P. MICHAEL STURLA, CHAIRMAN
414 MAIN CAPITOL BUILDING
P.O. BOX 202096
HARRISBURG, PENNSYLVANIA 17120-2096
PHONE: (717) 787-3555
FAX: (717) 705-1923

HOUSE DEMOCRATIC POLICY COMMITTEE
www.pahouse.com/PolicyCommittee
Policy@pahouse.net
Twitter: @RepMikeSturla

House of Representatives
COMMONWEALTH OF PENNSYLVANIA
HARRISBURG

HOUSE DEMOCRATIC POLICY COMMITTEE PUBLIC HEARING

Topic: Youth Violence as Public Health Epidemic

418 Main Capitol Building – Harrisburg, PA

June 13, 2013

AGENDA

10:00 a.m. Welcome and Opening Remarks

10:10 a.m. Panel One:

- Joel Fein, MD, MPH, Board of Directors Chair at the Institute for Safe Families and Director of Advocacy and Health Policy in The Division of Emergency Medicine at The Children's Hospital of Philadelphia
- Brian Bumbarger, Assistant Director for Knowledge Translation and Dissemination at the Prevention Research Center, Penn State University
- John Rich, MD, MPH, Director of The Center for Nonviolence and Social Justice, Drexel University
- Ted Corbin, MD, MPH, Co-Director of The Center for Nonviolence and Social Justice, Drexel University

10:50 a.m. Panel Two:

- Joan Duvall-Flynn, EdD, Education Committee Chair of PA State Conference of NAACP Branches and Trauma Committee Chair of Chester County Coalition for Public Education
- James Solomon, Member, Father's Day Rally Committee
- Dorothy Johnson-Speight, MHS, LPC, Founder/Executive Director, Mothers in Charge
- Betty Lee Davis, PhD, LCSW, Youth Violence Public Health Epidemic and Trauma-Informed Education Activist

11:40 a.m. Panel Three:

- Marla Davis Bellamy, JD, MGA, Executive Director, Philadelphia Ceasefire at Temple University School of Medicine
- Rasheed Smith, Participant, Philadelphia Ceasefire
- Joi Spraggins, President, Legacy Pathways, LLC

12:20 p.m. Closing Remarks

HOUSE DEMOCRATIC POLICY COMMITTEE
JUNE 13, 2013

My name is Joel Fein, and I am a pediatrician and emergency physician at the Children's Hospital of Philadelphia. Many years ago, my work in the Emergency Department exposed me to notion that the medical community needs to step up and contribute to solving the problem of violence in our city, rather than just patch up the victims and send them on their way. We need to attack the problem of violence from multiple angles, recognizing that there is no single solution to the violence that plagues the youth of our Philadelphia. As a consequence, I became involved in leading a number of Violence Prevention efforts in Philadelphia, many of which involve collaboration between multiple academic institutions. I am proud that The Children's Hospital of Philadelphia has been highly supportive of these efforts and will continue to support them in the future.

A few months ago I was working in CHOP's Emergency Department and met a 15 year old boy who grew up in South Philly and came to the ER with a busted lip and a bruised ego. He was stating that he had big plans for later that day to retaliate against the kids that assaulted him. While his mother sat completely silently in the corner of the room, he also let me know, in very certain terms, that he is an angry kid; that is just the way he is. We talked for a few minutes about how his plans for the next day could lead to him being severely injured, even dead, because the way he sees it going is not necessarily the way the other guys see it going. I was not really getting anywhere with him along these lines, and I switched topics to learn a bit about his current situation and how he learned to be such a good fighter. It turned out that this teenager had seen people fight ever since he was a small child, both inside and outside of his home, even watching his own father drink, scream, threaten, and at times hurt his mother and older siblings. It is no wonder that this child is angry. I would be too. Clearly I was not going to solve all of these problems in one ER visit, but learning this changed my approach, concentrating on his strength and perseverance rather than his risky behaviors or current anger. This was not going to be a short, in and out visit that his minor bruises might have suggested.

