YouthALIVE!

Developing Trauma Informed Practices for Young People Caught in the Crossfire

innovation

This project was funded by the Innovation Grants Program through the Prop 63 Mental Health Services Act

MENTAL HEALTH SERVICES ACT · PROPOSITION 63 · CALIFORNIA

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Our Story

Transitional aged African American youth are often overlooked as victims - their behavior interpreted as angry, or threatening, or a lack of emotion, even in the wake of great trauma. Those symptoms, looked at with a racial lens, are often not seen as symptoms of trauma at all.

While people see and tend to physical wounds, emotional and mental ones are more complex to identify and to address. Yet, without addressing emotional and mental wounds, people are vulnerable to further trauma, and symptoms of trauma can make it difficult to engage fully with the world.

Youth ALIVE's project pulled from the experiences of African American youth and their interactions with medical and other social services, to create best practices. Trust, respect, communication, and safety are all at the core of what was missing in unsuccessful interactions with doctors, social workers, and others who were meant to help.

This project illuminates the need for Trauma Informed Care/Practice (TIC/P) and the need to be mindful of racial lenses in the application of TIC. This set of tools is intended to help providers learn the symptoms of trauma and how to provide TIC/P, and a way to factor race into potential interactions.

Sincerely,
Linnea Ashley, MPH

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Course Title: **COLORBLIND CARE: Trauma Informed Care and African Americans**	Total Length of Time: 6 hours
Course Purpose: Teach an age-based culturally-informed provider training course on trauma informed care for the BHCS African American clients/consumers.	
Learning Objectives: 1: Define trauma informed care 2: identify trauma symptoms 3: identify reasons trauma symptoms in AA males might be perceived differently than in other populations 4: analyze the requirements for establishing productive relationships with AA 5: define a warm hand off and its necessary components	
Key Concepts to be Taught: Trauma Informed Care, Cultural competence/literacy	
Target Audience: Direct service providers of African Americans or anyone who comes in routine contact with African American clients	

TRAINING OUTLINE

Module/Section & estimated length of time	*Specific Content- Focus Area (provide detailed content information in a training manual*	*Relate To Objectives*	*Methodology*
Module 1/Section 1 (3.5 hours)	An introduction to Trauma Informed Care in an African American specific context	1,2,3	Lecture, group discussion, DVD
Module 1/Section 2 (2.5 hours)	Steps to establishing a healthy relationship with African American clients and best practices for extending that relationship to other service providers	4,5	Lecture, group discussion, role play

Identifying Trauma Symptoms in African Americans

1. Explain to participants: Trauma and adversity are common and may have impacted any of us. The information we are going to discuss may be upsetting for some and self-care is essential. If at any time people are uncomfortable or need a moment to themselves, please feel free to step out of the room and do so. Remember deep breathing is often helpful.

Module 1 Section 1:

1. Explain to participants: Today's training is on identifying trauma symptoms in African Americans (with an emphasis on males) and building better working relationships with African American clients.
2. Ask participant: Describe attributes of a difficult client.
   (write down the descriptions but when the exercise is over do not leave that list visible as it will be used in a later activity and it might impact that activity if still visible.)
3. Ask participants: What is trauma informed care?
   Answers may include:
   a. An approach to treatment goes beyond just treating the physical wound that can result from a traumatic event such as a shooting but considers the mind and

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emotions as well. It recognizes people have often experienced or been exposed to other traumas in life and possibly have trauma symptoms.

b. Understanding trauma as a root cause of behaviors

4. Lecture: Trauma Informed Care is an approach to treatment goes beyond just treating the physical wound that can result from a traumatic event such as a shooting but considers the mind and emotions as well. It recognizes people have often experienced or been exposed to other traumas in life and possibly have trauma symptoms. In other words, understanding that trauma, past and present, can be a root cause of behavior.

   The idea around TIC is that you may not know who has experienced trauma and so we should treat everyone in the same caring way that assumes that they have.

   Discuss:

   - the difference between the amygdala and the prefrontal cortex
   - the impacts stress has on the physical body
   - types of stress

Introduce trauma symptoms:

a. Hyperarousal (insomnia or difficulty staying asleep, outbursts of rage or anger, difficulty concentrating, feeling jumpy and easily startled)
b. Avoidance/numbing (Avoiding activities, places, thoughts, or feelings that remind someone of the trauma, loss of memory about parts of the trauma, loss of interest in activities, feeling detached or removed from others and emotionally numb, feeling of foreshortened future/expectation of not living long or experiencing aspects of life such as marriage or career, flat affect)
b. Re-experiencing (upsetting memories of the event, flashbacks, nightmares of the event, feelings of distress when reminded of the trauma, pounding heart, rapid breathing, nausea, muscle tension, sweating)

PTSD isn't everything. Explain other issues associated with trauma.

5. Activity 1: Having just talked about the three types of symptoms, please break into small groups and write down specific symptoms of trauma.
6. Brainstorm: What do those trauma symptoms look like? Ask people to act out or describe in detail what they look like.
   (write down all answers on the board/flip chart, be sure to include "flat affect"/ "lack of care" and angry to the list)
   Pull out the first list of "difficult clients" and circle any overlap of descriptions. If there is overlap begin a conversation about what that might mean:
   a. Misinterpretation
   b. Jumping to conclusions about a client

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c. Lost opportunity to learn more about the client or establish trust/understanding
If no overlap draw some connections between how some other people may see trauma symptoms as "difficult client" behavior and implications for that thinking (see previous points a,b, and c)

7. Tell participants: We are now going to add a race lens to this discussion. This is not designed to call anyone a racist, it is intended to recognize how cultural difference and preconceived ideas can exacerbate the already normalized tendency to view trauma symptoms as behavior problems.
8. Activity 2: Group discussion. Be sure to include ideas about "threat" and "threatening behavior" and the subjectivity of how that is perceived, ideas about dress (hoodies or sagging pants) and size.
9. Activity 3: Case study videos. Questions: clip 1- Is Flamo like the young people you work with? What trauma(s) has Flamo experienced? What trauma- or stress-related behaviors does Flamo exhibit? Clip 2 - What trauma-informed practices did Cobe use with Flamo? Why were they effective? What else could be/should be done? Clip 3: What reason does Flamo give for Cobe's help being effective?
10. Review: Review the definition of trauma informed care, the symptoms, and things to consider when working with African American male clients.

Module 1 Section 2:

1. Remind participants that they will be discussing establishing relationships with potential.
2. Ask participants: What makes a good relationship in general? (write down responses)
3. Ask participants: Is there anything that isn't included here that makes for a good client relationship? (write down anything they missed, cross out anything they think does not apply) Make sure trust is on the list, if it is not, offer it as a suggestion and add it to the list.
4. Ask participants: what are some reasons African American clients may not trust providers? Once the list is generated, ask the group what things they can "control" or impact – circle those. If not listed, talk about stigma around mental health care in the African American community. Discuss the importance of names: counseling vs therapist/psychologist/mental health services – the need to find language that isn't off-putting to clients.
5. Activity 4: Small group/big group exercise.
6. Discuss with participants: Just as the presence of police do not universally bring relief to some groups, the same can be true for mental health professionals or other degreed/jargon heavy positions. Direct service personnel and paraprofessionals with solidly established relationships that we described earlier can leverage their relationship to others.
    a. they can act as detective, translator

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i. detectives because they spend extended amounts of time with clients and are able to reference things they see and say in relation to trauma symptoms
ii. translators because they are knowledgeable about their clients and where they come from and are able to decipher and share language and their understanding of behavior so that everyone has a proper context.

