



'Ain't nobody gonna come back because you didn't do nothin' while I was there': Making your Organization Responsive to Boys and Young Men of Color

The goal of this action brief is to help practitioners and policymakers – particularly those affiliated with organizations that interact with boys and young men of color (BMoC) such as hospitals, clinics, schools, courts and nonprofit service providers – to understand how BMoC who have experienced violence and trauma perceive their treatment and services provided. Our hope is that this brief will lead organizations and institutions to commit to addressing trauma in BMoC, to tailor their approaches to better care for the needs of BMoC, and to change the policies that lead to BMoC mistrust and avoidance of care providers.

The insights in this action brief are drawn from four focus groups conducted by Youth ALIVE! in Oakland, California, with young (18 to 30 years old) African-American and Latino men who were gunshot survivors. These conversations took place between August 2013 and April 2014. We analyzed these young men's words and stories to identify common themes related to their traumatic experiences. Their stories helped us to understand their lived experiences of trauma and their interactions with health care and human services organizations. Given their shared experience of medical care after gun violence, much of the conversation revolved around treatment in medical settings. However, we believe that many of these lessons can be extrapolated to other providers and settings, to answer the question:

HOW DO YOU EFFECTIVELY SERVE BMOCC?

Our qualitative focus groups with BMoC who survived violent injury revealed several themes. These young men were able to articulate what constitutes *effective* versus *ineffective* care, especially in emergency and primary care settings. Our focus groups analyses revealed key lessons about providing effective care: it's personal, attentive, caring, timely, honest and informative.

Personal Care

A key theme that emerged was the idea of *personal care*, highlighting how important it is for the provider to care for and treat the young man as an individual. One participant talked about how the provider's attitude and demeanor affected his receptiveness to care:

"Whenever I've been in [the hospital], I could tell which doctor was cool and which one wasn't. You can basically tell how they act, 'cause you gonna act the same way. They actin' messed up, you gonna be messed up. They cool, you cool."

He contrasted this to an experience where he did not receive *personal care*, where providers pay more attention to "paperwork" than to the patient sitting before them:

"They just write stuff on the paper. [They say] 'This what was wrong with you last time. This what's wrong with you this time. This is getting better. Okay.' Bam. 'Two week check-up, see how you're doin'. Come back.' And that's it. Ain't nobody gonna come back because you didn't do nothin' while I was there."

Another young man shared a similar frustration with how impersonal and paperwork-driven his care was:

"They goin' by just what's on this paper. A year ago this was on this paper. Thirty months ago this was on this paper. Three days ago this was on this paper. When you was born this was on this paper. This is your mama paper. This one's goin' back to you. How I suppose to know what's wrong with me if you dependin' on paper? Y'all know nothin'. You just know what's on that paper."

Not only was it problematic for these young men when provider attention was focused on the paperwork rather than asking the person directly about his current condition, but there was also some skepticism and mistrust of paperwork itself, particularly when the contents of the paperwork were not shown or shared directly with the young men. When the paperwork was hidden, the default assumption seemed to be that the paperwork was inaccurate or at least only provided partial information about the real, live individual in the room. This leads to the next theme.

Attentive Care

The idea of *attentive care* is closely related to the concept of *personal care* but is specifically related to how the young person is acknowledged in the encounter and how their needs are prioritized. One young man described *attentive care* at a local hospital:

"Soon as you walk in they got your attention. They start treating you. 'What's wrong with you?'"

This young man points out that the provider immediately acknowledged him and focused on asking him what was wrong rather than depending on the chart.

“ The experience of care seems as important as the outcome of the care. ”

Another young man described an experience which lacked *attentive care*, which in this case related to the lack of a physical examination, which for these young men, constitutes a form of acknowledgement.

"One time my cousin, he was in [the clinic]. He was there 'cause he said his breathin' was bad or somethin'. He got somethin' on his chest or somethin'. So he went up in there or he went to the doctor or whatever. I realized that they didn't even listen to his chest or try to see what was wrong with his breathin'. They just said, 'This is what's wrong with you.'"