This kid has not been acting "right" for quite a long time, And we are learning so much about the long-lasting physiologic changes that occur when horrible childhood experiences are unbuffered by caring adults and natural coping mechanisms. Many of these physiologic changes make it difficult for this child to think straight during a crisis or even afterward, and also impede his ability to process new information and learn enough to succeed in school. In addition to psychological and psychiatric illnesses, these adverse experiences can reduce his body's ability to handle inflammation and weaken his immune system to the point where he is more likely to suffer from true medical illnesses such as asthma, obesity, diabetes, heart disease, and chronic lung disease.

So what is an ER doc like me supposed to do about this? As it turns out, the hospital can be a portal of entry into a larger public health model that has a better chance of supporting individuals, families and communities.. HR 191 calls for A public health approach to violence prevention, and supports the premise that training in trauma-informed care can help ameliorate the incidence and impact of violence over the long term. The public health approach to violence has three component that set it apart from our medical model:

1. It tries to prevent rather than just treat violent injuries
2. It supports and advances the research needed to design and implement effective prevention approaches
3. It addresses the issue using a multidisciplinary, integrative approach, organizations, and individuals

Currently we are promoting some initiatives in Philadelphia that give legs to the public health approach to violence prevention. To address the foundations of aggression and violence, the Institute for Safe Families, or ISF, is a small but mighty non-profit that has devoted decades of work to ameliorating the incidence and impact of domestic violence. Recently ISF has been working in the pediatric arena, recognizing that the cycle and lineage of domestic violence is tied directly to childhood exposure and adverse childhood experiences, or ACES. We have formed the Philadelphia ACE Task Force, with the goal of learning how to ensure that routine childhood medical visits include assessment and management of childhood stressors that are directly associated with long term health outcomes. I am proud to be the Chairman of the Board of ISF and co-lead the Task Force with Drs. Lee Pachter from St. Christopher's Hospital and Dr. Sandra Bloom from Drexel. At the other end of the childhood age spectrum, CHOP's Violence Intervention Program provides close, personal, intensive case management for older youth who come to the hospital after being assaulted. This program is based on the good work of the Healing Hurt People program at Drexel, which you will hear about from Dr. Ted Corbin later in this hearing. Dr. Corbin and I also direct the headquarters for the National Network of Hospital-based Violence Intervention Programs (www.nnhvip.org) which is a consortium of 23 programs around the country that provide case management and psycho-emotional support for youth who have been seen in hospitals after an assault injury. These programs bring together trauma surgeons, social workers, psychologists, and community and government agencies to provide comprehensive services that support our injured patients and their families and integrate health care systems into the larger social context of the patients we see. They are examples of how important cross-institutional collaboration and thoughtful integration of best practices are paramount to the application of a public health approach to violence prevention. Another example is the work that Mr. Robert Reed at the U.S. Attorney's office is doing to apply the trauma-informed approach that we use in our hospital-based efforts to educate front-line criminal justice workers on how prior trauma influences the way that people react to and deal with police, probation, or other criminal justice or social service systems.

In the more than two decades that I have been working in the field of violence prevention it has become clear to me that no one intervention, initiative, or approach is going to fix the violent lives that are led by so many Philadelphians. Violence prevention is not just about identifying high risk youth or communities, or running "interventions" that will cure the problem. All of our efforts fit somewhere into the jigsaw puzzle of successful violence prevention. It is, however, incumbent on us to make sure that we evaluate initiatives in order to determine how the affect our kids and families, and most importantly in our limited resource environment we need to know how they compare to other things out there. The Philadelphia Collaborative Violence Prevention Center (www.phillyviolenceprevention.org) is based at CHOP also brought together faculty from Penn, Drexel and Temple to work with community members and evaluate violence prevention efforts in West and Southwest Philadelphia. Our Center is a testament to how universities in Philadelphia can work together, transcending institutional boundaries, to respectfully join community efforts that address a huge public health issue. Our community partners were co-directors of the center along