7. Ask participants: what is a third benefit of a strong relationship.(list their answers, if they don't offer it, include "bridge").
8. Activity 5: Role play. Introduce the last role play.
9. Ask participants: how might a strong existing relationship be extended and to whom? (list what they say)
10. Introduce the "warm handoff". Ask what they think it means. Define the warm handoff: Instead of passing on a name and phone number "case managers" extend their relationship with their client to help establish a foundation for a TRUSTED third party
11. Explain the warm hand off:
    a. Barriers to further client services is willingness of clients. One way we have been successful in increasing the number of African Americans willing to see- in our case, a therapist, but potentially other services- is through the "warm handoff".
    b. Discuss the usual method of referrals vs. a warm handoff - Clients who have had interactions with public systems (schools, medical, and/or criminal justice) that often do not engage in trauma informed practice, in addition to suffering symptoms of trauma , and successful uptake of mental health services is not a given.
    c. Only possible if: 1) the case managers/referring party has an established trusting relationship with clients 2) case managers/referring party know who they are referring to and that person's approach, and trust her to provide services to their clients that are culturally appropriate and trauma informed.
    d. The actual handoff: Before any formal sessions are scheduled between the referred person and the client an informal meeting is held that also includes the case manager. This meeting is intended to introduce the new provider as a trusted person and safe space.
12. Explain: Another important thing to remember when thinking about client relationships is the case manager/staff member. Keep in mind:
    a. Because everyone has experienced trauma/adversity be aware of staff triggers
    b. Consider staff areas of expertise (not simply matching of language, gender, or race)
    c. Think about styles (lecture, stern, former victim/perpetrator)
    d. An ability to blend/fit into different areas
    e. Be aware that some interactions may act as modeling for healthy relationships
    f. More education isn't always better

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13. Explain: Introduce "dos" and "don'ts" for African American families. Discuss potential differences in communication styles (volume, intonation, animation) – be sure to stress potential and explain the importance of observation and learning a client as an individual.
14. Review examples of good relationship traits, definition of warm hand off, and benefits of using that method.

Methodology

Module 1 (Lecture, Video, Group discussion, Case Study, and Role Play)

Activities Details Module 1

1) *Post it Notes:* Break into groups of 3-5 people and have them discuss and write down symptoms of trauma. After 5 minutes have the groups report back. Write Hyperarousal, Avoidance, and Re-experiencing on post it notes on three different parts of a wall and have the groups place their post it's in the appropriate place. Go through the list, discussing and correcting any that are listed wrong.(20 minutes)
2) *Group discussion (possibly small group discussion depending on the size of the training):* It is necessary to make sure participants are familiar with trauma symptoms in general so that they can home in on how they might look different – or be judged differently on African American males. This discussion has potential to be uncomfortable because it will focus attention onto some preconceived notions some people may have about African American males and their behavior. The discussion is not meant to be accusatory, rather, revelatory, so that participants can help themselves and others identify behavior that is not trauma informed and culturally appropriate. (15 -20 minutes)
3) *Case study:* Discussing what trauma symptoms look like for African American males is helpful; however, seeing them and hearing them speak about their experiences is far more beneficial. We will watch video clips of several different young men who have experienced trauma and compare they behavior (shown and described) to what we have learned about trauma symptoms. (20 – 30 minutes)
4) *Small group/big group:* Relationships are constantly growing and changing, it is no different with clients. Break the group up into four to six smaller groups. Half should brainstorm things they believe will strengthen a relationship with a client and half should brainstorm things that would weaken it. Periodically the facilitator will provide extra information that may impact decisions such as: the family is vocally upset at the hospital or a meeting in the office, or the client "looks disinterested". The groups will come back together and share and discuss their reasoning as part of a larger discussion. (30 minutes)
5) *Role play:* First impressions can dictate the direction relationships take. For this role play a scene will be set (hospital with upset family and friends, office for first time meeting) participants will act out/describe their work role, the questions they would ask, and their demeanor towards a client under the varying conditions. Participants will discuss what was done, why it was appropriate or provide suggestions for improvement. Depending on

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how familiar participants are with both trauma informed care and culturally appeopriate behavior the role play may be done again with the chance for improvements to be made.(30 minutes)

Resources

Reading lists

Wrong Place, Wrong Time: Trauma and Violence in the Lives of Young Black Men

Online resources

- What is Trauma? from The Center for Nonviolence and Social Justice
- Transforming Violence Intervention in Health Care through Trauma-Informed Practice webinars (National Network to End Disparities)
- Safety, Emotions, Loss and Future (S.E.L.F.) curriculum

Services within the community

Youth ALIVE! violence prevention and intervention non-profit: www.youthalive.org; 510.594.2588

Materials and Equipment

- Flipchart or writing board
- Post it notes
- Markers
- Laptop computer
- Projector
- Speakers

Pre-Training Preparations

This training is hinged on the type of interaction an office expects to have with clients and should be tailored accordingly; however, trust and respect are imperative regardless of the anticipated length and frequency of interaction.

Contact Information

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Other Items

PowerPoint to accompany this training

Literature review

Other: Final report raw data of the CIC Intervention Specialists' assessments of clients vs. our mental health clinician

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COLORBLIND CARE: Trauma Informed Care and African Americans

Training developed by: Youth ALIVE! (Oakland, CA) and The Center for Nonviolence and Social Justice, Drexel University (Philadelphia, PA)

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KEEPING YOURSELF SAFE

- Many of us have suffered trauma or adversity, either directly or indirectly
- Some of the content here might make you anxious or remind you of past traumas or losses
- If that happens, think for a moment about what action you could take

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Module 1: TIC

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UNIVERSAL PRECAUTIONS

Universal precautions are techniques that assume everyone in an environment is at risk for spreading an infection and therefore risk should be minimized whenever possible.

WHAT EVERYONE NEEDS TO KNOW ABOUT TRAUMA

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THE ANATOMY OF ANXIETY

TIME Diagram by Joe Lertola.
Text by Alice Park

WHAT TRIGGERS IT . . .

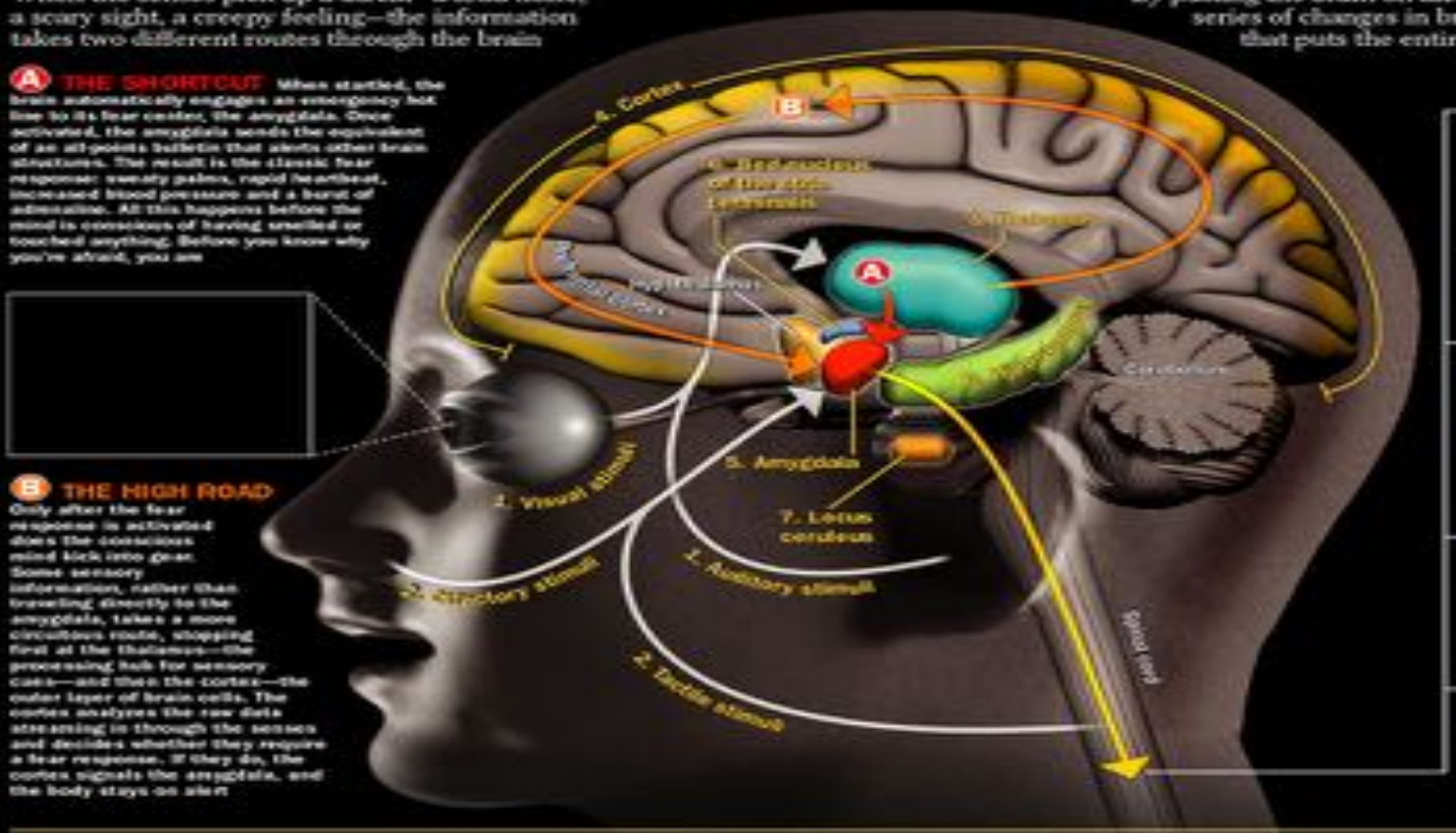
When the senses pick up a threat—a loud noise, a scary sight, a creepy feeling—the information takes two different routes through the brain

