- an approach that takes into account the impact of trauma on children, fathers, and families;
- a culturally relevant design and approach, including language adaptation;
- information that addresses the challenges of non-custodial parents, including incarcerated fathers;
- skills and information around building healthy relationships, including the father's relationship with the mother and the mother's family;
- skills and practice in identifying, processing, and managing feelings, especially shame and loss;
- responsiveness to the developmental needs of both fathers and their children;
- information about the stages of child development (physical, emotional, social and intellectual) to promote realistic expectations and reduce potential abuse and neglect;
- appropriate literacy adaptation;
- information about positive parenting, including discipline, alternatives to physical punishment, setting limits and creating structure, conflict resolution and problem solving.

Health Care

Background

African American and Latino men in California suffer a disproportionate burden of acute and chronic illness including, but not limited to:

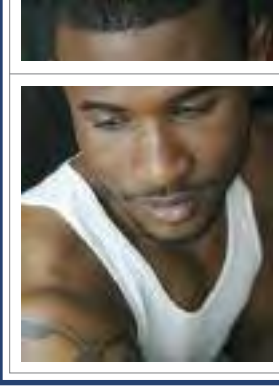
- low birth weight;
- infant mortality;
- childhood asthma;
- childhood obesity;
- post-traumatic stress disorder;
- HIV/AIDS;
- sexually transmitted infections;
- homicide and violent injury (Davis 2009).

Across the country, men and boys of color have limited access to health care due to:

- lack of a usual source of care;
- lack of insurance;
- lack of culturally and linguistically competent caregivers;
- racial and ethnic disparities embedded in health care systems (Randolph-Back 2006).

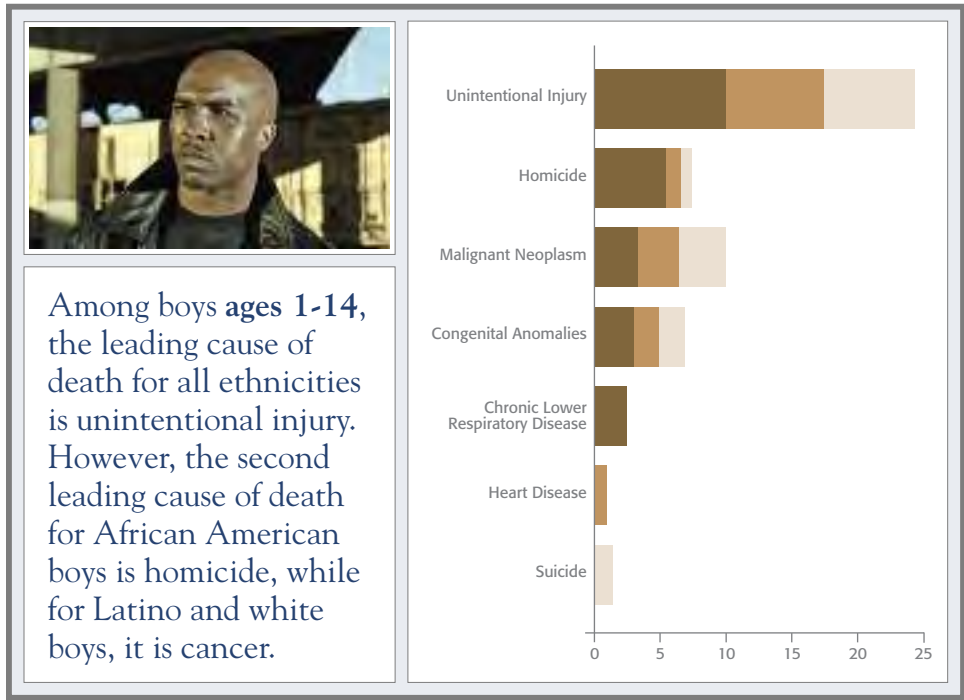
Health care providers in general are poorly trained in trauma, basic principles of men's health and masculinity, and the social context in which many men of color have lived their lives.

Early childhood adversity—common in this population—has been shown to predict future chronic health problems and behavioral health problems, as evidenced by the ACE Study previously described (see pages 12-13). Males of color in California suffer

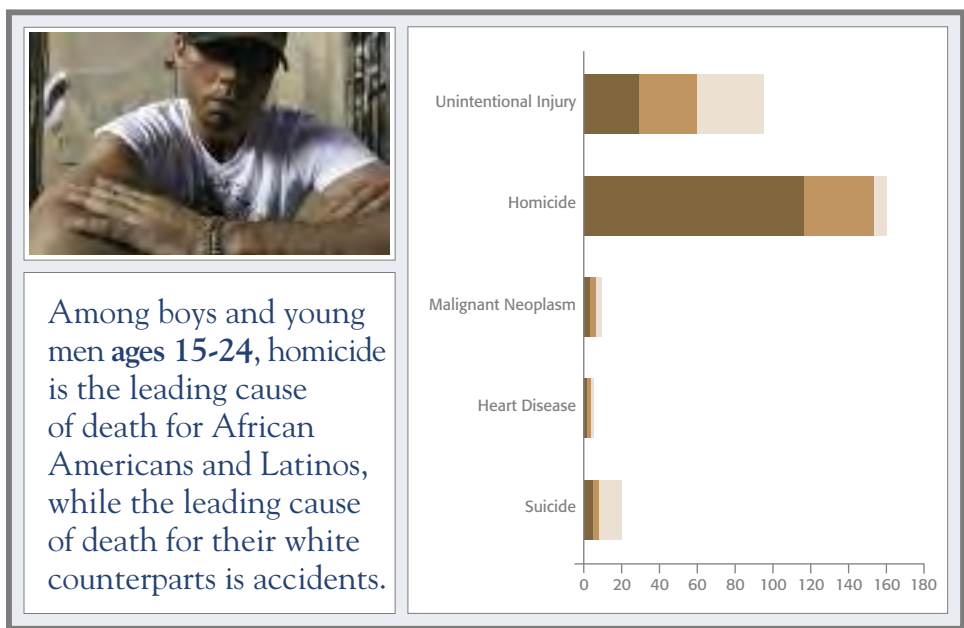


“... Among boys ages 1-14, the leading cause of death for all ethnicities is unintentional injury. However, the second leading cause of death for African American boys is homicide...”

Leading Causes of Death Among Men of Color in California:



Among boys ages 1-14, the leading cause of death for all ethnicities is unintentional injury. However, the second leading cause of death for African American boys is homicide, while for Latino and white boys, it is cancer.



Among boys and young men ages 15-24, homicide is the leading cause of death for African Americans and Latinos, while the leading cause of death for their white counterparts is accidents.

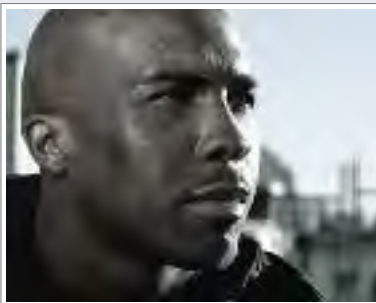
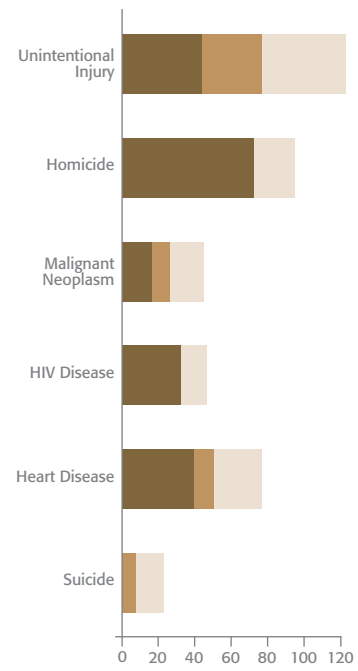
■ African-American
■ Latino
■ White

Source: CDC 2008.

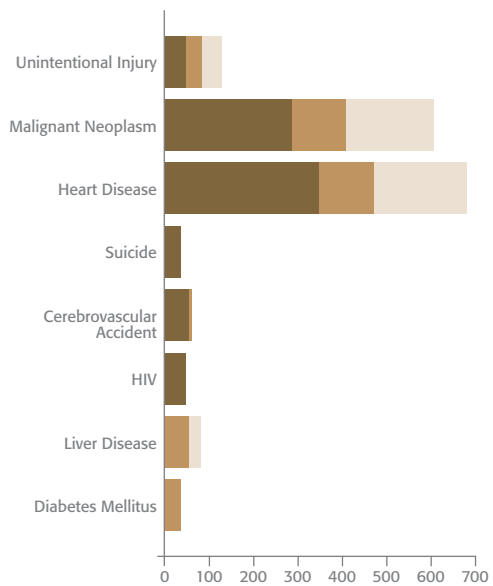
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Among men ages 25-44, homicide remains the leading cause of death for African American men, while for Latino and white men, the leading cause is accidents. Heart disease appears as a cause of death for all men, while HIV appears for African American and white men. Suicide is among the leading causes of death for white and Latino men in this age group.



Chronic diseases such as heart disease and cancer are the leading cause of death for all men ages 45-64, but African American men have higher rates than other men.