with the academicians from the four institutions. With CDC funding we ran and evaluated a cognitive behavioral intervention, designed using evidence based programs, at 6 after school sites in West and Southwest Philadelphia. We also performed studies on environmental improvements such as green space can reduce crime, and some studies that informed us about how violence is perceived and what the community members thought would be good indicators of our success as we progressed. Through the work of Dr. Steve Leff and colleagues, supported by CHOP and some federal funding, we will continue to develop and rigorously evaluate community-driven, school-based and afterschool initiatives that show great promise in creating young, leaders who can problem solve and not always make a point through fighting behavior. Most importantly, the research that we do focuses on efforts that are sustainable over time and are guided by the needs of the community.

To close the loop on our assaulted teenager, it turned out that this 15 year old angry, hurt and somewhat dangerous boy was much less frightening and certainly less frightened by the end of his ER visit. He seemed very interested in getting his anger under control, feeling that it was getting in the way of his short and long term goals. I contracted with him to avoid retaliating for now, and he seemed to be more calm after a short talk and a promise that someone would follow up with him soon.

A final point that I would like to make is that violence prevention is not just about identifying high risk youth or communities, or running "interventions" that will cure the problem. It is about providing families with the tools to parent well and lead well, and to decrease community-level and individual-level stress. Neighborhoods that have a sense of empowerment and self-efficacy will be most successful because they don't solely relying on police and city agencies to repair and rebuild and protect. It is only in support of multi-level efforts, and recognizing the strong contribution they can make to the public's health, that hospitals and medical centers will demonstrate that they care about the community rather than just caring for the community

Testimony of Brian Bumbarger, Assistant Director for Knowledge Translation and Dissemination at the Prevention Research Center at Penn State University, in response to House Resolution 191, Establishing Youth Violence as a Public Health Epidemic

Testimony provided June 4, 2013

Good morning Chairman Waters and members of the Committee, and thank you for the invitation to provide testimony regarding House Resolution 191 and a public health and trauma-informed approach to youth violence.

My name is Brian Bumbarger, and I am the Assistant Director for Knowledge Translation and Dissemination at the Prevention Research Center at Penn State University, where I direct a project called the Evidence-based Prevention and Intervention Support Center (or EPISCenter). For the past 15 years, I have been working closely with Commonwealth agencies, communities, and prevention providers to apply a public health, risk-focused model to address youth violence and delinquency, drug and alcohol use and school failure.

This 15 year long initiative, with bi-partisan support through 4 Gubernatorial administrations, has supported the development of collaborative multidisciplinary partnerships called Communities That Care coalitions, in over 100 diverse Pennsylvania communities. These coalitions, including schools as vital partners, collect local data on the risk and protective factors known to increase the likelihood of violence and other poor outcomes for youth, and use that local data to establish prevention priorities and a strategic prevention plan that is specific to their community, to prevent and reduce these problem behaviors and promote positive youth development and school success.

The model recognizes that youth violence is preventable, and that there are specific conditions and characteristics within communities, schools, families, and individual youth and their peer groups, that collectively form a complex pathway leading to youth violence, and that although every community experiences youth violence and childhood trauma, the pathway to these problems may be different from one community to another, because Pennsylvania communities are very diverse. In this regard, the model provides a sophisticated diagnostic tool that gives precision to the process of prevention planning, increasing our confidence that the strategies chosen will be effective and that scarce resources will be used efficiently. Key to that process is the use of evidence-based prevention and intervention programs.