A THE SHORTCUT When startled, the brain automatically engages an emergency hot line to its fear center, the amygdala. Once activated, the amygdala sends the equivalent of an all-points bulletin that alerts other brain structures. The result is the classic fear response: sweaty palms, rapid heartbeat, increased blood pressure and a burst of adrenaline. All this happens before the mind is conscious of having smelled or touched anything. Before you know why you're afraid, you are

B THE HIGH ROAD Only after the fear response is activated does the conscious mind kick into gear. Some sensory information, rather than traveling directly to the amygdala, takes a more circuitous route, stopping first at the thalamus—the processing hub for sensory cues—and then the cortex—the outer layer of brain cells. The cortex analyzes the raw data streaming in through the senses and decides whether they require a fear response. If they do, the cortex signals the amygdala, and the body stays on alert

. . . AND HOW THE BODY RESPONDS

By putting the brain on alert, the amygdala triggers a series of changes in brain chemicals and hormones that puts the entire body in anxiety mode



STRESS-HORMONE BOOST Responding to signals from the hypothalamus and pituitary gland, the adrenal glands pump out high levels of the stress hormone cortisol. Too much cortisol short-circuits the cells in the hippocampus, making it difficult to organize the memory of a trauma or stressful experience. Memories lose their context and become fragmented

RACING HEARTBEAT The body's sympathetic nervous system, responsible for heart rate and breathing, shifts into overdrive. The heart beats faster, blood pressure rises and the lungs hyperventilate. Sweat increases, and even the nerve endings on the skin tingle into action, creating goose bumps

FIGHT, FLIGHT OR FREEZE The senses become hypersalert, drinking in every detail of the surroundings and looking for potential new threats. Adrenaline shoots to the muscles, preparing the body to fight or flee

DIGESTION SHUTDOWN The brain stops thinking about things that bring pleasure, shifting its focus instead to identifying potential dangers. To ensure that no energy is wasted on digestion, the body will sometimes respond by emptying the digestive tract through involuntary vomiting, urination or defecation

1. Auditory and visual stimuli Sights and sounds are processed first by the thalamus, which filters the incoming cues and shunts them either directly to the amygdala or to the appropriate parts of the cortex

2. Olfactory and tactile stimuli Smells and touch sensations bypass the thalamus altogether, taking a shortcut directly to the amygdala. Smells, therefore, often evoke stronger memories or feelings than do sights or sounds

3. Thalamus The hub for sights and sounds, the thalamus breaks down incoming visual cues by size, shape and color, and auditory cues by volume and dissonance, and then signals the appropriate parts of the cortex

4. Cortex It gives raw sights and sounds meaning, enabling the brain to become conscious of what it is seeing or hearing. One region, the prefrontal cortex, may be vital to turning off the anxiety response once a threat has passed

5. Amygdala The emotional core of the brain, the amygdala has the primary role of triggering the fear response. Information that passes through the amygdala is tagged with emotional significance

6. Bed nucleus of the stria terminalis Unlike the amygdala, which sets off an immediate burst of fear, the BNST perpetuates the fear response, causing the longer-term unease typical of anxiety

7. Locus ceruleus It receives signals from the amygdala and is responsible for initiating many of the classic anxiety responses: rapid heartbeat, increased blood pressure, sweating and pupil dilation

8. Hippocampus This is the memory center, vital to storing the raw information coming in from the senses, along with the emotional baggage attached to the data during their trip through the amygdala

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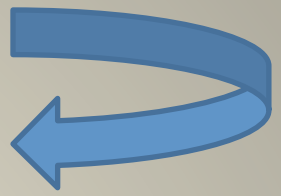
ACUTE FIGHT-FLIGHT-FREEZE
CHRONIC HYPERAROUSAL



ACUTE ADAPTIVE RESPONSE	CHRONIC HYPERAROUSAL
State of high alert, hypervigilance	State of high alert, hypervigilance
Massive release of neurohormones	Massive release of neurohormones
Action, not thought	Action, not thought – bad decisions
Loss of emotional management	Loss of emotional management
Attention focused on threat	Attention focused on threat
Unable to calm down	Unable to calm down
Intense and prolonged anxiety	Intense and prolonged anxiety
Irritable, aggressive, impulsive	Irritable, aggressive, impulsive

Re-Experiencing, Emotional Numbing, Reenactment

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TYPES OF STRESS

- Positive stress
- Tolerable stress
- Toxic stress
- Traumatic stress

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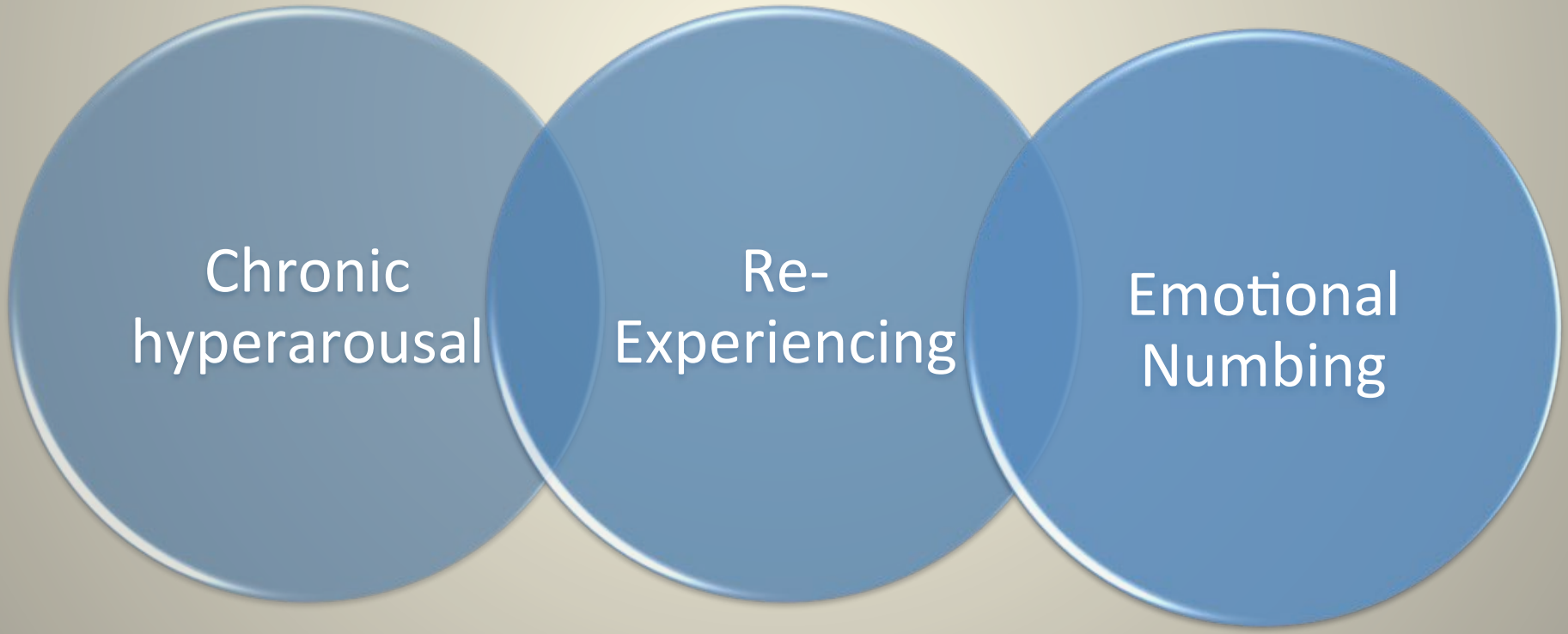
MAJOR SYMPTOMS OF TRAUMA