African-American
 Latino
 White

Source: CDC 2008.



a disproportionate burden of a number of adversities as reported in the RAND Corporation's *Reparable Harm* report (Davis 2009). Men and boys of color have more than twice the risk of:

- witnessing domestic violence;
- substantiated child abuse and neglect;
- having an incarcerated parent.

Community violence, which was not measured in the ACE Study, is a form of adversity that affects these boys and men as well, and presumably increases their risk of future chronic disease.

Guiding Principles

Health care providers caring for men and boys in emergency and hospital settings should:

- incorporate an understanding of traumatic stress in their encounters with boys, men and their families;
- minimize the potential for trauma during medical care;
- understand the important role that ideas of masculinity, racism, discrimination and poverty play in the physical and mental health of patients and the way these ideas serve as barriers to accessing medical care;
- provide screening, prevention, anticipatory guidance (for children/parents) and referral to needed social services;
- identify boys, men and families in distress or at risk;
- promote healing by paying attention to the S-E-L-F: *Safety*, managing *Emotions*, dealing with *Loss*, envisioning a *Future* (Ko July 2007).

Evidence Review

Primary care based studies have shown high rates of PTSD among African American primary care patients. One study found that 65% had been exposed to trauma and of those exposed, 51% had PTSD. Of those with PTSD, only 21% were receiving

treatment. A significant proportion (35%) of patients exposed to trauma had major depression, another trauma-related illness. The authors suggest that screening and intervention in primary care settings will improve treatment and referral (Alim, Graves et al. 2006).

A study of patients attending the Young Men's Health Clinic in Boston found a high rate of victimization and trauma. Forty five percent of patients reported that they had been shot, stabbed, shot at, or physically assaulted in the past. Those young men who reported past victimization were also more likely to have fathered children, failed to complete high school, used illicit drugs and been incarcerated in the past (Rich and Sullivan 2001).

A study of the 590 clients of a men's health clinic in Denver demonstrated a positive return on investment evidenced by an increase in primary care and specialty visits and a decrease in urgent care, inpatient and outpatient behavioral health care in a population of largely homeless and recently incarcerated men. These changes resulted in a reduction of monthly uncompensated care costs by \$14,244. The ROI was calculated to be 2.28:1.00 for a savings of \$95,941 annually (Whitley 2006).

The CDC funded Adverse Childhood Experiences Study found a high rate of exposure to childhood adversity among enrollees of Kaiser Permanente in the San Diego area. Of the more than 17,000 people studied, almost two-thirds of study participants reported at least one ACE, and more than one in five reported three or more ACEs. The short- and long-term outcomes of these childhood exposures include a multitude of health and social problems (listed on page 13 of this report).

Expert Interviews

Young men lack interest in health care even though they need it.

“And then, around issues of health care, most don't seem at all interested. Kids need access to health care. They need the inoculations. They need well care. They need all this other stuff. But that is not what is on the minds of teenage boys. When they need it, it's gotta be there and it should be there and all kids should be covered.” – Deanne Calhoun

“A big improvement we’ve seen over the years is the school based health centers that have developed at some of the high schools in Oakland.”



Competing concerns

“Accessing health care, following up with health care. There is this real, awful sense of hopelessness of you know? When you hear young people saying ‘oh I made it to 19’ or ‘he just made 20’ you know? You don’t really expect that you’re gonna live a long and healthy life so what’s the point? You’re not gonna go to your annual physical and be doing your preventive health care if the expectation is you’re gonna be dying young anyway.” – Marla Becker

Lack of access to health insurance

“So, I think that it’s really surprising that so many of our young people who are MediCal eligible are not on MediCal yet because it does show to me that they haven’t been part of the health care system. So we try to hook them up then with other health care providers beyond just going to the ER and becoming yet another person in the United States who goes to the ER for their primary medical care because they don’t have a primary medical care provider.” – Marla Becker

Effectiveness of school-based models for youth

“A big improvement we’ve seen over the years is the school based health centers that have developed at some of the high schools in Oakland. And to me that was a big turning point in getting our youth to actually be connected with ongoing mental health care and also physical health care.” – Marla Becker

“I just remember the doctor talking about a kid who he brought in who had awful vision but he had never been to an eye doctor in his life or had his vision tested. So he got a prescription for glasses and it totally changed his academic performance. Just getting physical health care where they have doctors there for their regular ongoing preventive care and it’s at the schools. But I think the issue is if you’re not school affiliated you don’t have access to that, right?” – Emilio Mena

Masculinity as a barrier to accessing health care for African American and Latino Men

“And I think that the whole pride thing really does play into it when we’re talking about accessing health care. Whether it’s physical health or mental health, I think that both African American and Latino young men feel that if you’re a man and you’re masculine, you don’t need that help or any kind of help.” – Emilio Mena

Existing Models

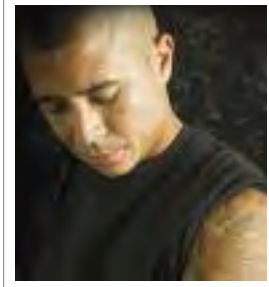
Male-Focused Primary Health Care Services

Several models exist that have focused on providing specialized health services to men, particularly those in poor urban settings. Collectively, the models described here share a number of features:

- focus on the health needs of poor men of color;
- providers who understand issues of masculinity and the barriers that these ideas present;
- a focus on prevention;
- integrated mental health services with a particular focus on trauma;
- linkages to community-based and non-profit organizations that provide concrete services such as legal and child support advice, employment, educational, drug rehabilitation, fitness and nutrition and other needed services.

Male focused health clinics have been established in a number of cities across the United States. While each of these clinics has a distinct focus, they all share the mission to increase access to male sensitive health services.

- **Young Men’s Health Clinic, Boston Medical Center, Boston, MA** – focus on young men 18-29 in Boston.
- **Project Brotherhood, Chicago, IL**, Cook County Bureau of Health Services Health Center, Chicago, IL – focus on black men in Chicago.
- **Baltimore’s Men’s Health Center, Baltimore City Health Department, Baltimore, MD** – focus on uninsured males, ages 19 to 64.
- **Denver Health Community Voices’ Men’s Health Initiative, Denver Health** – focus on underserved men including homeless, incarcerated and ex-offender men.
- **Miami Community Voices Men’s Health Initiative** – focus on poor urban men in Overtown area of Miami.



- **Grady Teen Services, Atlanta, GA**, The Grady Health System, Atlanta – focus on adolescent males and reproductive health.
- **La Clinica de la Raza, Oakland, CA** – focus on Latino men, including ex-offenders and undocumented immigrant men.

Conclusions/Recommendations

Male focused health initiatives have potential to address physical health, behavioral health and trauma-related issues. Little evaluation data have been generated regarding the effectiveness of these models, despite abundant anecdotal evidence that such models are effective in opening access to basic primary care for marginalized men. Even less data are available to document the optimal configuration of services to address trauma-related problems in men. Studies suggest that health services focusing on this population can be cost effective. Trauma theory and the Sanctuary Model speak to the need to create trauma-informed health care settings to serve these often traumatized men and boys.

WE RECOMMEND that a trauma-informed approach to health care that addresses the needs of African American and Latino boys and young men should consider the following:

- Health care providers serving boys and men of color should be trained in trauma and supported by follow-up technical assistance and professional development.
- Providers in community settings must understand the role of masculinity in health and develop systems and settings that serve men.
- Co-location of physical and mental health services is critical to addressing the health needs of men and boys of color.
- Sanctuary framework is an attractive framework for implementation for health providers (to address caregiver and organizational issues).
- Health outreach/navigator support is an essential service for traumatized men and boys moving through systems.
- Coordination between systems – health, schools, behavioral health and community resources, (as well as juvenile justice and foster care/child welfare,

when applicable) – is critical to meeting the health and social needs of men and boys of color.

- Health care systems must be equipped to meet the needs of particular vulnerable populations including undocumented immigrants, gay and bisexual youth and men, youth in foster care, and gang-involved youth.

Foster Care/Child Welfare

Background

There are more than 76,000 children in foster care in California. Of these, 71% are African American or Latino (Kidsdata.org 2008).


African American children have a rate of substantiated maltreatment that is 19.7/1000 children, nearly 2.5 times that for white children. Latino children have a rate of substantiated maltreatment of 10.2/1000, 1.3 times that of white children (Davis 2009).

African American boys are disproportionately represented among children in foster care compared to white boys (Davis 2009). Boys are also less likely to move through the system to adoption, either by kin or by adoptive parents.

Guiding Principles

According to the National Child Traumatic Stress Network (NCTSN), child welfare workers, in coordination with other systems, should:

California	Number
<i>African American/Black</i>	20,461
<i>Asian/Other</i>	1,825
<i>Caucasian/White</i>	19,109
<i>Hispanic/Latino</i>	33,521
<i>Native American</i>	1,093
Total Children in Foster Care	76,126



“... most agencies dealing with maltreated children do not receive or gather in-depth information about a child’s trauma history.”



- maximize the child’s sense of safety;
- assist children in reducing overwhelming emotion;
- help children make new meaning of their trauma history and current experiences;
- address the impact of trauma and subsequent changes in the child’s behavior, development, and relationships;
- coordinate services with other agencies;
- utilize comprehensive assessment of the child’s trauma experiences and their impact on development and behavior to guide services;
- support and promote positive and stable relationships in the life of the child;
- provide support and guidance to the child’s family and caregivers;
- manage professional and personal stress.