Notice that in the case of attentive care the young man was asked what was wrong, while in the encounter which lacked attentive care, the provider *told* the patient what was wrong, even without physically examining him. This highlights the perspective that acknowledging the patient rather than making assumptions is a key aspect of attentive care.

Moderator: *What would encourage you to go to a clinic for help when you were sick or injured?*

Male 1: *They give you more of what you want when you go in there.*

Moderator: *Like what? What are some of those things that you would want?*

Male 1: *Help or whatever. Somethin'.*

Male 2: *TLC.*

Male 1: *I don't know. When you go in there, man, just to get some attention.*

This brief conversation between two young men highlights the fact that these young men are not focused only on medication or treatment, as is often assumed by medical providers, but rather on “help” and “attention.” For them, the experience of care seems as important as the outcome of the care.



Photo courtesy of Jason Mongue/Youth ALIVE!

“ In the case of attentive care the young man was asked what was wrong, while in the encounter which lacked attentive care, the provider told the patient what was wrong. ”

Displays of Caring

The lack of acknowledgement was expressed in the desire for attentive care. The young men we spoke with felt like they were not shown care and sympathy, or “TLC”. They were able to contrast this with the way that they were treated as children. Young black and brown men negotiate a world where they face discrimination based on their race. In addition, society’s attitude about masculinity causes providers and young men themselves to lack empathy for the suffering of males. In addition to their race and gender, young men of color also face a bias due to their age, as the traumas experienced by children are treated with more caring than that of adults.

The young men we spoke to elaborated on how treatment differed between the local children’s clinics and the adult clinics. A clear theme was that the experience at the pediatric setting was more caring and at the adult hospital, more callous.

One young man described what he called “little big boy” care at the children’s site:

*“[They treat you] extra good. Like a kid or somethin'. Take care of me. They pay more attention to you. They give you warm food. They give you real food. Pizza, pie and all that good s**t. They care about the little big boy.”*

By contrast in the adult site:

*“They give you that nasty a** food. Expired, all that s**t. It's like at [the adult site] if you don't have a life-threatening thing they don't give a f**k about you.”*

Simple things can convey caring, such as good food, or how colorful and inviting the atmosphere looks.

Another simple way to show care is to respect the BMoC point of view and give BMoC the benefit of the doubt when they say what is wrong with them. Unfortunately,

many providers treat BMoC with suspicion rather than caring. A common complaint among the young men in the focus groups was that their pain was not taken seriously by providers, that providers treated them like they were exaggerating or inventing their pain in order to get medication.

“You done got shot with a thirty-round and they give you a pack of Motrin. That's crazy.”

This young man voices a familiar concern that the treatment does not seem to match the severity of the injury. While it is impossible to judge whether this treatment may have been appropriate to his injury, it is clear that he felt a disconnect or a sense that his pain was being disregarded.

Timely Care

Among focus group participants, *timeliness* was closely related to a sense of caring. One young man described what he considered to be a timely encounter, even though he was at the hospital for four hours:

“Four hours, and they did all the check-up and I was out of there.”

By contrast, one young man described what he called “county care” where a public hospital functions with the same inefficiency as other government agencies that he has encountered:

“Everything within the county takes so long. It's like if you goin' to the General Assistance office to get your ID or somethin' like that, that take long. Or the DMV. For some reason the DMV, the jail, the General Assistance office, the hospital, all run by the county, but they all resemble the same kinda' like not give a care-ency. Ya' feel me?”

These young men were clear that timely care was not about the brevity of the encounter. Rather, timely care was characterized by using their time productively, which in turn communicated that their well-being was important and their time had value. Using one’s time productively is one important way to show respect. If care is not timely, BMoC may leave the provider untreated or unserved. Worse, BMoC may never even bother to seek care at all.

*“Yeah, because you go and wait like five hours, three hours, and they don't even do s**t to you. I could do that at home by myself.”*

“ An honest 'no' with an explanation why is better than a hopeful but ultimately broken promise of 'yes'. ”

Integrity of Care

Availability of, and honesty with, information was another theme from the focus groups. For example, a young man who received care for his gunshot wound at a local hospital was not informed that it was a teaching hospital, and so did not understand why multiple doctors were in the room and why some were silent and others were asked questions. Without other information, he suspected that the doctors did not know what they were doing, or did not care enough to offer better care to him.