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Continuous Reenactment

- Demoralization
- Loss of hope
- Foreshortened sense of future
- Meaninglessness
- Violence

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DISSOCIATION

- Buffering the Central Nervous System
- Complex fragmentation of experience
- Body memories
- Chronic pain
- Hallucinatory experiences – voices, visions
- Amnesia
- Emotional numbing – prolonged “shock”

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Beyond PTSD

As many as 67% of trauma survivors experience lasting psychosocial impairment including:

- posttraumatic stress disorder (PTSD);
- panic, phobic, or generalized anxiety disorders
- depression
- dissociative disorders
- personality changes
- substance abuse

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GROUP EXERCISE: WHAT ARE TRAUMA SYMPTOMS AND BEHAVIORS?

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COMPLEX AND CO-OCCURRING PROBLEMS

- Irritability, aggression, tension
- Sleep problems, nightmares, flashbacks
- Hair-trigger tempers
- Mood instability – depression, anxiety
- Poor impulse control – risk taking behavior
- Dichotomous, extremist thinking and behavior
- Increased attachment to dysfunctional groups
- Hostility and violence projected outward
- Multiple addictions & compulsive behaviors
- Psychosomatic illness
- Revictimization
- Poor parenting

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HOW AFRICAN MEN DESCRIBE IT

- **Re-experiencing**
  - **Replay**
  - **Surviving**
  - **Scars**
  - **Déjà vu**
- **Avoidance**
  - **Staying under (the radar)**
  - **Lay low**
- **Hyperarousal**
  - **Mental pain**
  - **Insomnia**
  - **Being on Ps and Qs**

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OTHER WAYS IT EMERGES

- **Smoking weed**
- **Disrupted sleeping patterns**
- **Discomfort waiting in the same spot**

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THE INTERRUPTERS

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Clip #1 (1:13:49 – 1:17:31)

- Is Flamo like the young people you work with?
- What trauma(s) has Flamo experienced?
- What trauma- or stress-related behaviors does Flamo exhibit?

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Clip #2 (1:25:40 – 1:28:55)

- What trauma-informed practices did Cobe use with Flamo?
- Why were they effective?
- What else could be/should be done?

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Clip #3 (2:02:57 – 2:04:15)

- What reason does Flamo give for Cobe's help being effective?

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UNIVERSAL PRECAUTIONS

- Recognize fight-flight-freeze
- Reduce threat
- Increase safety
- Minimize hyperarousal
- Promote trust
- Promote mastery

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Module 2: Crafting Relationships

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TIPS FOR PROVIDERS: DON'T

- Don't use Jargon
- Don't talk too much/ask too many questions
- Don't try to be "down" or cooler than you are
- Don't be or act fearful
- Assume your norms are the only norms

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TIPS FOR PROVIDERS: DO

Do map- explain what is happening and what is going to happen

Do give personal examples or of other clients, but don't hijack the conversation and don't use names

Do pay attention to family dynamics/hierarchy and include family and build a relationship with them if appropriate

Do check in: "let me know if something isn't right or I'm misunderstanding."

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Developing Health Care Standards of Practice for Boys and Men of Color Exposed to Violence

Introduction

African American and Latino males are facing a health crisis in the U.S. The most significant factor in this crisis for boys and men of color (BMoC) is their exposure to violence, both as witnesses to trauma and as victims of violent injuries. This literature review attempts to capture the available research related to the challenges facing boys and men of color relating not only to their health, but also where they seek care, and how they can better be served, specifically as it relates to assessment and intervention for their trauma-related symptoms.

The health problems of boys and men of color have been explored by experts in several fields; however, that has not led to an abundance of research on what works to improve access to care – and in mental health, proper diagnosis, and accessible treatment. The need to understand how to improve care is especially great where the physical and psychological converge. Access to medical services is imperative for the treatment of physical wounds from violent trauma; but equally necessary and often more difficult to access, are services focused on diagnosis and treatment for potential mental health issues such as posttraumatic stress disorder (PTSD), depression, and substance abuse. A common effect of violent trauma, PTSD is underdiagnosed and misdiagnosed in BMoC and therefore is also undertreated. Screening, brief intervention, and referral to treatment (SBIRT), a tool used most widely to universally screen patients for alcohol misuse, could potentially be used to detect violent trauma indicators using the same format.

SBIRT's universal screening approach (at primary care facilities, emergency departments, or wherever patients are presenting for care), and brief and immediate interventions, increase the odds that people with problems are both identified and provided care. While SBIRT has been used to screen for domestic violence with varying results it has not been used to detect the impacts of violent trauma. The potential benefits of such a tool used at places where BMoC access health care or present for other service, are great. For an adjusted SBIRT to be successful it is necessary to know: (a) where BMoC seek care and why they seek care in those particular places (b) why violent trauma indicators are under- and misdiagnosed (c) what screening tools are available and how effective they are for boys and men of color (d) and what brief interventions are available and appropriate for boys and men of color.

In-depth interviews with African American men who are victims of violence show that symptoms of trauma combine with the so-called "code of the street" to compel traumatized victims to self-medicate with drugs, arm themselves and sometimes seek to retaliate, all to reestablish a sense of safety (Rich & Grey, 2005). This dynamic is not limited to African

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American men but resonates with other men of color who find themselves facing a limited horizon of life possibilities in communities that they see as hostile. Despite this knowledge, the criminal justice system remains the dominant model for addressing youth violence

The central role of trauma

Evidence in the medical and psychiatric literature supports the idea that trauma is at the center of physical and psychological pain (Bloom, 1997). Trauma has a direct connection to many important health problems. Most recently, the Adverse Childhood Experiences (ACE) Study has provided overwhelming evidence that trauma is strongly related to adverse health outcomes (Felitti, et al., 1998); the study revealed a strong, dose-response relationship between ACEs Score and: smoking, COPD, hepatitis, heart disease, fractures, diabetes, obesity, alcoholism, substance abuse, depression, attempted suicide, teen pregnancy (including paternity), sexually transmitted diseases, occupational health and job performance.

Other critical social, political, environmental and structural factors are known to adversely affect the health of men of color. The literature implicates societal pressures of masculinity (Courtenay & Keeling, Men, gender, and health: toward an interdisciplinary approach, 2000), fear about seeking health care (Sabo & Gordon, 1995), lack of access to health insurance, stigma associated with using mental health services (Banks, 2001), the trauma of racism and discrimination in health care, employment and housing (Jones, 2000), and traumatic encounters with the criminal justice system (Mauer & King, 2007).