Key Evidence

According to a study of child service systems by the National Child Traumatic Stress Network:

- most agencies dealing with maltreated children do not receive or gather in-depth information about a child’s trauma history;
- more than one-in-three agencies do not train staff about assessing child trauma;
- fewer than half of agencies train staff about effective evidence-based treatments for child traumatic stress;
- almost two-thirds of agency staff who refer children for treatment say they never or rarely consider whether a treatment provider uses state-of-the-art practices;
- schools were, overall, found to be less aware of trauma-related issues and interactions than other agencies (Ko July 2007).

The Northwest Foster Care Alumni Study, conducted by the Annie E. Casey Foundation, studied the case record reviews of 659 foster care alumni (479 of whom were interviewed) who had been in the care of Casey Family Programs or the Oregon or Washington state child welfare agencies between 1988 and 1998. They found that, compared to the general population, a disproportionate number of alumni had mental health disorders. Within the 12 months prior to being interviewed, their diagnoses included:

- one or more disorders: 54.4%;
- post-traumatic stress disorder (PTSD): 25.2% (a rate nearly **double** that of U.S. war veterans);
- major depression: 20.1%;
- social phobia: 17.1%.

They concluded: “PTSD and major depression may be the most far-reaching mental health conditions for alumni in young adulthood. PTSD and depression may contribute to difficulty in gaining or retaining employment” (Pecora 2005).

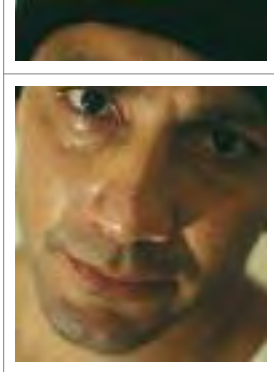
Expert Interviews – Defining the Problems

Most children in foster care have a history of trauma.

“You don’t end up in foster care unless there’s trauma going on. And so you know, that’s one issue and population that I think from a prevention standpoint is crying out for some comprehensive attention.” – Howard Pinderhughes

Foster care placement must be seen as a type of trauma in itself.

“Part of our problem is we have all these kids with issues at home and then they get removed from there and placed in foster care. There’s a whole different level of traumatization that goes on when you get pulled from your family regardless of how abusive they are. And then you have literally no psychological or cultural anchor in life and you have to construct it in a system that really doesn’t provide ways to do that. One of the ways would be to start with foster kids. Because we know the disproportionate number of kids who end up in juvenile hall for violent offenses have come through foster care.” – Howard Pinderhughes

**Emerging from foster care is akin to getting out of jail.**

“When you move out of the system, when you age out of the system, only recently have they started to provide support for kids who age out at 18. It used to be like getting out of jail. You’re done. You know here’s a few things you can do. But now there’s a program in California where they provide housing and support for going to community college and things of that sort. There are all sorts of scholarships for kids who come through foster care but you have to you know, you have to come through it okay to be academically viable.” “...when we did the violence prevention plan for the City of San Francisco, one of the things we did was we said what are you gonna do with re-entry? We’re gonna count re-entry foster care as a re-entry category because it’s really, that’s a population of kids who are coming from a system that has been problematic and their re-integration and ability to function is at question.” – Howard Pinderhughes

Children in foster care are not getting the trauma treatment they need.

“You’re in a bad family situation either being the victim of violence or abuse or upsetting conditions that happen to you in the family and then you go into the place where that continues to be played out. Sadly, in our foster care system, I think there’s very little trauma-related treatment. Even though people increasingly talk about trauma, there are so many kids in the system who don’t get any treatment at all for this. You could be physically abused by one or both of your parents and still not get any therapy for it. It happens more often than anyone would like to admit.” – Sue Burrell

Trauma and violence within families is intergenerational.

“There was a case recently where a little kid was tortured by his mother, his mother’s live-in partner and their baby sitter. I mean brutally tortured. And when they started to do this case study, all three of the perpetrators had entered into the system not from the criminal justice but from DCFS. So there was this kind of continuum, this pathway that led them to them committing violence from their exposure to early childhood trauma and the entry into the system and the traumatic experience while in the system. So the system that was supposed to protect, really persecuted and didn’t quit. And so there’s this intergenerational nature of that and so and if there’s this pathway it goes for some folks that then end it in violence, it is in the dependent court and then from dependent to delinquency.” – Ruben Gonzales

Treat children in their communities.

“We think the vast majority of [foster] kids would be treated more effectively with family therapy programs in their own communities. Or if they need to be taken from their homes because their homes aren’t stable enough, in a foster family program but one where the parents are trained to follow this approach. And meanwhile, that same approach, the parents are being trained so when they take over you know, when the kids are back with them, they’re following the same rules and approaches so they can effectively teach these kids not to just run the streets and do whatever they want.” – Barrie Becker

Provide trauma-informed transitional services for youth while recognizing the stigma of mental health services.

“And there might be opportunities in California to expand multidimensional treatment, foster care or some kind of foster care related programs and one interesting thing, a small program but has gotten a lot of good outcomes is the First Place for Youth, that’s one that if they’re gonna look at Oakland, it basically is a housing transition service for youth exiting foster care but they’re really clever about how they embed mental health component into it. They don’t call it mental health counseling or therapy. They call it something else. They have some mentors trained in mental health and we need to look at some of those innovative models and try to bring those to scale for the older kids.” – Barrie Becker

Existing Models

California-Based Models

First Place for Youth – www.firstplaceforyouth.org

First Place for Youth is a Bay Area-based nonprofit organization founded in 1998 to remedy the lack of services available to youth who are making the difficult transition from foster care to independent living. One of their services, **My First Place**, is a supported housing program that aims to provide stability for former foster youth through safe, permanent, affordable housing, intensive case management, and advocacy and support services. Young people live in one- and two-bedroom apartments and receive support with move-in costs, rent, food, self-reliance planning, health and mental health needs as well as employment and education. My First Place allows former foster youth the opportunity to develop a sense of permanency for the first time in their lives. Staff supports young people to set and achieve goals that move them toward greater independence and develop self-esteem.



“My First Place allows former foster youth the opportunity to develop a sense of permanency for the first time in their lives.”

Through the stability provided by My First Place housing, youth build communities, pursue their dreams, and pave their own way for successful, independent living for years to come.

Conclusions/Recommendations

WE RECOMMEND that a trauma-informed approach to foster care/child welfare that addresses the needs of African American and Latino boys and young men should consider the following:

- CA Endowment support for training and institutional transformation for this system, which serves a large number of African American and Latino Boys;
- advocacy for screening, assessment and treatment for PTSD among all youth in foster care, but especially for boys of color;
- sharing trauma history with foster parents so both staff and foster parents can facilitate healing for youth in foster care;
- preparing foster parents with training and support to enable them to understand and address developmental and behavioral issues through a trauma-informed lens;
- support for trauma-informed reunification efforts;
- support for trauma-informed transition from foster care that focuses specifically on healing the wounds of trauma.

Juvenile Justice/Re-Entry/Prison

Background

In California, African Americans represent eight percent of the adolescent population (ages 10 to 17), but account for 17 percent of juvenile arrests. Latinos represent about 46 percent of the adolescent population, but account for almost half of juvenile arrests (Davis 2009). Numerous studies document that many of the youth in the juvenile justice system have been exposed to myriad traumatic events, either as victims or as witnesses. Because of this exposure, many of these youths have developed post-traumatic stress disorder (PTSD) and other stress-related disorders.

Nationally, African-American men are 5.5 times more likely than white men to go to prison in their lifetimes. The likelihood of Latino men going to prison during their lifetimes is 2.9 times higher than for white men (Bonzcar 2003). Overall, the trajectory for men going to prison in their lifetime is one in three African-American men, one in six Latino men, and one in 17 white men.

In California, African Americans and Latinos represent approximately 43 percent of California's population, but 68 percent of its prison population (Statistics 2008). By the end of 2007, the prison population in California reached over 170,000, which is equipped to hold 100,000. Latinos constituted the largest group in the prison system at 39 percent followed by African Americans at 29 percent with a mean age of 37. According to Bureau of Justice reports:

- approximately 650,000 state and federal prisoners reenter society each year;
- about half of all former prisoners are returned to prison for a new crime or parole violation within three years;
- at any given time, approximately 750,000 ex-prisoners are on parole supervision;
- about 1.5 million children have a parent in prison;
- 91 percent of released prisoners are male; 55 percent are white; 44 percent are black; 17 percent are Hispanic;
- the median age of released prisoners is 33, and the median level of education is 11th grade (Justice 2005).

Guiding Principles

As defined by the National Child Traumatic Stress Network, juvenile justice and judicial staff and administrators should:

- undertake systematic efforts to assess post-traumatic stress and psychological trauma among detainees;
- implement trauma-focused interventions for youth;



- protect juveniles from victimization while detained;
- pay special attention to high-risk populations, such as gay and bisexual youth, in juvenile justice settings (Ko July 2007).

Evidence Review

Evidence suggests it is important to involve family members in the treatment and rehabilitation of their traumatized children for reasons related both to child and family functioning and to delinquency (Cohen, Berliner et al. 2003).