The young men we spoke with expressed a preference for service providers to explain everything that you are doing (or not doing) as you do it, and show or, better yet, share copies of all paperwork you use when you meet with BMoC. This builds on the previously discussed ideas about why paperwork should be minimized when interacting with a BMoC. Not only is it less personal than human interaction, it is also usually not shared with the client being served.

A number of young men in one focus group referenced their reasons for their trust in a particular community based staff member from Youth ALIVE! that had to do with his transparency:

"Cause he cool. You ain't gotta be nobody different, man. You just be yourself. No matter if you bad, good, sick, green, purple, ugly, man. If you know how to talk, he understandin'. He gonna talk to you. If not, he's just gonna be like, 'I can't help you.' Or he gonna tell you why he can't help you. He ain't speakin' down to you. He just said, 'Well we can't do it because of this reason'".

The young men we spoke to emphasized being real and straightforward about what you can and cannot, will and will not, do. Although it is not the word they used, this is what is often called "integrity," and experiences of integrity build trust. For an understandably mistrustful population, an honest "no" with an explanation why is better than a hopeful but ultimately broken promise of "yes."

HOW DO YOU BUILD TRUST WITH BMOC?

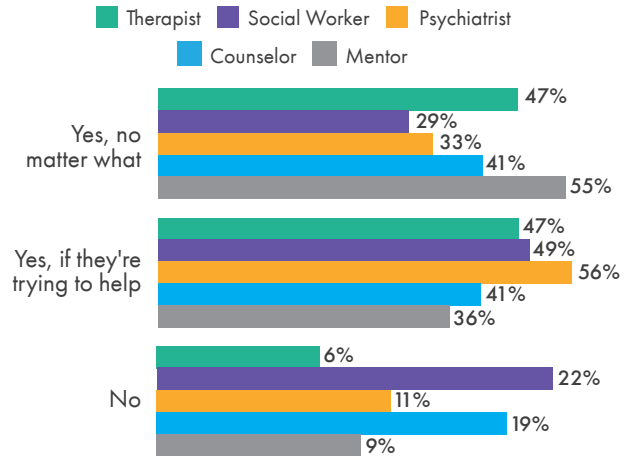
After the focus groups, we conducted 69 interviews with young men from the Oakland area (between 18 and 30 years old) who were African-American and/or Latino. We did not have any prior knowledge about their specific histories of adversity or trauma. Instead, we assumed that they were likely to have had traumatic or stressful experiences, and proceeded to ask them questions about how they coped with that trauma and stress.

Our research also revealed how critical the notion of trust is for BMoC in health care and other settings. Trust for these young men is closely linked not only to their past treatment in these systems, but also to the larger context in which trust has also been historically broken within their communities.

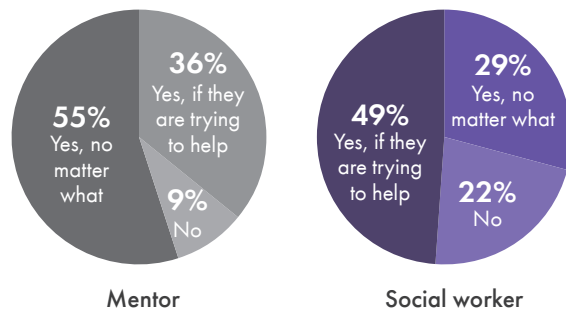
Pay attention to how you identify yourself

We interviewed BMoC about their comfort sharing information with various types of helping professionals:

Would you answer these questions (about your trauma symptoms) if a ___ asked?



The charts below display their results specifically for "mentors" versus "social workers":



The young men in our focus groups provided context for this broader community mistrust of “social workers”:

"Somebody told me that your social worker is lyin'. Several people have told you that your social worker's lyin'. A dozen people started tellin' you that your social worker's lyin' to you. So you startin' to think like more people tell you that the social worker's lyin' or might lead you to a wrong way or lead you astray or somethin' like that."