The Emergency Department as locus of intervention

The Centers for Disease Control have outlined a four-step approach to addressing youth violence as a public health issue: (1) defining and monitoring the problem, (2) identifying risk and protective factors, (3) developing and testing prevention strategies, and (4) insuring widespread adoption of such strategies (Centers for Disease Control and Prevention, 2008). Whereas many approaches to violence prevention are founded on the assumption that youth must be reached before they become involved in violence, research shows great potential to break the cycle of violence by providing positive supports to youth who have become victims of violence.

According to "Children's Exposure to Violence: A Comprehensive National Survey," more needs to be done at all levels of policy and practice to identify children at risk from exposure to violence and to coordinate the delivery of services to these children. This study mentions the need to involve emergency room physicians, nurses, and social workers in responding to the needs of these youth and in connecting with other service providers in the young person's life to coordinate services (Finkelhor, Turner, Ormrod, Hamby, & Kracke, 2009). Another study that looked at repeated exposure to violence concluded that the multiplicity of interrelated risk factors mandated a comprehensive approach to violence recidivism and called for hospital-based

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intervention strategies that address the complex needs of this population (Cooper, Eslinger, & Stolley, 2006).

This literature attempts to capture the available research related to the challenges facing boys and men of color relating not only to their health, but also where they seek care, and how they can better be served.

Portals of Care

While the poor health of BMoC is widely known, where they go for health care services is lesser understood. Pinpointing the portals of care for BMoC is imperative if we are to better serve them. Knowing where they seek care is necessary and we must also uncover the things that encourage them to seek care in certain places or to avoid it at others.

Where They Go

There is little research that indicates where BMoC go for health care, both physical and mental. Prison is inferred as place where care and treatment are provided, but the degree that is true is unclear and unsubstantiated. It is well documented that young African American men are incarcerated three times more than Latino young men and seven times more than white young men (not including those on parole) (Race, Ethnicity and Healthcare Fact Sheet: Young African American Men in the United States, 2006). Additionally, African American men are 5.5 times more likely to go to prison in their lifetime and Latino men 2.9 times more likely than white men; and the likelihood of African American and Latino men, respectively, going to prison has increased more than any other groups (Davis, Kilburn, & Schulz, 2009). This is important because many incarcerated men lack healthcare access upon reentry, and are unable to receive Medicaid funds while incarcerated. There may be a delay in accessing services upon reentry, which compounds the burden of high prevalence of disease among incarcerated people, particularly men of color.

African American boys have disproportionate levels of expulsion and suspension when compared to other racial, ethnic, and gender groups in the US (National Center for Education Statistics, 2005). The policies that create this disparity in expulsion rates are also thought to be a driving force behind increased incarceration rates among African Americans, who are also likely to be expelled, which is sometimes described as the "school-to-prison" pipeline (Fenning & Rose, 2007).

It can be inferred that while treatment and access to care can be delayed as a result of incarceration, it is provided during incarceration; however, no research that verified or quantified that assumption. Another suspected portal of care is school, but again, no research was found that confirmed that as a source of care for transitional aged boys and men of color.

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Seeking Care

Where people are able to access medical care is often tied to financial considerations and access to insurance. Low-income men are more likely than middle-income men to seek care at hospitals, emergency rooms and clinics, rather than primary care, where there is poor continuity of care due to physician turnover (Leigh, 2004). This only indicates a comparison of access – middle to low income- not percentages or demographic specific information. Additionally, this research only references conventional medical portals of care, possibly overlooking other potential access points.

Having a health home and/or usual source of primary care is a stronger predictor of receiving care than insurance alone and is associated with more accurate diagnoses, better health problem/needs recognition, reduced emergency room use, fewer hospitalizations, lower costs, better prevention, and increased patient satisfaction (Starfield & Shi, 2004). Source of care and convenience of medical care facilities also influence whether services are received and of what quality (Leigh, 2004).

Powell (2011) found that men who have a usual source of care (USOC) are more likely to obtain preventive services, screenings, and treatments for a variety of medical issues, particularly chronic illness and cancer. Fewer men than women have USOC, and men in the US generally make fewer health visits, are less likely to seek help for health problems, and obtain fewer preventive health screenings than women (Powell-Hammond, Mohottige, Chantala, & Hastings, 2011). Powell (2011) also found that Black men are even less likely than white men to report having a USOC, but little research exists on the determinants of having one; although Caribbean black men that had USOC were more likely to have neighborhood medical clinic access, health insurance, and more health conditions than those without USOC.

Cultural comfort and comprehension by patients also impacts medical care's usefulness and potentially the willingness to access it. Culturally incompetent communication and poorly understood health interventions reduced satisfaction (Leigh, 2004). A majority of African American (54 percent), Latino (59 percent), and Asian (63 percent) men reported that they did not find information from their doctor's office easy to understand (Leigh, 2004).

Additionally, there are gender-specific differences in how healthcare providers treat men and women. Leigh (2004) found that providers generally spend less time with men than with women, and provide men with fewer services, less health information, and less advice. Providers also are less likely to talk to men about the need to change behavior(s) to improve their health (Leigh, 2004).

African Americans are also impacted by the diagnoses and treatments they receive. Specific to mental health services, African Americans are over-diagnosed with psychotic disorder, like schizophrenia, and under-diagnosed with affective disorders, like depression and anxiety (Baker & Bell, 1999). African Americans are also more likely than whites to be prescribed older

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generation/less commonly prescribed anti-depressants which have more side effects and are less efficacious (Melfi, Croghan, Hanna, & Robinson, 2000). Already less likely than whites to seek mental health services (U.S. Department of Health and Human Services, 2001) misdiagnosis and suboptimal medications can lead to continued or increased symptoms and erode trust in treatment.

Trust

Many African Americans distrust the healthcare system, often attributed to the Tuskegee Syphilis study from 1932-1973 (Cook, Kosoko-Lasaki, & Obrien, 2005) (Musa, Schulz, Harris, Silverman, & Thomas, 2009) (McGary, 1999) (Jacobs, Rolle, Ferrans, Whitaker, & Warnecke, 2006) or other experiences with institutional racism (Musa, Schulz, Harris, Silverman, & Thomas, 2009). Using grassroots efforts for involvement in health care research and services may backfire, given that the same tactics were used to recruit subjects to the Tuskegee Study (McGary, 1999). Conspiracy theories of a black genocide are prevalent and are often fueled by the Tuskegee Study and the high HIV/AIDS prevalence in the Black community, especially given the government's poor initial response to the epidemic (McGary, 1999).

Lack of trust in the healthcare system is an impediment to participation: higher trust is generally associated with greater likelihood to use health services, higher patient satisfaction with care, and stronger adherence to physicians' recommendations (Keating, Gandhi, Orav, Bates, & Ayanian, 2004) (Musa, Schulz, Harris, Silverman, & Thomas, 2009) (Shelton, et al., 2010) (Jacobs, Rolle, Ferrans, Whitaker, & Warnecke, 2006). A telephone survey of older Blacks and Whites showed that blacks had significantly less trust in their own physicians and greater trust in informal health information sources than did Whites. High distrust of physicians contributes to disparities through reduced utilization of preventative services (Musa, Schulz, Harris, Silverman, & Thomas, 2009). There was no research focused specifically on transitional aged BMoC to establish their levels of trust of healthcare systems and if any distrust is also linked to the Tuskegee study or other issues. Such research is essential to establish portals of care that BMoC will use.

The "Group-Based Medical Mistrust Scale" (GBMMS), an instrument to measure health care-related trust with a focus on health care provided in the social context of racism and discrimination, showed that men reporting no physical exam in one year or longer had higher GBMMS scores compared to those men who had an exam in the past year. Those with higher mistrust scores were less likely to be involved in routine care (Shelton, et al., 2010).