Two controlled studies indicate that grouping delinquent or high-risk youth may inadvertently reinforce problem behaviors (Dishion 1999). This research finding is most relevant to adolescents ages 11 to 14. It is important to note that not all interventions with peer groups have shown adverse effects. Some strategies to guard against these potential adverse effects include involving parents in treatment, mixing antisocial and prosocial youth in groups, limiting group size, and using co-facilitators in groups so that inappropriate behaviors can be addressed immediately prior to peers' reinforcement of the negative behavior.

Juvenile justice facilities have an opportunity to raise the standard of care for youth by providing effective trauma-focused treatments and family-based interventions. Additionally, since some youth express trauma symptoms behaviorally, treatments that address trauma symptoms can also be expected to assist juvenile justice staff with issues related to behavioral management.

Expert Interviews

Bay-area expert Pastor Tony Ortiz describes a restorative justice model:

"...we would go into a community...and then we would recruit the residents from that community that would volunteer to sit on what we call neighborhood accountability boards (NAB)...whenever a kid in their area got in trouble, instead of them going to the system to formally get introduced to the probation juvenile system, they would be referred to us through the Project Pride program or through the restorative justice program and then we would handle the case...So, the whole concept of it was at the community taking ownership and the kid being responsible to his community and not to the system." – Pastor Tony Ortiz

Negative behaviors as adaptation to adverse circumstances:

“Many of these children have already been exposed to abuse, neglect or troubled neighborhoods or things. They came by their behaviors honestly so many of them have already been exposed to trauma...our effort is to try to prevent that from escalating and helping them when we can.” – Barrie Becker

Detention as critical point of intervention:

“Our entry point into this work is the point [just before] detention... the options [for young people of color] are increasing yet are significantly degraded when they are in detention. And we know that statistically kids of color that enter the detention system don’t recover from it as well as their white counterparts. And that in fact, they are turbo-charged through it and go deeper quicker...every day that these young people are in trouble with the law [they are] getting further and further behind.” – James Bell

Biased views of adolescents of color who are involved with the juvenile justice system:

“...if you talk to any public defender, if you talk to any juvenile court judge if you talk to any D.A., they really don’t see the young people...They’ll tell you all about their clients but they really don’t see them competing with their [own] kids. They don’t see those clients sitting in the same SAT classes, they don’t see those kids going to Temple [University]. These kids got post-traumatic stress.” – James Bell

Children “raised by the system”:

“And so there are kids that have almost grown up in the system. Let’s say something happened to them when they were 6 years old. They could wind up going through foster care until they are 18 and never have those issues addressed that brought them to the attention of the system...In San Francisco, when you talk to James Bell, when they did their community mapping of what services are available, they found a huge percentage of the children in the juvenile justice systems come from five zip codes. And it corresponds with African American and Latino communities a lot. And so I think that those are the communities where there’s just really horrible violence. And so many young men either experience that and wind up in the emergency room or they see it, they’ve lost friends and relatives and that’s certainly trauma producing.” – Sue Burrell



“They could wind up going through foster care until they are 18 and never have those issues addressed that brought them to the attention of the system...”

Addressing consequences rather than the root of the problem:

“I love what Greg Boyle, father Greg Boyle says, and we also talk about building prisons to combat this problem. And Greg Boyle says that building prisons to combat this problem is like building cemeteries to combat the problem of AIDS... you’re dealing with the consequence rather than the problem... So we’ve got this thing wrong from the beginning. Any effective public health approach has to have a grass roots community basis. It’s gotta come from the community, from born and bred and culturally consistent with the area of the program that’s being offered. That’s number one. Number two, you are looking at a cross generational problem. Third of all, very important, you need a partnership between former gang members, former violent youth, former offenders, the ones who have walked the walk. But you need them with the professionals, with the physicians, with the social workers... The best outcomes we see are the two together in an uneasy but nevertheless effective alliance. And the fourth and most important... is we must commit ourselves to be in the business of building identities... the core issue is identity. And until we face up to that and commit to that, all this other stuff about the crime rate and this and that means it’s not gonna change.” – Jorja Leap

Existing Models

California-Based Models

Public Private Ventures’ Ready4Work:

An Ex-Prisoner, Community and Faith Initiative

Ready4Work is a three-year national demonstration project that has been implemented in 17 sites, where programs have been developed to help local community- and faith-based organizations support the reentry and reintegration of ex-prisoners (both adults and juveniles) into their communities. Public/Private Ventures helped the lead organizations at each Ready4Work site to build effective partnerships among local faith, criminal justice, business and social service communities. These partnerships provided services—including case management, job training and placement, mentoring and education—to nearly 5,000 participants. Outcomes from the initiative have been impressive, including recidivism rates 34 to 50 percent below national averages.

Homeboy Industries

Established by Father Greg Boyle in 1988, Homeboy Industries provides job training and employment to youth in Los Angeles with a particular focus on youth involved in gangs. Through active and successful businesses—a bakery, café, silk-screening and merchandising—Homeboy Industries provides job skills and employment. In addition, they provide on-site mental health, reentry, drug and alcohol recovery, legal services and tattoo removal. Implicit in the work of Homeboy Industries is the understanding that these young people have been affected by intergenerational trauma. A core value of Homeboy Industries is the need for healing from past pain in order to identify a safe and productive future.

The W. Haywood Burns Institute

The W. Haywood Burns Institute is a San Francisco-based nonprofit with the mission to protect and improve the lives of youth of color by working to ensure fairness and equity throughout youth service systems, primarily the justice system. Their work is driven by the core belief that youth in legal trouble are best served by alternatives to incarceration. Two approaches that frame their work are: 1) bringing together law enforcement representatives, legal representatives, community leaders, parents and youth and leading them through a process of changing policies and practices that disparately impact youth of color and poor children; and 2) building the capacity of local organizations to improve and strengthen their programs and to engage in policy work. The Burns Institute has worked with over 30 jurisdictions nationally and has achieved significant results in reducing racial and ethnic disparities.

Barrios Unidos

Barrios Unidos is a Santa Cruz-based organization that is rooted in the Chicano experience. A central premise of the Barrios Unidos theory of change is the understanding that the identities of Latino and other socioeconomically disadvantaged youth are shaped by political and economic forces that do not always have their best interests at heart. The focus of Barrios Unidos programs is to restore a sense of belonging to young people, their families and communities. Today the work of Barrios Unidos is embodied in three areas: education (specifically, the Cesar E. Chavez School for Social Change, a charter school that seeks to empower youth to become positive role models of social change), community



outreach and community economic development. Barrios Unidos has developed in parallel to the work of the National Latino Fatherhood and Family Institute to promote the healing properties of culture. Barrios Unidos served as one of the key community action projects of the California Wellness Foundation's Public Health Initiative to Prevent Youth Violence.

Conclusions/Recommendations

WE RECOMMEND that a trauma-informed approach to juvenile justice/reentry/prison that addresses the needs of African American and Latino boys and young men should consider the following:

- training and education for juvenile justice professionals and systems in trauma-informed approaches;
- courts should divert youth to community-based, trauma-informed programs as an alternative to further traumatization in jail and prison;
- evidence-based treatment of PTSD and other trauma-related problems must be provided for youth in detention;
- job development in programs that understand and address historical and intergenerational trauma are critical to preventing reoffense (e.g., Homeboy Industries);
- models of restorative/participatory justice should be supported to facilitate healing of the victim and offender alike and as an alternative to incarceration when possible;
- need to engage workers who were formerly in gangs or jail as navigators, counselors and violence interrupters;
- trauma-informed gang intervention/prevention initiatives are a critical component of prevention for youth who are at risk for gang involvement (e.g., Homeboy Industries, Barrios Unidos).



The Sanctuary Model

Given the extent of exposure to childhood adversity, we cannot rely only on specialized trauma treatment programs to address trauma-related problems in boys and young men of color. It should be possible for boys and young men of color to enter any health care, mental health, school, juvenile justice, social service or community environment and have experiences that are healing, rather than experiences that compound their injuries.

The health and human service systems that serve boys, young men and their families are fragmented, do not share common knowledge or language, compete for limited resources, and are under constant stress. When boys and young men of color interact with these stressed systems, their problems are often worsened. The complex stress-related problems affecting our health and human service systems can be compared to the problems of the clients they serve. In many ways, our social service network is largely functioning as a “trauma-organized system” (Bentovim 1992), often unaware of the ways that chronic stress negatively impacts providers and hinders the client recovery. What needs to occur is a transformation of these systems that moves them toward a trauma-informed approach (Bloom 2006).

The Sanctuary Model, developed by Sandra Bloom, MD, is a trauma-informed method for creating an organizational culture in which healing from psychologically and socially traumatic experiences can be addressed (Bloom 1997). The model is an “evidence-supported” practice according to the National Child Traumatic Stress Network (de Arellano 2008) and listed as a “promising practice” by the California Evidence-Based Clearinghouse (2008). The Sanctuary Model is currently being adopted by over ninety human service delivery programs nationally and internationally including: adult inpatient and outpatient mental health settings (Bloom 1994);

residential and acute care settings for children and adolescents (Rivard, Bloom et al. 2002; Abramovitz and Bloom 2003; Bloom 2003; Bloom 2005; Rivard, Bloom et al. 2005); substance abuse programs for adults and for children; schools (Bloom 1995); shelters for the homeless and victims of domestic violence; and community-based as well as school-based social service organizations (Bloom, Bennington-Davis et al. 2003; Bloom 2007).