By contrast, we asked the young men we interviewed about “mentors” as this was a term that came up in the focus groups as people who could be trusted. “Mentors” were viewed as people who show consistency, straightforwardness and integrity, which the young men defined as doing what they say they will do.

Consider sharing something about yourself

Being face-to-face, while important, does not equate to success. Being present is important and so is being open. We learned from the BMoC we interviewed to not simply refer to paperwork, but to look at and engage with the person in front of you. Engage in dialogue, not monologue.

It is often the default training for providers to simply ask questions and never answer questions that are not directly related to treatment or services, not to offer up anything personal about themselves. Ken Hardy (see resources in box, at right) has suggested that self-disclosure can be a powerful tool in a longer term therapeutic relationship, especially with people of color, but that many providers trained as “white therapists” are not taught its value. In other words, with a population as mistreated by, and mistrustful of, authority as BMoC, there is a “give/get” principle. Consider some limited, appropriate self-disclosure when it is in the best interest of the client, to establish trust and create a more level playing ground that shares power and agency between provider and client. Make sure that is timely and relevant to the conversation at hand. Do not force self-disclosure, instead be in the moment with the client and let it develop naturally. There is, of course, a delicate balance between oversharing or even hijacking the interaction with your own thoughts and stories and demonstrating genuine care, but it is a worthwhile one to learn to navigate.

“ Self-disclosure can help to reduce the power differential between providers and BMoC. ”

Because BMoC experience interrogation from institutions and individuals that purport to serve them, self-disclosure can help to reduce the power differential between providers and BMoC. Used correctly, disclosure can be a tool to enhance connection, build trust, lessen the inherent hierarchical or patriarchal dynamic in white cultural norms of therapeutic relationships, and help BMoC feel more understood rather than observed and judged. Keys to effective self-disclosure include: using it judiciously, keeping it brief, and limiting details to what is helpful to the person you are working with.

Some resources on provider self-disclosure and working with BMoC

- Watts-Jones, Thandiwe Dee. “Location of Self: Opening the Door to Dialogue on Intersectionality in the Therapy Process.” *Family Process*, vol. 49, no. 3, 2010, pp. 405–420.
- Hardy, Kenneth V., and Toby Bobes. *Culturally Sensitive Supervision and Training: Diverse Perspectives and Practical Applications*. Routledge, 2016. – See especially Chapter 4 “Naming It and Claiming It”
- The Ethics of Therapist Self Disclosure with Kenneth Hardy* | Psychotherapy Networker. <https://www2.psychotherapy-networker.org/home/2013/12/the-ethics-of-therapist-self-disclosure-with-kenneth-hardy/>.
- Pinderhughes, Elaine. *Understanding Race, Ethnicity and Power: The Key to Efficacy on Clinical Practice*. 1 edition, Free Press, 1989.
- Gibson, Margaret F. “Opening Up: Therapist Self-Disclosure in Theory, Research, and Practice.” *Clinical Social Work Journal*, vol. 40, no. 3, pp. 287–96.
- Lamb, Erica. “The Art of Self-Disclosure.” *Field Educator*, vol. 3, no. 1, 2013.

This give/get principle is true no matter who you are. Of course, hiring men of color as staff is one important strategy in creating programs that are both welcoming and responsive to BMoC. But they are not the only people who can connect successfully with BMoC. The key is to be authentic.

Be transparent about what you are doing and why

There is often an assumption among white and/or female staff at organizations that serve BMoC that they have nothing to personally add or share in a dialogue with BMoC. However, we asked explicitly in our focus groups

about race and gender of service providers, and were told that while that was important, the most important factor in building trust with BMoC is not what you look like ("bad, good, sick, green, purple, ugly"), but how you act. We were told that what mattered most is if they believe "that you are trying to help."