Communication appears to be at the root of mistrust, Keating stated, "Perceptions that physician communication was less supportive, less partnering, and less informative accounted for black patients' lower trust in physicians" (2004). Studies have shown that Black patients reported less positive communication, and that physicians engaged in less participatory decision making with black patients (Tarrant, Stokes, & Baker, 2003) (Fiscella, et al., 2004).

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While perceived racism is often cited as potential reasons for mistrust and under-utilization of health services, studies show conflicting results on the value of racial or ethnic similarity between patient and physician (Cook, Kosoko-Lasaki, & Obrien, 2005). One study showed a patient's rating of a doctor's care and effort is higher when of the same race (Cooper, Roter, & Johnson, 2003). Another study showed patients do not have a preference for physicians of the same race, but rather nonverbal behavior was associated with both satisfaction and trust (Aruguete & Roberts, 2002). Another study showed that the race of the physician was not as important as establishing trust as was language and cultural barriers (Jacobs, Rolle, Ferrans, Whitaker, & Warnecke, 2006). Overall, race appears to be less important than the development of interpersonal trust, which is a variable process among individuals.

Most studies of interpersonal trust with physicians involve white patients. Most studies specifically addressing mistrust in healthcare among people of color involve surveys of older adults (40+), and are often specific to particular chronic diseases or conditions (i.e. cancer, preventative service for older adults). Since health disparities exist along the continuum of age for boys and men of color, more research is needed to describe mistrust among younger BMOC. Also, the inconsistent finding relating to race's impact on trust and accessing services may be impacted by perceived racism and lack of trust in the process for acquiring the information. A closer examination of who conducted interviews/surveys could be helpful in establishing how much trust is impacting research on trust.

Underrepresented minorities (Latinos, African American, and Native Americans) represent only six percent of practicing physicians, whereas they account for approximately 25 percent of the US population (Gonzalez & Stoll, 2002). Health care providers are often unaware of biases that can affect their patient outcomes (Cardarelli & Chiapa, 2007). In one study, physicians were found to rate African American patients as less intelligent, less educated, more likely to abuse drugs and alcohol, more likely to not follow medical advice, and less likely to participate in cardiac rehabilitation than white counterparts (van Ryn & Burke, 2000). Cardarelli and Chiapa (2007) posit that to reduce bias, unintentional or otherwise, clinicians serving disadvantaged populations must: undergo cross-cultural education, improve communication across cultural and language divides (related to health literacy levels), and adhere to evidence-based medicine which degreases unintentional bias in health service delivery to minorities.

PTSD

Because BMoC are disproportionately affected by violence there is a need to understand the treatment they receive because of it. While physical wounds from violent trauma leave little room for misdiagnosis, psychological ones are less concrete. Additional challenges stem from the rigidity of psychological diagnoses. While BMoC with exposure to violence may have symptoms that indicate a potential problem, if all the criteria are not met diagnoses of specific mental disorders are not possible.

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PTSD Definition

Limited research has been conducted on diagnosis and treatment of Post-traumatic stress disorder (PTSD) in BMoC. PTSD develops in response to exposure to a traumatic event during which an individual feels extremely fearful, horrified or helpless. The diagnosis is characterized by persistent re-experiencing of the event, persistent avoidance of stimuli associated with the event, emotional numbing and hyper-arousal (American Psychiatric Association, 1994). PTSD, as it is currently understood, has evolved over decades. Dating back to World War I, the common term for violent nightmares, flashbacks, and other symptoms returned soldiers experienced was "shell shock". An understanding of the myriad of these post-war symptoms as PTSD did not happen until 1980 (Peterson, 2009).

In more recent years PTSD research has tended toward single episodic traumas, such as natural disasters. The American Psychiatric Association is preparing to add to the current definition so that it is inclusive of Complex PTSD, which is not currently recognized a diagnosis. Complex PTSD, which extends its definition to repeated traumas (Cloitre, et al., 2011), is an important distinction primarily because community violence is repetitive and unpredictable, and victims of it have no expectation of a reprieve. If the current development holds, the subtype – Posttraumatic stress disorder- with prominent dissociative (depersonalization/derealiztion) symptoms- will be added (G 03 Posttraumatic Stress Disorder, 2012).

More than any other exposure to violence, PTSD is closely associated with community violence (McCart, et al., 2007). An increased understanding of community violence and the compounded effects of repeated traumas has shown the necessity of early intervention for low-income children of high risk in urban areas with exposure to trauma in their communities and at home (Carrion & Hull, 2010).

PTSD Symptomology in BMoC

Some research asserts there is no difference in symptomology for BMoC based on race or gender. However, for youth in particular, other research shows that gender and age impact diagnosis. Although children with "complex trauma histories" show PTSD symptoms, other DSM diagnoses criteria are met (van der Kolk, et al., 2009). Morris (2009) found that violence is damaging to mental health because their cognitive and coping skills are underdeveloped, making them vulnerable to mental health and emotional problems. In the presence or absence of PTSD symptoms, children raised in the midst of ongoing trauma are not well-served by the current system that often leads to un- or mis-diagnosis and emphasis on behavior without focus on the reasons for that behavior (van der Kolk, et al., 2009)The need for coping skills is evident because youth involved in the juvenile justice system experience trauma at much higher rates than youth in general. Adams (2010) showed "that while 34 percent of children in the United States have experienced at least one traumatic event, between 75 and 93 percent of youth entering the juvenile justice system…have experienced some degree of trauma", a vast difference.

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Additionally, higher rates of recovery are found when children with PTSD are provided mental health treatment rather than incarceration (Adams, 2010). Adams (2010) also posited that identification of children who have experienced trauma is either being done insufficiently or not as often enough, leaving them without treatment and at risk.

There are different PTSD lifetime prevalence rates along racial lines. Exposure-to-trauma rates do not correspond to the difference in prevalence and other issues appear to be impacting rates.

Roberts, Gilman, Breslau, Breslau, and Koenen (2011) posit, race and ethnic differences are likely the result of variation in exposure to trauma and variation in the risk for developing PTSD. Roberts, Gilman, Breslau, Breslau, and Koenen (2011) found that African Americans were significantly more at risk, Latinos equally at risk, and Asians at lower risk than whites of developing PTSD. They also found that African Americans had a higher risk of developing PTSD despite lower reported trauma exposure rates than whites; however, perceived discrimination and other related issues, which are not typically included in trauma exposure incidents or otherwise factored, may account for some of the elevated risk for PTSD among African Americans (Roberts, Gilman, Breslau, Breslau, & Koenen, 2011). Despite the conclusions, the research indicated the lower rate of trauma exposure found in African Americans in that study was unusual. Bias from nondisclosure resulting from distrust or unwillingness to share stigmatizing information may be the cause of that inconsistency (Zhai & Gao, 2009).

Research indicates some misdiagnosis of mental health problems for people of color owing to physical manifestations of psychological ailments being treated without attention to the underlying problems (Harris, Edlund, & Larson, 2005). Misdiagnosis influences diagnosis data leaving African Americans over diagnosed.

"Regardless of race, higher rates of PTSD occur in individuals who have lower SES, and /or are poor academic achievers, unemployed, and/or homeless. African Americans are more likely to be in in those high-risk categories." (Alim, Charney, & Mellman, 2006).

Screening Tools

There are a myriad of tools, of varying lengths and targeting specific populations, in use to screen for PTSD. The military created a PTSD Checklist which has three versions, including a civilian version. It has been adjusted for length, and the Short Form of the PTSD Checklist has six items, shortened from the original 17 items. The civilian version is helpful because it does not focus on a single event and can be used for people with multiple exposures to trauma (United States Department of Veterans Affairs, 2007). The PTSD Checklist screening tools have also been validated.