In 1994 the Pennsylvania Commission on Crime and Delinquency, then under the direction of Tom Corbett, partnered with the Centers for Disease Control, the United States Department of Justice, and the Colorado Division of Public Safety to fund a comprehensive review of all of the publish research literature to identify what works in preventing youth violence. A review of over 600 studies resulted in the

identification of 10 specific prevention and intervention programs that were labeled the Blueprints for Violence Prevention. These were the 10 programs with the most clearly documented evidence of effectiveness. Since that list was first published, Pennsylvania is the only state in this country to have actively attempted to disseminate those Blueprint programs at a scale that could impact population level public health outcomes. From 1998 to the present PCCD has funded over 200 replications of these proven effective programs to prevent youth violence and delinquency and to intervene effectively with youth and divert them from the juvenile and criminal justice system.

We've seen a significant impact from this effort. In two separate studies involving over 100,000 youth from nearly 150 Pennsylvania communities, we found that youth who grow up in communities using this data-driven public health prevention planning framework and implement evidence-based programs have significantly lower levels of risk factors, higher levels of protective factor, and significantly lower prevalence rates of delinquency and drug use. What is perhaps even more encouraging is that we found that youth in these communities also report significantly higher levels of school engagement and 33% percent better academic achievement than youth in similar Pennsylvania comparison communities.

This is really an achievement, because it means that this combination of public health, risk-focused and data-driven prevention planning, coupled with the use of proven effective prevention and intervention programs, can move the needle on population-level indicators of public health and public safety, and that through a public health approach we can simultaneously reduce violence, improve public safety, and increase school success.

We also conducted a cost-benefit analysis of the initiative, because PCCD had invested a significant amount of taxpayer resources to fund this approach and we needed to know whether it was also cost effective. After monetizing the benefits of the positive outcomes, and subtracting the cost of the programs, we found the initiative had a positive return-on-investment of over $200 million, a savings of $5 for every dollar the Commonwealth had invested.

Based on the success of the initiative, in 2008 PCCD partnered with the Department of Public Welfare's Office of Children Youth and Families to create a state center to expand the initiative and coordinate efforts across all of the Commonwealth agencies that work toward the goals of youth crime prevention, school success and positive youth development. The initiative promotes the use of this effective public health approach, and is overseen by a multi-agency steering committee that includes PCCD, DPW's Office of Children Youth and Families, Office of Mental Health and Substance Abuse Services, and Bureau of Juvenile Justice Services, the Juvenile Court Judges Commission and Council of Chief Juvenile Probation Officers, the Pennsylvania Department of Drug and Alcohol Programs, the Pennsylvania Department of Education, and the Pennsylvania Liquor Control Board.

[This interagency committee meets quarterly and is promoting a level of cooperation, coordination and resource sharing that I haven't seen before in 25 years of working with state government. I'll share two recent examples: First is an interagency effort to support and cooperatively fund the Pennsylvania Youth Survey, the diagnostic tool I mentioned earlier that allows communities to create a profile of their risk and protective factors as a foundation for strategic prevention planning. Through interagency cooperation and resource sharing, for the first time ever the Pennsylvania Youth Survey will be offered to any school district in the Commonwealth at no cost – because jointly the member agencies recognize its value in doing thorough needs assessment to strategically target scarce resources.

The second example is a recent multi-agency effort to encourage Pennsylvania schools to adopt an evidence-based middle school violence and drug use prevention program called LifeSkills training. We all know how busy schools are and how much pressure they are under to perform well in standardized tests, so it is no small feat to convince these already overwhelmed schools to add a violence and drug prevention curriculum to their already full plates. In a fantastic partnership between PCCD, the Department of Drug and Alcohol Programs, the Department of Education, the Juvenile Court Judges Commission, and the network of Communities That Care coalitions, we were able to get over 50 school districts to adopt this Blueprint program, and as a result we will reach nearly 50,000 Pennsylvania middle school students over the next three years.]