The Sanctuary Model is based on more than twenty years of clinical experience in responding to the needs of traumatized individuals. The model is not a specific treatment intervention; it is structurally “deeper” than a specific intervention, although many interventions are compatible with it. Using a computer analogy, in much the same way as a computer has foundation software, the Sanctuary Model can be thought of as an *operating system* for a trauma-informed organization. When applied, it operates underneath all the other functions in an organization—the approaches, kinds of therapy, techniques—as long as those functions are compatible with the Sanctuary *operating system*. It is designed to get people, from diverse backgrounds, with a wide variety of experience, on the same page, speaking the same language, living the same values, sharing a consistent, coherent and practical framework.

The demonstrated outcomes of the Sanctuary Model include:

- increased sense of community through the active creation of a nonviolent environment;
- increased democratic decision-making and shared responsibility in problem-solving and conflict resolution;
- opportunities for clients and staff to experience a safe and connected community;
- opportunities for traumatized clients to have healing emotional, relational, and environmental experiences;
- reduced interpersonal violence, including verbal, physical and sexual forms of harassment, bullying, and violence among staff and clients;
- promoting recovery, healing, and growth.

As an extension of this model, we often refer to “Sanctuary” to describe the trauma-informed approach we wish to promote—one with the aim of creating safe environments that promote healing, inclusion, respect for differences, and positive social change. Sanctuary is what can emerge when groups of people come together, create community, engage in authentic behavior, share common values and a common language and make seven specific cultural commitments:

- commitment to nonviolence;
- commitment to emotional intelligence;
- commitment to social learning;
- commitment to open communication;
- commitment to democracy;
- commitment to social responsibility;
- commitment to growth and change (Bloom 2005; Bloom 2007).

A computer metaphor may be used to illustrate a fundamental aspect of the change that is required in our service delivery systems. In a sense, human brains and computer “brains” have some things in common: hardware, foundation software, and application software. In a computer brain the hardware is comprised of microchips, hard drives, monitors, and input devices like keyboards and mice. The human mind has hardware too—the DNA, proteins, neurons (and other types of cells), veins, and arteries comprise the brain. But hardware just sits there unless there is software installed.

A computer has foundation software that we have come to know as an operating system—a master program that controls a computer’s basic functions and allows other programs to run on a computer if they are compatible with that system. The operating system is the *foundation software* for the computer. The programs that allow you to do all the things you want to do on a computer—word processing, spreadsheets, email, etc.—are called *application software*.

“We assert that the operating system for the human brain is attachment because without attachment, human brains and minds cannot develop properly. This is where the issue of trauma comes in.”



We believe that human brains have something analogous to an operating system because we certainly have millions of applications that allow us to do all the things we do: movement, language, memory, etc. We assert that the operating system for the human brain is attachment because without *attachment*, human brains and minds cannot develop properly. This is where the issue of trauma comes in.

A computer virus is a small piece of software that attaches itself to useful programs. Each time the program runs, the virus has a chance to spread and wreak havoc on the entire computer. Traumatic experience is to the human mind what computer viruses are to computers. Trauma disrupts attachment and disrupted attachment wreaks havoc with a person’s health, wellbeing and development. For people to heal from traumatic experience, it is not enough to just change their “applications.” Changing things at a deeper level than that—changing their operating system—is what is required. Changing the operating system in a computer, is a metaphor for how complicated an issue that is.

We believe that our health and human service system as a whole is subject to chronic stress and may become engaged in recreating destructive parallel processes with the clients who seek our help. To change this, our systems need a new operating system. With a new operating system, each component could do its own job—use its own “applications”—but would all share the same underlying operating system—in this case, a trauma-informed approach.

Evaluation and Research: Developing an Evidence Base Early Findings

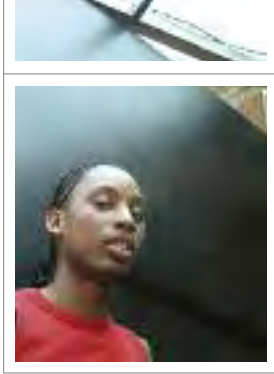
The Sanctuary Model, as in other models of organizational change, is subject to many challenges—namely changing the way that staff conducts business as usual and changing the organizational culture. However, in general, investigators who have studied children’s service systems have found that organizational climates with greater job satisfaction, fairness, cooperation, and personalization, and lower levels of conflict were associated with both service quality and positive outcomes in children’s psychosocial functioning. We believe that these findings are relevant, not just to children’s services but to services directed at all ages of people with complex behavioral and social problems.

Early assessments of the Sanctuary Model in children's residential programs found the model to have two primary components: 1) the creation and maintenance of a non-violent, democratic, therapeutic community and 2) a psychoeducational program. A study funded by the National Institutes of Mental Health (R21 mechanism) and conducted at the Westchester campus of the Jewish Board of Family and Children Services reported positive changes in staff perception of themselves and clients, founded on the following measures:

- **support** – how much clients help and support each other, how supportive staff is toward clients;
- **spontaneity** – how much the program encourages the open expression of feelings by clients and staff;
- **autonomy** – how self-sufficient and independent clients are in making their own decisions;
- **personal problem orientation** – the extent to which clients seek to understand their feelings and personal problems;
- **safety** – the extent to which staff feel they can challenge their peers and supervisors, express opinions in staff meetings, will not be blamed for problems, and have clear guidelines for managing aggressive clients.

Staff became aware that the extent and nature of their own communication was integral to the creation of a safe treatment setting. Similarly, a more psychologically and socially safe environment encouraged staff to openly share their ideas, opinions, frustrations, and mistakes. There was a general observation that the quality of team meetings and case conferences had improved with more active involvement and communication of all staff, and that these meetings provided a forum for practicing how to deal with program issues in non-hierarchical and more complex ways.

Another study (McSparren 2007) measured changes in attitudes from staff at different agencies—those implementing the Sanctuary model and those who were not—and found that staff members in the Sanctuary agencies reported statistically more positive differences in their organizational culture than the staff members of non-Sanctuary



agencies. In short, the study found support for the use of the Sanctuary Model in positively impacting the culture of the workplace.

Success in creating Sanctuary in an organization depends on the development of a trauma-informed culture and a nonviolent, community-oriented environment. The examination of Sanctuary implementation must include looking at how the community members perceive their environment. Thus, one question becomes: do the members of the community perceive the environment as a safer and healthier place to work? One way to examine this is to look at staff turnover.

A detailed analysis of staff turnover found decreases in the number of direct care staff leaving their facility following training in the Sanctuary model. These results suggest that the staff began to see their facilities as places where they wanted to continue to work at. This may be due to the feeling that their workplaces were safer and more healing places. This is particularly important for direct care workers—individuals who are exposed most directly to the clients' trauma—who, after their training in Sanctuary, may better understand clients' behavior, and feel more equipped to manage it.

Another means of examining organizational culture change, as impacted by Sanctuary model implementation, is to measure whether community members perceive the climate of the organization as changing and developing in a more trauma-informed manner. Within a 12-month period, staff members saw statistically significant changes in how well members of their community were working towards creating a trauma-informed organization. This finding has two important implications. First, the findings indicate a greater awareness and monitoring by staff members of actions related to trauma-informed care. Second, and more importantly, staff members acknowledged that their organizational community (including administrators, managers and peers) was truly working toward making the Sanctuary model a reality at their facility and therefore creating a trauma-informed culture that is better able to serve clients and provide for the needs of its staff.

Ongoing Evaluation

Examination of the Sanctuary Model and its impact on the care and treatment of clients, the staff members who provide that care, and the larger organizational climate continues. Currently, Sanctuary trained facilities throughout the world are conducting individual and collaborative evaluations of this trauma-informed model. Of particular note are research endeavors being conducted at statewide levels. These projects involve state governmental agencies, leading academic institutions and the Sanctuary Institute of the Andrus Children's Center. Now underway through Stonybrook University and the Office of Child and Family Services, State of New York is a study to evaluate the implementation of the Sanctuary Model in a number of voluntary and juvenile justice residential programs for children in New York. Also underway through the University of Pittsburgh and the Department of Public Welfare, Commonwealth of Pennsylvania, is an evaluation of Sanctuary implementation in voluntary and juvenile justice programs for children. Consistent with the Sanctuary Model—these organizations and endeavors embody the commitments of 'Creating a Culture of Inquiry and Social Learning,' 'Social Responsibility' and 'Growth and Change' in their efforts to ask the important questions, report them in a responsible manner and continue the growth of this model.





Overall Conclusions

Trauma and adversity are potent and powerful forces that touch the lives of African American and Latino boys and young men. The trauma that affects them is not limited to physical trauma but includes adverse experiences such as racism, poverty, incarceration, and the loss or lack of positive emotional attachments. Childhood trauma is related to behavioral risks and emotional health as well as the risk of future chronic disease.

Furthermore, the larger social ideas about masculinity—or what it means to “be a man”—impact the behavior and health outcomes of males of color. Boys and men of color are disproportionately affected by trauma and adversity because of the social position that they occupy in the larger society. They are disproportionately:

- impoverished;
- ill;
- incarcerated;
- unemployed;
- undereducated;
- discriminated against;
- isolated from the mainstream of society.