Other screens include Brief Anxiety Inventory-Primary Care (BAI-PC), a subset of the 21-item Beck Anxiety Inventory. One benefit of this screen is it that the seven item screen also screens

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for other disorders. Short Screening Scale for PTSD, also a seven question screen was designed for use by all trauma victims. Primary Care PTSD Screen (PC-PTSD), a four item screen, was designed for medical settings and is in use for military veterans. It does not offer a list of possible traumas. Startle, Physiological Arousal, Anxiety, and Numbness (SPAN) is a shorter version of the Davidson Trauma Scale with only four items. The Short Post-Traumatic Stress Disorder Rating Interview (SPRINT) has eight questions that measure intrusion, avoidance, numbing, and arousal, among other things. SPRINT is useful for measuring changes of symptoms over time and can be used to measure "global improvement". The Trauma Screening Questionnaire (TSQ), a 10 item screen, was designed for all kinds of trauma and is intended to be used 3-4 weeks after the event to allow time for normal recovery (National Center for PTSD, 2007).

Screens specific to children and adolescents are also available. Child Report of Post-traumatic Symptoms (CROPS) is specific to children and adolescents can measure changes in symptoms and does not require an identified event. It has 16 items but the measures have not been standardized but the language is suitable for young, undereducated, and other respondents where non-language comprehension may be a problem. Child Stress Disorders Checklist (CSDC) is free and easily accessible and it does not require a clinician to complete it. However, some of the language is technical. The Child's Reaction to Traumatic Events Scale-Revised (CRTES-R) is a 23-item meant to evaluate responses to stressful events. The update includes language that is consistent with the DSM-IV. While this is intended for use by 6-18 years-old, the language may be too difficult for younger children. Additionally, this tool has not been used as widely as some of the others. The Trauma and Attachment Belief Scale (TABS), was not designed for children but was designed to be appropriate for adolescents. Its use seems to be directed to vicarious trauma and more research is necessary to gauge success with direct trauma (National Center for PTSD, 2007).

Interventions/treatment

For both the military and civilians, Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) is the preferred treatment for PTSD (Carrion & Hull, 2010). TF-CBT mixes traditional CBT with other interventions – including family and interpersonal (Cohen, Mannarino, Murray, & Igleman, 2006).

For children and adolescents with PTSD, CBT, psychological first aid, play therapy, and medication have been successful treatments (National Center for PTSD, 2009). In this vein, the Center for Mind Body Medicine uses a panoply of techniques including: relaxation, meditation, breathing, and self-expression (drawing, spoken word), in supportive and non-judgmental settings (Gordon, Staples, Blyta, Bytyqi, & Wilson, 2008). This approach has been found to have impact even in a continued environment of stress and violence (Staples, Atti, & Gordon, 2011).

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Resiliency is another factor to consider; children with community support, encouraging and organized school, and a consistent and structured family tend to show resiliency (Morris, 2009)

Historically, the military, US and others, researched PTSD and its treatments. The inherent trauma of war prompts the military to produce and pilot innovative approaches to care. Because military conflicts are frequently paired with sustained mental illness, prevention is preferential to treatment (Vitzthum, Mache, Joachim, Quarcoo, & Groneberg, 2009). Primary, secondary, and tertiary prevention strategies for PTSD range in military terms, from selection procedures and coaching, to short psychological debriefing and professional treatment (Wiederhold & Wiederhold, 2006; Brusher, 2007). These approaches, while potentially beneficial for combat situations, are not in practice for community violence. Communities experiencing sustained and constant violence have no selection process to indicate when violence will happen, and because the nature of the violence is unpredictable it would be difficult to coach.

Virtual therapy, used both for prevention and therapy, exposes soldiers to animated scenarios that are used to either "train their responses" or revisit memories (Vitzthum, Mache, Joachim, Quarcoo, & Groneberg, 2009). "Trauma risk management", a psycho-educational management tool aids patients in stress reduction and trains them how to spot and refer vulnerable colleagues (Gould, Greenberg, & Hetherton, 2007). Internet-based counseling has also been used with success (Litz, Engel, Bryant, & Papa, 2007). Litz, Engel, Bryant, and Papa found that self-managed CBT is a potentially viable option for care that reduces cost and stigma (2007).

SBIRT

Screening, brief intervention, and referral to treatment (SBIRT) is, as the name implies, a model initially designed for primary care settings to conduct "universal screening" – screening everyone who presents-, provide interventions, and refer people to more involved treatment when necessary, for alcohol use (Babor & Higgins-Biddle, Brief Intervention: For Hazardous and Harmful Drinking, 2001; Babor, et al., 2007).

In recognition of the populations that do not frequent primary care facilities and that up to 31 percent of emergency department (ED) patients and as many as 50 percent of traumatically injured patients have positive screens for alcohol, SBIRT's use was extended to emergency departments (National Institutes of Health and National Institute on Alcohol Abuse and Alcoholism, 2005). Despite concerns by doctors about encroachment on their time and possible negative reception by patients (Higgins-Biddle, Hungerford, & Cates-Wessel, 2009) the tool was found successful for alcohol, promising for drug use, and with little or no evidence of effectiveness for mental health problems and trauma and anxiety disorders. (Screening, Brief Intervention, and Referral to Treatment (SBIRT) in Behavioral Healthcare, 2011). The Substance Abuse and Mental Health Services Administration (SAMHSA) reported reduced heavy drinking at the 6-month follow-up for their grantees' patients and fewer arrests, better health, and more

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stability in housing for patients receiving brief interventions or referred to treatment (Clay, 2009).

SAMHSA has shown its support for SBIRT through grants and continued research, gathering data to illustrate the benefits of the approach. Using one of those grants, Colorado has extended SBIRT to HIV clinics in recent years (for alcohol not HIV) and in more remote areas of Alaska (Clay, 2009).

In addition to alcohol and substance abuse, SBIRT has also been used for intimate partner violence with little success in part because there is no "gold standard" assessment for intimate partner violence among patients and even less so for male intimate partner violence, and in the context of an ED (Anglin & Sachs, 2003).

Benefits and Challenges in ED context

Although primary and secondary prevention are not largely considered part of emergency care by most practitioners, interventions are; and identifying needs and providing appropriate referrals to counseling or services is considered within the emergency medicine scope (Irvin, Wyer, & Gerson, 2000).

Hindrances to the uptake of SBIRT in the ED do not vary much from those expressed by primary care physicians. Lack of time, fear of upsetting patients, and belief that primary care environments are better suited to the work rank as clinicians' concerns about using SBIRT (Babor & Higgins-Biddle, 2001); however, SBIRT can be conducted in about 10 minutes and reports show that it is both inexpensive and successful, leaving little credible evidence against conducting alcohol and, increasingly, substance abuse, screenings in the ED (Higgins-Biddle, Hungerford, & Cates-Wessel, 2009).

There are other concerns related to SBIRT's use in the ED. Follow-up data is necessary to test the efficacy of an intervention; limitation of the "episodic" nature of emergency care approach is that it makes follow-up difficult (Irvin, Wyer, & Gerson, 2000). Another cautionary thought is that the US Preventative Services Task Force (USPSTF) views youth and family violence as examples of where preventive measures are better suited for community programs (Irvin, Wyer, & Gerson, 2000). Although community violence is not specifically listed, some may see it as an overlapping issue better suited for attention beyond medical walls.

Screening Tools

Like PTSD, a number of pre-existing screening tools are in use for SBIRT; the tools vary in length and some may be more efficient than others, depending on population and environment (Higgins-Biddle, Hungerford, & Cates-Wessel, 2009). Screening tools include: AUDIT, a 10 question assessment; Binge question, a single question; Cut down, Annoyed, Guilty, Eye-opener (CAGE), three questions; and Car, Relax, Alone, Friends, Forget, Trouble (CRAFFT), a six

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question instrument; can all be used independently or grouped with consumption information and/or blood alcohol content. (American Public Health Association and Education Development Center, Inc., 2008; Higgins-Biddle, Hungerford, & Cates-Wessel, 2009). In some cases, such as AUDIT, the abbreviated version – already validated for its efficacy- is used to keep the screening short. This shortened time frame is beneficial to emergency room personnel and patients whose primary concern is treatment for injury or illness and not for interventions.