Because of the positive impact and return on investment I described previously, Pennsylvania's approach has become a national, and indeed international model and has generated significant interest from other states and other countries. I spent two days earlier this week in an interagency meeting with seven federal agencies who are interested in replicating Pennsylvania's model in every state in the U.S., and I'm leaving directly from this hearing to go to Washington to testify on federal legislation to create a national initiative called the Youth PROMISE Act, modeled after Pennsylvania's approach.

With all of this evidence about the success of Pennsylvania's model you may be wondering, and I'm often asked, why then does Pennsylvania still have one of the worst incarceration rates in the country, with over 50,000 inmates in state prison at a price tag of nearly $2 Billion per year. The answer is that although Pennsylvania has a world-class model for violence prevention with clearly demonstrated success, it is being implemented at the scale of a pilot project; it is in place in only about 4% of Pennsylvania's communities. And the budget for the initiative, which is a specific line-item in the state budget, has decreased by over 90% over the last decade. In 2002 funding for this initiative was approximately $22 million, in 2012 it was barely $2 million, even in the face of growing evidence of its impact and positive return-on-investment.

In closing Mr. Chairman, I applaud the goals of HR191. There is very clear evidence that a public health approach to youth violence is both effective and cost-effective.

And I encourage this committee to consider how Pennsylvania's existing infrastructure can be better utilized and better resourced to take this public health approach to a scale that will ultimately drive down our adult prison population and corrections budget, and promote healthier and more productive youth and safer communities throughout the Commonwealth. Thank you Mr. Chairman and members of the Committee, and I am happy to take questions after the panel.

My name is Dr. John Rich and I am the Chair of Health Management and Policy at the Drexel University School of Public Health and the co-director of the Center for Nonviolence and Social Justice. In this hearing, all of the opinions expressed are my own and not those of Drexel University.

From a public health perspective, we think of violence as a critical public health problem because of the toll of death and disease that it exacts on communities. In 2011, the last year for which homicide injury data are available, 611 Pennsylvanians lost their lives due to homicide. Another 1441 lost their lives to suicide in 2007. In Philadelphia, last year 331 people lost their lives to homicide, there were more than 1400 shootings and there were another 8,662 aggravated assaults that were reported to the police.

But these numbers dramatically undercount the impact of violence. These numbers fail to capture the grandmother who was sitting on her porch who saw the young person lying injured or dead in the street. They do not count the little girl who had to walk past a pool of blood and yellow police tape on the way to school. They do not capture the anxiety of the parent several blocks over

who hears the sound of gunfire and wonders if the victim is a friend or family member.

The fact is that trauma is a universal condition for many urban residents of Pennsylvania. The consequences of such trauma go beyond the physical injuries, but have a dramatic impact on physical and mental health. HR 191 is a groundbreaking step in acknowledging the impact of trauma on those who have experienced or been exposed to violence whether in combat or in their own neighborhoods. In fact, a comparison between war casualties in Afghanistan and homicide deaths in Philadelphia between 2001 and 2011 makes this case compellingly. Over this period, 1446 soldiers lost their lives in combat in Afghanistan. Over the same period, 3391 people lost their lives due to homicide in Philadelphia.

The consequences of exposure to urban violence are consistent regardless of the population affected. Post traumatic stress disorder, depression and other traumatic symptoms affect not only combat veterans but also young people in the inner city. Dr. Corbin has documented that among young urban victims of violence seen in Healing Hurt People, 75% have full-blown PTSD.

As I documented in my book Wrong Place Wrong Time: Violence and Trauma in the Lives of Young Black Men, young victims of violence who are faced with the disruptive symptoms of post traumatic stress often feel constantly unsafe, have severe flashbacks and nightmares and often feel numb, isolated and cut off from any sense of the future. These very real symptoms often lead them to take actions, such as using alcohol or marijuana to ease their distress or getting a weapon, which puts them at even greater risk of injury. This vicious cycle, to which Dr. Corbin has already referred, is happening every day in our cities.
Hearing their voices.