The *social determinants of health*—e.g., poverty, stress, social exclusion, unemployment, addiction—exercise their damaging effects through the loss of autonomy, disempowerment, the loss of social inclusion, and the resulting negative impacts on self-esteem. The lower people are in the social hierarchy, the less autonomy and control they possess, and the less able they are to participate fully in society. These negative effects are mediated through chronic stress responses, such as self-medicating, depression, and anxiety.

The social service systems that serve boys, young men and their families are fragmented, exist as silos, do not share a common knowledge base or language, compete for diminishing resources, and are chronically stressed. When boys and men of color interface with these stressed systems, their problems are often compounded.

What We Must Do

Support and expand community-based efforts that are consistent with a trauma-informed approach. At their core, effective programs must have principles and values that are trauma-informed, regardless of the specific health or social issue that they are attempting to address.

- Identify existing community-based programs that are trauma-informed and strengthen them through more intentional application of common trauma language using the Sanctuary Model as a guiding framework.
- Replicate and expand effective community-based programs.

Focus on trauma-informed prevention activities for boys and young men. For example:

- school-based activities (violence prevention, health, parenting support and education, mentoring), beginning in the early years, that are responsive to adverse social and family conditions within at-risk communities;
- preventive healthcare with an understanding of the roles that masculinity, racism, discrimination and poverty play in the physical and mental health of boys and men and how they serve as barriers to accessing medical care;
- substantive training and preparation of young men for meaningful employment;

- parenting education and support for fathers to empower them in their role as caregiver and to build and reinforce relationally healthy connections between fathers and their children.

Infuse health and human service systems with trauma-informed practices to promote healing from trauma and adversity at the individual, family, and community levels. For example:

- provide in-depth, ongoing professional development in the Sanctuary Model to provide a common language for speaking about trauma within and among systems;
- foster care and child welfare practices that engage the whole family (both foster family and family of origin) and that include trauma histories and assessments in providing care;
- behavioral health care that provides trauma-informed treatment;
- rehabilitative options within the juvenile justice system that focus on addressing trauma to divert youth from detention or incarceration.

Focus on cultural frameworks that promote healing and positive male development and identity to address the effects of trauma, improve health, and decrease disparities.

- Support for male development efforts should be stable and long-term and not linked to the “disease of the month.” The “wounded warrior” concept from a variety of cultural frameworks can be an especially powerful healing tool for men. Several California models (*Barrios Unidos*, *El Joven Noble*, *circulos*) that employ cultural frameworks are valuable resources and worthwhile strategies. By providing cultural and linguistic touchstones, they help to rebuild a sense of positive male identity for boys and young men of color. Most critically, they address intergenerational trauma and adversity with a focus on **healing**.

“The need for early investment with a focus on trauma-informed approaches to children is critical. We must also invest in the men who impact the lives of their children...”



Coordinate care among multiple systems that simultaneously serve boys, young men and their families.

- These systems should share a commitment to trauma-informed practice and work together to coordinate the best possible care.

Next Steps For Trauma-Informed Approaches To The Health Of Boys And Young Men Of Color

Build a cohort of leaders. Using Sanctuary as an “operating system,” it is critical to provide organizational development that will evolve systems toward a trauma-informed approach and build a cadre of providers who speak the same language around trauma. Existing approaches that embody a culturally relevant healing core should be supported, built upon, and acknowledged as valuable resources.

Invest in children and fathers. The need for early investment with a focus on trauma-informed approaches to children is critical. We must also invest in the men who impact the lives of their children in the context of both intact and struggling families.

Invest in social marketing to: change and encourage a cultural shift in how we think and talk about trauma and adversity; create support for positive ideas about masculinity; address issues of stigma around behavioral health services.

Invest in evaluation. Long-term investment in evaluation strategies will be needed to examine the outcomes of trauma-informed practice in communities.

Generate new knowledge and research. Moving forward, it will be critical to further research the broader impact of trauma and adversity on boys and young men of color, as well as to further explore racism, culture, masculinity, and the social determinants of health and their relationship to trauma.



Selected References

(2008). "Sanctuary Model - Detailed Report." Retrieved June 27, 2009, 2009, from <http://www.cachildwelfareclearinghouse.org/program/99/detailed>.

Abramovitz, R. and S. L. Bloom (2003). "Creating Sanctuary in a residential treatment setting for troubled children and adolescents." *Psychiatric Quarterly* 74(2): 119-135.

Alim, T. N., E. Graves, et al. (2006). "Trauma exposure, posttraumatic stress disorder and depression in an African-American primary care population." *Journal of the National Medical Association* 98(10): 1630-6.

Allen, S., Daly, Kerry (2002). "The Effects of Father Involvement: A Summary of the Research Evidence." *Newsletter of the Father Involvement Initiative* 1(Fall): 1-11.

Appelbaum, P. S. (2002). "Starving in the Midst of Plenty: The Mental Health Care Crisis in America." *Psychiatric Services* 53(10): 1247-1248.

Bazon Center for Mental Health Law (2001). *Disintegrating Systems: The State of States' Public Mental Health Systems*, Bazon Center for Mental Health Law.

Bentovim, A. (1992). *Trauma-Organized Systems: Physical and Sexual Abuse in Families*. London, Karnac Books.

Blanch, A. (2003). *Developing trauma-informed behavioral health systems: Report from NTAC's National Experts Meeting on Trauma and Violence*. U. S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration: Alexandria, VA.

Bloom, S. L. (1994). The Sanctuary Model: Developing Generic Inpatient Programs for the Treatment of Psychological Trauma. *Handbook of Post-Traumatic Therapy, A Practical Guide to Intervention, Treatment, and Research*. M. B. Williams and J. F. Sommer, Greenwood Publishing: 474-49.

Bloom, S. L. (1995). "Creating Sanctuary in the classroom." *Journal for a Just and Caring Education*, 1.(4): 403-433.

Bloom, S. L. (1997). *Creating Sanctuary: Toward the Evolution of Sane Societies*. New York, Routledge.

Bloom, S. L. (2002). *The PVS Disaster: Poverty, Violence and Substance Abuse in the Lives of Women and Children. A Literature Review*. Philadelphia, PA, Women's Law Project.

Bloom, S. L. (2003). "The Sanctuary Model: A Trauma-Informed Systems Approach to the Residential Treatment of Children." *Residential Group Care Quarterly: Child Welfare League of America* 4(2): 1, 4-5.

Bloom, S. L. (2005). "The Sanctuary Model of Organizational Change for Children's Residential Treatment." *Therapeutic Community: The International Journal for Therapeutic and Supportive Organizations* 26(1): 65-81.

Bloom, S. L. (2006). *Organizational Stress as a Barrier to Trauma-Sensitive Change and System Transformation, White Paper for the National Technical Assistance Center for State Mental Health Planning (NTAC), National Association of State Mental Health Program Directors*. <http://www.nasmhpd.org/publications.cfm>.

Bloom, S. L. (2007). *Loss in human service organizations. Loss, Hurt and Hope: The Complex Issues of Bereavement and Trauma in Children*. A. L. Vargas and S. L. Bloom. Newcastle, UK, Cambridge Scholars Publishing: 142-206.

- Bloom, S. L. (2007). "The Sanctuary Model of Trauma-Informed Organizational Change." *The Source: The National Abandoned Infants Assistance Resource Center*. 16(1): 12-14, 16.
- Bloom, S. L., M. Bennington-Davis, et al. (2003). "Multiple opportunities for creating sanctuary." *Psychiatric Quarterly* 74(2): 173-190.
- Bonzcar, T. (2003). Prevalence of Imprisonment in the U.S. Population, 1974-2001. Washington, D.C., Department of Justice, Bureau of Justice Statistics Special Reports.
- Bremner, J.D. (2002). *Does Stress Damage the Brain?: Understanding Trauma-Related Disorders from a Neurological Perspective*. New York, Norton.
- Breslau, N., R. C. Kessler, et al. (1998). "Trauma and posttraumatic stress disorder in the community: the 1996 Detroit Area Survey of Trauma." *Archives of General Psychiatry*. 55(7): 626-32.
- CDC. (2008). "Center for Disease Control National Center for Injury Prevention and Control Web-based Injury Statistics Query and Reporting System." Retrieved October 15, January 12, 2008, from <http://www.cdc.gov/ncipc/wisqars/default.htm>.
- Chamberlain, L.B. (2009). "The Amazing Adolescent Brain: What Every Educator, Youth Serving Professional, and Healthcare Provider Needs to Know." Accessed July 10, 2009 from http://www.instituteforsafefamilies.org/the_amazing_brain_materials.php.
- Cohen, J. A., L. Berliner, et al. (2003). "Psychosocial and Pharmacological Interventions for Child Crime Victims." *Journal of Traumatic Stress* 16(2): 175-86.
- Cooper, C., D. M. Eslinger, et al. (2006). "Hospital-based violence intervention programs work. [see comment]." *Journal of Trauma-Injury Infection & Critical Care* 61(3): 534-7; discussion 537-40.
- Courtenay, W. H. (2000). "Constructions of masculinity and their influence on men's well-being: a theory of gender and health." *Social Science & Medicine* 50(10): 1385-401.
- Courtenay, W. H. and R. P. Keeling (2000). "Men, gender, and health: toward an interdisciplinary approach." *Journal of American College Health* 48(6): 243-6.
- Davis, L. (2009). *Reparable Harm: Assessing and Addressing Disparities Faced by Boys and Men of Color in California*. Santa Monica, CA, RAND Corporation.
- de Arellano, M. A., Ko S.J., Danielson, C.K. & Sprague, C.M. (2008). *Trauma-informed interventions: Clinical and research evidence and culture-specific information project*. Los Angeles, CA & Durham, NC, National Center for Child Traumatic Stress.
- Dishion, T. (1999). "When Interventions Harm: Peer Groups and Problem Behavior." *American Psychologist* 54(9).
- Eckes, A. and H. Liss Radunovich (October 2007). Trauma and Adolescents. Gainesville, University of Florida Institute of Food and Agricultural Sciences.
- Edwards, V. J., G. W. Holden, et al. (2003). "Relationship between multiple forms of childhood maltreatment and adult mental health in community respondents: results from the Adverse Childhood Experiences Study." *American Journal of Psychiatry* 160(8): 1453-1460.
- Eliot, L. (1999). *What's Going On In There?: How the Brain and Mind Develop in the First Five Years of Life*. New York, Bantam Books.
- Fein, J. A., K. R. Ginsburg, et al. (2000). "Violence prevention in the emergency department: clinician attitudes and limitations." *Archives of Pediatrics & Adolescent Medicine* 154(5): 495-8.