Initial screenings are not only conducted in person by a clinician (doctor or nurse), the internet has been used with some success- (Cunningham, et al., 2009) including the World Health Organization's Alcohol, Smoking, and Substance Involvement Screening Test (Bernstein, Bernstein, Stein, & Saitz, 2009) and interactive videos with actor "doctors" (National Insitute on Alcohol Abuse and Alcoholism, 2005). These techniques are attempting to address the issue of physician time and at the simultaneously may offer some added anonymity for patients.

There are validated screening tools, both long and short format, readily available for alcohol misuse and other substance abuse; for other health/social ills that is not the case. Domestic violence (DV) is one example. ED screening for domestic violence has been tried, however, there is no "[gold standard] test for the identification of DV among patients (Anglin & Sachs, 2003). Considering the SBIRT approach for community violence, there is no evidence yet of an effective screening tool.

Brief Interventions/Treatments

Brief interventions are the counterpart to universal screening. A brief intervention generally consists of individualized feedback and personalized counseling based on the screening results (National Institutes of Health and National Institute on Alcohol Abuse and Alcoholism, 2005); but they are not intended to treat alcohol dependence (Babor & Higgins-Biddle, 2001). The intention of the brief intervention or treatment is not limited to immediate behavioral change but attempts to positively impact longer-range behavioral change (Screening, Brief Intervention, and Referral to Treatment (SBIRT) in Behavioral Healthcare, 2011).

A strength of the intervention component of SBIRT, beyond its brevity, is the tiered approach. Universal intervention would negate the need for screening; but the tiered approach allows interventions to be appropriately tailored for each risk level. Interventions range from minimal risk which requires only education on maintaining safe levels of alcohol consumption to severe risk and dependency which involves a more specialized evaluation and treatment (Babor & Higgins-Biddle, Brief Intervention: For Hazardous and Harmful Drinking, 2001; Screening, Brief Intervention, and Referral to Treatment (SBIRT) in Behavioral Healthcare, 2011).

For the abstainers and low risk drinkers, the intervention is actually intended to prevent increased drinking over time through education. Providing praise for current drinking habits and basic information about standard drink sizes and recommended intake is all that is necessary for this group (Babor & Higgins-Biddle, 2001). For those who are screened as moderate risk, simple

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advice is provided, while for moderate-to-high risk simple advice plus brief interventions are provided. The final Zone goes beyond the brief intervention structure and requires a referral to a specialist (Lawson & Flocke, 2009; Cunningham, et al., 2009).

Motivational Interviews (MI), "... client-centered, directive method of enhancing intrinsic motivation to change by exploring and resolving ambivalence..." are a common intervention tool because they are brief and can be conducted by people other than clinicians (Monti, et al., 2007). While not suitable for all interventions (it is not suitable for people who are resistant to intervention and people who have serious drinking/substance abuse problems are more suited to referral for treatment) they have proven beneficial for people ready to change.

Conclusion

While the poor health outcomes of BMoC are well researched, little is known about where BMoC seek care. Until there is more information about where they go for medical and mental health care, why they go there, and what keeps them from seeking care at other places, it will be difficult to establish what services they most need and the best way to provide them. While education and criminal justices systems are both potential portals of care, little research is available to indicate these not simply as viable places for care but portals being utilized.

Community violence and other traumas impacting BMoC are further exacerbated by sometimes unconventional access to health care environments. Doctors' offices are not always the way BMoC enter into the health system. Juvenile justice centers, school clinics, and emergency/trauma departments –in times of acute injury- are viable common pathways into the medical system. However, staffs at these facilities are not necessarily trained to work with traumatized populations and the complexities of their needs. Insurance/money, trust, transportation, and unfamiliarity with medical systems can emerge as challenges to seeking care. And in cases where men access services at places untrained for their particular needs, the treatment/mistreatment they receive may prevent future voluntary access.

The "where" of care is all the more important because violent trauma impacts both body and mind; while body is often tended to, the psychological issues, such as PTSD, that are often the consequence of trauma, is frequently untreated. PTSD has been studied largely through a military lens and, more recently, natural disaster or other one-time events. Community violence related PTSD is less studied. Additionally, clarification of why some research studies shows that people of color experience fewer traumas despite trauma statistics that show otherwise. It is also important to investigate how racism impacts/feeds into trauma, and screening tools that prevent misdiagnosis of BMoC.

Although beginning to gain some traction through the adoption of the term Complex PTSD to distinguish it from the more commonly known and diagnosed PTSD, there is still limited research on how continuous exposure to violence and violent surroundings without expectation

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of a change in environment impacts individuals and the best way to treat such cases. One study, in Kosovo, sited success in treatment with continued protection after continued exposure to violence but that intervention was not brief and does not fit easily into the SBIRT model.

Research related to Trauma-Focused-Cognitive Behavior Therapy is growing as it is more widely accepted as the preferred treatment of PTSD. Other methods of treatment, such as art therapy haven't been well researched in relation to PTSD and so there are few published alternatives for care. The military has created a few alternative methods of treatment which are still within the scope of TF-CBT, in the form of group sessions not conducted by clinicians and online sessions; however, there is limited published/accessible information on those methods and their success. Additionally, where the military research is concerned there are questions of informed consent- as soldiers may not have the power to opt out/forced participation – which is something other populations will not have, which could skew the numbers.

SBIRT and its potential use to screen for trauma exposed people presenting at the ED, could prove a valuable. However, to be useful, the creation of a standard screening tool is necessary and testing of this approach related to violent trauma is important.

In general, the cultural impact for assessment tools has not been explored beyond translations into other languages, such as Spanish. The nuance of language for other ethnic groups was not explored in relation to the adoption of, and comfort with, existing tools. The impact of racism, perceived or actual, although mentioned in several articles, has not been researched much to determine if it has a bearing (other than speculation) on diagnosis.

Another weakness relates to the lack or research on PTSD resulting from community violence. There has been little in the way of brief interventions for community violence, which is unique (outside of a military context) because there is no expectation that the trauma is over or will not be repeated because the community a person lives in is the site of trauma.

The dearth of research on BMoC and community violence in relation to SBIRT is expected because SBIRT has not been used for community violence screening. Some limited research has been conducted on its use in other health arenas, but lack of universal tools, definitions, and evaluation criteria make it difficult for people to use and evaluate the success of the approach. The lack of data related to BMoC and the use of SBIRT is less expected as cultural biases are widely documented in health systems. There is evidence of mis/under diagnosis in screening tools and varied outcomes related to trust if health systems on the macro and specific doctors on the micro levels which makes it probable that similar trends might be found within SBIRT.

Future Research

Considering the current gaps in research as starting points, it is important to give more attention to complex PTSD, and more specifically, what that looks like in relation to community violence- and within a population of young BMoC.

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There is also a gap in research related to PTSD and how it might be treated in the context of the criminal justice system where people have high rates of trauma exposure and risk, by nature of the criminal justice system, being further traumatized. This is significant because BMoC are disproportionately represented in the criminal justice system.

While the ACE study included both men and women and many college educated people in its testing body, it included few people of color or people with less education. The striking findings in the economically and educationally advantaged populations studied suggest that similar or possibly more extreme outcomes might be found in a study of people of color living in urban areas. Additionally, while the ACE covers broad areas of commonly exposed trauma there are additional adverse events, such as seeing a dead body, losing someone close to them (through violence or otherwise), or feeling unsafe in the school or immediate community, that are not addressed at all. Researching how perceptions of racism impact people adversely would be another important contribution, especially to help explain the consistently lower rates of exposure to trauma for African Americans despite higher rates of many traumatic events. The convergence of these three areas is ripe with potential for closing the gap that currently prevents BMoC from accessing health services they need, and treating mis/under/undiagnosed PTSD using a new approach.

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