When we conducted surveys, we asked the young men of color who they would share personal information with,

and while less than half would share information with a therapist, social worker, psychiatrist or counselor who was a blank slate, upwards of 78% to 94% stated that they would answer personal questions if they believed that the provider was trying to help. The key, then, is to demonstrate that intention. This can be accomplished, in part, by simply stating that you want to help and then explaining what you are doing and why you believe it will help.

FOUR THINGS YOU CAN DO TO MAKE YOUR ORGANIZATION MORE RESPONSIVE TO BMO C

1. Examine how your organization provides service to BMoC and ask...

- Do you make services personal?
- Are your staff attentive?
- Do you display as much caring for a young man as you would for a child?
- How are you valuing the time of the BMoC you are serving?
- Do you accept and believe the problems and complaints of BMoC at face value or question their veracity and motive?
- Are you providing information and explanation about what you are doing as you do it?
- And are you doing so honestly and with integrity?

2. Develop trust intentionally at your organization by...

- Hiring and training trusted staff who are familiar with the communities in which these young people live.
- Even if the staff you hire are not BMoC, training them to be open, authentic and transparent in their interactions with BMoC.
- Paying attention to what your staff people call themselves. It is also important that providers realize that certain professions – social workers, in particular – often hold a negative connotation among BMoC, potentially because social workers are associated with child protection agencies. Understanding this reality should help providers to clearly communicate their helping roles, rather than simply their titles or disciplines.
- Prioritizing caring face-to-face interaction that acknowledges the individual, rather than depending on records or "paperwork", which often fuels mistrust and poor communication.
- When possible, providing private and peaceful settings for interactions. Crowded, loud spaces can exacerbate trauma symptoms and may not be safe for BMoC negotiating their safety.
- Practicing skilled, appropriate self-disclosure.
- Providing clear explanation both during and after the encounter and provide written information to take home, recognizing that trauma can disrupt attention and memory.
- Not assuming literacy. Read information on paperwork aloud and answer questions as you go. Provide culturally responsive translation services.
- Assuming that complaints of pain are real and worthy of treatment, whether with medications or other effective modalities. BMoC express that they are often stigmatized as "drug seeking" when seeking care for physical or emotional pain.
- Recognizing the importance of visual and verbal tone. BMoC express that providers treat them in uncaring and insensitive ways as adults, in contrast to how they were treated when they were in pediatric settings. Recall that many are still youth/young people and may need TLC.
- Explicitly stating that you are trying to help, and explaining why what you are offering will help. Also, explicitly informing the patient that you have previously worked with other young people in their situation may put the person a little more at ease.

3. If you are a health care provider, consider implementing these strategies to reach and address trauma in BMoC.

Hospital-based Violence Intervention Programs -

These programs meet victims where they are in the hours following their injuries. Programs provide services ranging from brief trauma intervention, safety assessment, intensive case management, navigation, referral to psychological treatment, trauma informed group therapy and peer support. These programs, which coalesce in the National Network of Hospital-based Violence Interventions (NNHVIP), have tremendous potential to meet the acute trauma related needs of young victims. More information and resources are available at NNHVIP.org

Medicaid Enrollment - With the expansion of Medicaid under the Affordable Care Act, many young people between the ages of 18 and 35 who were previously uninsured now have access to insurance coverage (at least for the time being). With insurance coverage comes

the potential to access both physical and mental health services. A challenge, reinforced by the focus groups and interviews we conducted, is the lack of cultural competency among healthcare providers in dealing both with trauma and with the needs of young people of color.

Linkage to Primary Care - A key strategy for addressing the physical and mental health needs of young people of color is to connect them to primary care. Hospital-based Violence Intervention Programs often prioritize linking clients to primary care, historically by using free care providers. With expanded insurance access now comes greater potential to refer clients to care. Training will be an important step as well since lack of awareness of trauma, and lack of cultural competency among primary care providers.

4. Develop tailored approaches to addressing trauma in BMoC.

BMoC value providers who acknowledge them as individuals, are attentive to their needs and provide timely care. Timely care need not be brief, but should engage them productively in their care. These principles were central to our development of the Screening and Tool for Awareness and Relief of Trauma (START), a brief trauma-informed intervention. START engages BMoC in identifying which aspects of trauma are most bothersome to them and tailors healing approaches to their symptoms.