- Fein, J. A., N. Kassam-Adams, et al. (2002). "Persistence of posttraumatic stress in violently injured youth seen in the emergency department." *Archives of Pediatrics & Adolescent Medicine* 156(8): 836-40.
- Felitti, V., R. Anda, et al. (1998). "The relationship of adult health status to childhood abuse and household dysfunction." *American Journal of Preventive Medicine* 14(4): 245-258.
- Felitti, V. J., R. F. Anda, et al. (1998). "Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. The Adverse Childhood Experiences (ACE) Study." *Am J Prev Med* 14(4): 245-58.
- Felitti, V. J., R. F. Anda, et al. (1998). "Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. The Adverse Childhood Experiences (ACE) Study. [see comment]." *American Journal of Preventive Medicine* 14(4): 245-58.
- Finkelhor, D., R. Ormrod, et al. (2005). "The victimization of children and youth: a comprehensive, national survey.[erratum appears in *Child Maltreat*. 2005 May;10(2):207]." *Child Maltreatment* 10(1): 5-25.
- Furstenberg, F. F., & Harris, K.M. (1993). *When and Why Fathers Matter: Impacts of Father Involvement on the Children of Adolescent Mothers*. Philadelphia, Temple University Press: 117-138.
- Goodman, L. A., S. D. Rosenberg, et al. (1997). "Physical and sexual assault history in women with serious mental illness: prevalence, correlates, treatment, and future research directions." *Schizophr Bull* 23(4): 685-96.
- Herman, J. (1992). *Trauma and Recovery*. New York, Basic Books.
- Jones, C. P. (2000). "Levels of racism: a theoretic framework and a gardener's tale." *American Journal of Public Health* 90(8): 1212-5.
- Justice, U. D. o. (2005). *Prisoners in 2004*. Washington, D.C., Bureau of Justice Statistics, U.S. Department of Justice.
- Kang, J. (2005). "Trojan Horses of Race." *Harvard Law Review* 118.
- Kessler, R. C., A. Sonnega, et al. (1995). "Posttraumatic stress disorder in the National Comorbidity Survey." *Arch Gen Psychiatry* 52(12): 1048-60.
- Kidsdata.org (2008). *Teen Births: Teen Birth Rate, by Race/Ethnicity; 2003*.
- Ko, S. (July 2007). *Creating Trauma-Informed Child-Serving Systems*, National Child Traumatic Stress Network. 1.
- Lundahl, B. W., Tollefson, D., Risser, H., & Lovejoy, M.C. (2007). "A meta-analysis of father involvement in parent training." *Research on Social Work Practice* 18: 1-10.
- Margolin, G. and E. Gordis (1998). "The Effects of Family and Community Violence on Children." *Annual Review of Psychology* 51.
- Marmot, M. (2004). *The Status Syndrome: How Social Standing Affects Our Health and Longevity*. New York City, Henry Holt and Company.
- McAlister-Groves, B. (September 2002). *Identifying and Responding to Domestic Violence: Recommendations for Child and Adolescent Health*. San Francisco, Family Violence Prevention Fund.
- McEwen, B.S. and Magarinos, A.M. (1997). *Stress effects on morphology and function of the hippocampus, in Psychobiology of Posttraumatic Stress Disorder*, R. Yehuda and A.C. McFarlane, Editors. New York, New York Academy of Sciences: p. 271-284.

- McSparren, Wendy M. (2007). "Models of Change and the Impact on Organizational Culture: The Sanctuary Model® Explored" (MS thesis, Robert Morris University).
- Mejia, X. E. (2005). "Gender Matters: Working With Adult Male Survivors of Trauma." *Journal of Counseling & Development* 83(1): 29-40.
- National Association of Psychiatric Health Systems (2003). *Challenges Facing Behavioral Health Care: The Pressures on Essential Behavioral Healthcare Services*. Washington, D.C., National Association of Psychiatric Health Systems.
- National Scientific Council on the Developing Child (2007). *A Science-Based Framework for Early Childhood Policy: Using Evidence to Improve Outcomes in Learning, Behavior, and Health for Vulnerable Children*. Accessed March 23, 2009, from <http://www.developingchild.harvard.edu>.
- NCDC (2007). *The Timing and Quality of Early Experiences Combine to Shape Brain Architecture. Working Paper 5* Cambridge, The National Center for the Developing Child at Harvard University.
- Pecora, P. e. a. (2005). *The Foster Care Alumni Studies: Stories from the past to shape the future*. Seattle, Casey Family Programs.
- Peled, E., Jaffe P, Edleson J (1995). *Ending the Cycle of Violence: Community Responses to Children of Battered Women*. Thousand Oaks, Sage Publications.
- President's New Freedom Commission on Mental Health (2003). *Achieving the Promise: Transforming Mental Health Care in America*. Rockville, MD, New Freedom Commission on Mental Health.
- Randolph-Back, K. (2006). *Community Health Strategies to Better the Life Options of Boys and Young Men of Color: Policy Issues and Solutions*. Washington, D.C., Joint Center for Political and Economic Studies.
- Rich, J. A., C. M. Grey, et al. (2005). "Pathways to recurrent trauma among young Black men: traumatic stress, substance use, and the "code of the street"." *American Journal of Public Health* 95(5): 816-24.
- Rich, J. A. and L. M. Sullivan (2001). "Correlates of violent assault among young male primary care patients." *Journal of Health Care for the Poor & Underserved* 12(1): 103-12.
- Rivard, J. C., S. L. Bloom, et al. (2002). "Assessing the Implementation and Effects of a Trauma-Focused Intervention for Youths in Residential Treatment." *Psychiatric Quarterly*.
- Rivard, J. C., S. L. Bloom, et al. (2005). "Preliminary Results of A Study Examining the Implementation and Effects of a Trauma Recovery Framework for Youths in Residential Treatment." *Therapeutic Community: The International Journal for Therapeutic and Supportive Organizations* 26(1): 83-96.
- Sims, D. W., B. A. Bivins, et al. (1989). "Urban trauma: A chronic recurrent disease." *Journal of Trauma* 29(7): 940-947.
- Statistics, C. N. C. f. H. (2008). "CDC Census Bureau." Retrieved December 11, 2008, 2008, from <http://www.cdc.gov/nchs/about/major/dvs/popbridge/popbridge.htm>.
- Van der Kolk, B. (1996). *Trauma and memory. in Traumatic Stress: The Effects of Overwhelming Experience on Mind, Body and Society.*, B. Van der Kolk, A. McFarlane, and L. Weisaeth, Editors. New York, Guilford Press.
- Van der Kolk, B. (2005). "Developmental trauma disorder." *Psychiatric Annals* 35(5): 401.
- Whitley, E. (2006). "Measuring Return on Investment of Outreach by Community Health Workers." *Journal of Health Care for the Poor and Underserved* 17: 6-15.



Appendix

Bios of California-Based Trauma Experts

Frank de Jesus Acosta

Frank Acosta was born and raised in East Los Angeles. He has worked with a number of non-profit organizations in California, including the United Methodist Social Service Center, Downtown Immigrant Advocates, the Coalition for Humane Immigrants' Rights of Los Angeles, and the Center for Community Change in Washington, DC. Most recently, he served a five-year tenure as Senior Program Officer directing a California Wellness Foundation grant-making program, the Violence Prevention Initiative. He lives and works in Whittier, California.

Mr. Acosta authored the book *The History of Barrios Unidos: Healing Community Violence – Cultura Es Cura*.

Barrie Becker

Barrie Becker is the California State Director of Fight Crime-Invest in Kids. She previously served as Executive Director of Legal Community Against Violence for seven years. Ms. Becker also co-founded a small law firm where she represented clients in consumer, housing, contract and family law matters. She was the recipient of the Wallace Alexander Gerbode Foundation Nonprofit Leader Fellowship in 2001 and is a graduate of the University of California, Hastings College of the Law, and Yale University.