The intervention tool is designed to be delivered in familiar community settings by trusted staff, outreach workers or peers. START can be delivered in 20-30 minutes in a highly interactive discussion, satisfying the desire among these young men that their time be used productively. The third brief in this series describes START in detail and provides a roadmap for organizations to incorporate it into their work with BMoC.

“ Prioritize caring face-to-face interaction that acknowledges the individual, rather than depending on records or paperwork. ”



Photo courtesy of Jason Mongue/Youth ALIVE!

ABOUT THE *HEALING IN COLOR* ACTION BRIEF SERIES:

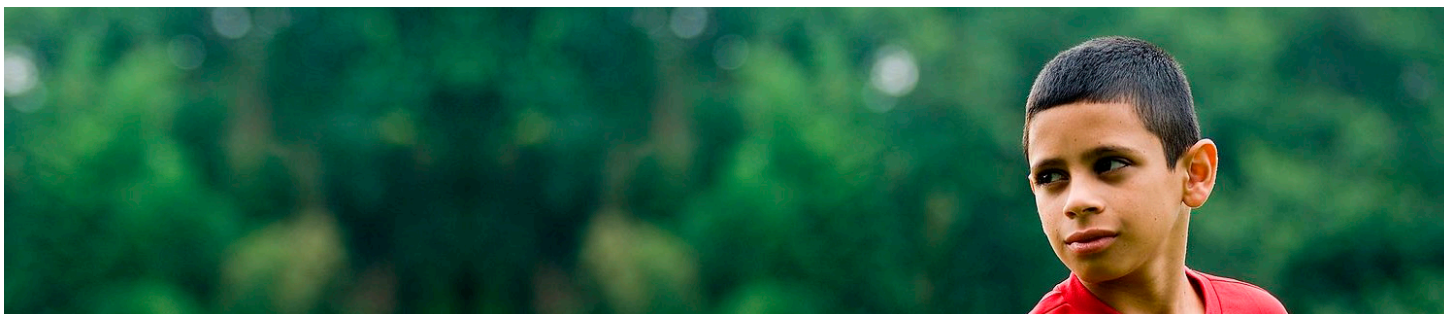
This is the second in a series of action briefs commissioned and funded by The California Endowment in partnership with Youth ALIVE! and the Center for Nonviolence and Social Justice at Drexel University entitled Developing Health Care Standards of Practice for Boys and Men of Color (BMoC) Exposed to Violence. Under this initiative, researchers from Youth ALIVE! and UCSF conducted 4 focus groups with male survivors of gunshot wounds and 69 individual interviews with young men of color from the local area, and analyzed their words to understand their lived experience of trauma and their interactions with health care, education, criminal justice and human services organizations.

Regarding these young men as experts in their own lives and their communities, we have summarized their wisdom and insights, and proposed approaches that will help systems that touch the lives of these young men to deliver more human and more effective care and intervention for trauma and its manifestations.

The first action brief, *"There is No 'Post': How Trauma and Violence Affect the Lives of Young Males of Color,"* addresses the sustained and persistent nature of the trauma that BMoC face. The second action brief, *"Ain't nobody gonna come back because you didn't do nothin' while I was there': Making your Organization Responsive to BMoC,"* addresses how BMoC who have experienced violence and trauma perceive their treatment and care from organizations and institutions, and what they would like to see. The third action brief *"Screening & Tool for Awareness & Relief of Trauma (START): A practical application of Trauma-Informed Care,"* describes an intervention tool developed through this initiative to not only screen for but to address the often hidden trauma that BMoC face. It is our hope that taken together, these three action briefs will provide a roadmap for BMoC-serving individuals and organizations to understand and intervene effectively to heal the wounds trauma.



Dedicated to the memory of Maceo Bell, Jr. (1993-2014), whose tragic death cannot overshadow his vibrant life. His words and wisdom live on in this work.



Thank you for reading!

For more information: youthalive.org | drexel.edu/cnvsj | START2Heal.org

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