Marla Becker

Marla Becker has served as the Associate Director of Youth ALIVE! since 1998 and has worked for youth prevention programs in California for over fifteen years. Ms. Becker received her Master's in Public Health from UCLA and has previous work experience with the University of California Family Welfare Research Group, Stanford University Hospital, and the University of California San Diego Division of Adolescent Medicine. Her work prior to Youth ALIVE! includes the development of "Power Though Choices," a teen pregnancy prevention/HIV risk reduction curriculum for youth in foster and group care as well as the coordination of the evaluation of state-funded teen pregnancy prevention programs throughout

California. Ms. Becker's work at Youth ALIVE! focuses on program development and administration, program evaluation and technical assistance.

James Bell

James Bell is the Founder and Executive Director of the W. Haywood Burns Institute. He is a national leader in devising and implementing strategies to remedy the disproportionality of young people of color in the juvenile justice system. Mr. Bell leads the Institute's intensive work in nine local sites to reduce the overrepresentation of youth of color in their juvenile justice systems. He also guides the Community Justice Network for Youth, a national network of programs working successfully with young people of color.

Prior to founding the Burns Institute, Mr. Bell served as a Staff Attorney at the Youth Law Center in San Francisco for over 20 years, representing incarcerated youth. He is the recipient of a Kellogg National Leadership Fellowship, the Livingstone Hall Award for Outstanding Juvenile Advocacy from the American Bar Association, the Clinton White Attorney of the Year Award from the Charles Houston Bar Association, the Advocate of the Year from the Department of Justice's Office of Juvenile Justice and Delinquency Prevention, and the Moral Leadership Against Injustice Award from the Delancey Street Foundation.

Sue Burrell

Sue Burrell joined the Youth Law Center in 1987. As a staff attorney, her primary focus has been in the area of juvenile justice. She has served as counsel in civil rights litigation and appellate court cases; drafted and testified on legislation; written on a range of juvenile justice, education, mental health and funding issues; and trained juvenile justice professionals around the country. Currently, Ms. Burrell works toward increasing community services that will reduce unnecessary incarceration for youth in the juvenile justice system. She trains and consults with defenders and fights for access to legal counsel through lawsuits like *L.H. v. Schwarzenegger* that seeks to provide children with lawyers in parole hearings.

Deane Calhoun

Deane Calhoun is the founder and Executive Director of Youth ALIVE! She has been with the organization since 1991. She received her Master's in Urban Health and Planning from the University of Wisconsin. She is responsible for the overall

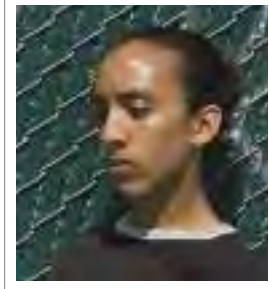
administration of the agency in collaboration with the Youth ALIVE! Board of Directors. Ms. Calhoun has had 30 years of experience leading non-profit agencies in service delivery, fund development, and successful planning efforts to provide services to young people at high risk for violence. She has extensive contacts with public health and violence prevention experts locally, statewide, and nationally. Some of Ms. Calhoun's awards and recognition include the California Peace Prize by the California Wellness Foundation, the Woman of the Year Constituency Award by California State Senate President Don Perata and a Public Affairs Residency Fellowship by The Rockefeller Foundation.

Ruben Gonzales

Ruben Gonzales currently works with the Center for the Study of Social Policy. The Center strives to help states and localities implement creative and effective strategies that strengthen disadvantaged communities and families and ensure that children grow up healthy, safe, and successful in school, and ready for productive adulthood. Previous to his tenure at the Center, Ruben served as the Executive Director of the Latino Health Collaborative whose mission it is to improve the health of Latinos and address barriers within the public and private health systems that impact those populations' access to health care in California.

Jorja Leap

Jorja Leap has been a member of the faculty of the UCLA Department of Social Welfare since 1992. She also currently teaches in the UCLA Graduate School of Education and Information Science. As a recognized expert in crisis intervention and trauma response, she has worked nationally and internationally in violent and post-war settings, focusing on issues of change, conflict, attachment and loss. Dr. Leap serves as an expert reviewer for the National Institute of Justice. In addition, she is part of a team selected by the Los Angeles City Council Ad Hoc Committee on Gangs to recommend policy and program changes in gang prevention and intervention. She also continues to work with the families of victims of the 9/11 World Trade Center disaster. Her current research and teaching focuses on gang violence and youth development, and the planning, implementation and evaluation of gang prevention and intervention programs. She is completing an evaluation of the Community in Schools Gang Intervention Project in conjunction with L.A. Bridges. Jorja Leap was born and raised in Los Angeles. She completed her BA in



Sociology, her MSW, and her PhD in Psychological Anthropology, all at UCLA. Dr. Leap currently serves as the policy advisor on gangs and youth violence for Los Angeles Mayor Antonio Villaraigosa.

Emilio Mena

Emilio Mena is the Dean of Students at LPS College Park High School, a public charter school in Oakland, CA. From 1999 to early 2009, he worked with Youth Alive!'s Caught in the Crossfire program, initially as an Intervention Specialist. In 2004, he became the Senior Intervention Specialist. In 2005, he was promoted to the position of Program Manager. Mr. Mena has worked with at-risk youth for over 15 years, as a mentor/tutor, peer counselor, intervention specialist, and now in public education. Mr. Mena grew up in Oakland and continues to live in the community that he serves.

Pastor Tony Ortiz

Pastor Tony Ortiz is the Founding Director of California Youth Outreach. He was awarded the 2004 California Peace Prize by the California Wellness Foundation. An ex-gang member and ordained minister, Pastor Ortiz has used his first-hand knowledge of gang life to minister to young men and women who have fallen prey to gangs and drugs. Over the years, Pastor Ortiz has become a nationally recognized expert in the field of gang intervention and prevention services. He has been honored for his work by the California Legislature, the California Youth Authority, and the City of San Jose.

Howard Pinderhughes

Social and behavioral scientist and author Howard Pinderhughes, PhD, is an expert in youth, racial and ethnic violence and race relations. His “participatory action” research involves observing and interviewing young people in their neighborhoods, where he can more closely examine the racial, class and gender problems that affect adolescent health and contribute to health inequality. Dr. Pinderhughes has conducted research and assisted in program development in the areas of race relations among youth and adolescent violence prevention and intervention. His research combines aspects of grounded theory, qualitative methods, survey research and participatory action research to examine problems related to the impacts of structural inequality, racial, class and gender dynamics on adolescent health and relations. Dr. Pinderhughes

earned his BA in Political Science and his MA and PhD in Sociology from University of California, Berkeley.

Cuco Rodriguez

Refugio “Cuco” Rodriguez is the IDA (Individual Development Account) Program Director for Families and Youth for the state of California, part of the U.S. Department of Health and Human Services, Administration for Children and Families.

Héctor Sánchez-Flores

For the past eleven years, Héctor Sánchez-Flores has served as a Senior Research Associate at the Bixby Center for Global Reproductive Health at the Philip R. Lee Institute for Health Policy Studies. Prior to this position, he worked in community-based programs that included teen and young adult men as part of the solution to prevent teen pregnancy and community violence. Through these efforts he has come to recognize that young men have many unmet needs that intersect with education, mental and sexual health, juvenile justice and community violence. He has come to understand that the services designed to assist young men are often one-dimensional and miss critical opportunities to connect them to needed services. Mr. Sánchez-Flores believes that efforts to promote community-wide health must also include programs designed to reach and serve the young men that reside in those communities. He serves on national boards and advisory committees that address teen pregnancy prevention and male involvement, advises policy analysts and legislative leaders on community-based solutions to teen pregnancy, and the importance of including young men in prevention efforts and sexual health education.

Jerry Tello

Jerry Tello comes from a family of Mexican, Texan roots and was raised in south central Los Angeles. He is co-founder of the National Compadres Network and the Director of the National Latino Fatherhood and Family Institute. He is an internationally recognized expert in the areas of family strengthening, community mobilization and culturally-based violence prevention/intervention efforts. He has extensive experience in the treatment of victims and perpetrators of abuse and in addictive behaviors, with a specialization in working with multi-ethnic populations. Mr. Tello is the author of various curricula including a male “Rites of Passage” curriculum, a Young Fatherhood Curriculum, a Bilingual Family Strengthening



curriculum, and a bilingual Fatherhood Literacy Curriculum. He served as a principal consultant for Scholastic Books on an International bilingual literacy curriculum. In addition, Mr. Tello has authored a series of children's books and is the co-editor of *Family Violence and Men of Color* (Springer Publishing Co., 1998).

Bobby Verdugo

Bobby Verdugo is the coordinator of *El Joven Nobel*, a campaign aimed at young men in the East L.A. area to teach positive male behavior, prevent unintended pregnancies and stop the spread of sexually transmitted diseases. He also works with Bienvenidos Family Services and the National Latino Fatherhood and Family Institute. The three groups are an integrated effort of nationally recognized leaders in the fields of Latino health, education, social services and community mobilization. Verdugo was part of the East L.A. High School walkouts of 1968. He has been featured in both a documentary on the incidents and the recent HBO movie, "Walkout" for his involvement in the Latino civil rights movement.



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