Dr. Corbin has also documented that more than 50% of the clients seen in Healing Hurt People have suffered 4 or more adversities in early childhood. As Dr. Fein has already testified, this level of exposure to trauma in early childhood puts these young people at risk for future health problems including diabetes, heart disease, obesity, depression, drug use and a range of other important chronic diseases. To the extent that poor people and people of color suffer greater levels of stress and adversity, due to such factors as discrimination and poverty, we will see higher levels of chronic diseases and health disparities in these groups.

A trauma-informed, public health perspective recognizes that we must prevent exposure to trauma among young people who are victims. A trauma informed approach compels us to recognize that often "hurt people hurt people". It compels us to ask not only "what is wrong with this person?" but "what happened to this person?"

At the Center for Nonviolence and Social Justice at Drexel University School of Public Health & College of Medicine, we are seeking to change the conversation about violence away from one that focuses on punishment or treatment, toward one that emphasizes healing from trauma. Through programs like Healing Hurt People, training health care professionals and frontline workers, research on the impacts of trauma and policy, we are working across disciplines to move toward more effective trauma-informed practice, firmly rooted in what we know about the science of trauma and stress.

We believe that such a shift can fundamentally redefine our approaches to violence. For example, we know that so-called Scared Straight programs that seek to instill fear or shame in young people do not work, and actually make young people worse. On the other hand, a trauma informed perspective would

lead us to develop programs to enhance the safety of young people who have been injured by trauma, and help them heal. This healing involves Safety, Emotional Management, Dealing with Loss and establishing a Future – key elements of the Sanctuary Model – which guide the practice of Healing Hurt People and the Center for Nonviolence and Social Justice.

A core element of the transition to trauma-informed practice involves training and education, not only for providers, but also for people affected by trauma. Currently, we are undertaking such training of providers in partnership with our colleagues at CHOP, UPenn and Temple, with funding from the Office for Victims of Crime of the US Department of Justice, using innovative in person and online methods. In fact, we are training not only health care providers and frontline workers in hospital-based programs, but also our partners in law enforcement, juvenile justice, behavioral health, schools and other related partners.

The public health perspective also compels us to use an ecosocial perspective and understand that the risks for violence can be thought of as existing on multiple levels. Risk factors exist at the societal, community, interpersonal and individual levels.

Research on violence tells us that the environment in which children grow and in which families and communities live, are powerful determinants of their overall health and of their risk of violence. At the societal level, income inequality and overall level of trust are powerful predictor of the level of homicide and violence. At the community level, a number of factors including residential segregation, community cohesion, presence of liquor stores, prevalence of vacant lots or unwanted land uses, general level of investment in the community, trust in the police all affect the risk of violence and the risk of other important chronic diseases.

At the individual level, exposure to violence either directly or as a witness, failure in school and a range of other factors increase the risk of violence.

At each of these levels, a trauma-informed approach is relevant and has the potential to improve policies and practices. As we go forward, increasing awareness through training, supporting model trauma informed programs and building the research that demonstrates the effectiveness of trauma informed practice have the potential to transform how we think about the public health approaches to violence.

Good morning. My name is Dr. Theodore Corbin and I am assistant professor in the Department of Emergency Medicine at the Drexel University College of Medicine in Philadelphia. At Drexel University I also direct a trauma-informed violence intervention program called Healing Hurt People. This program focuses on victims of interpersonal injury that were seen in the emergency department and are at risk for recurrent injury or death. The program uses trauma assessment, intensive case management and trauma treatment to address both the physical and psychological wounds of trauma. Today I will be speaking from my experience as an emergency medicine physician in the city with a high rate of violent injury. My goal in this testimony is to put forth, as clearly as possible, my belief that there is a strong link between early childhood adversity and exposure to violence, and this types of violence that we see among young people in the emergency department, most of whom are young men of color.

As you know, homicide is the leading cause of death for black men between the ages of 15 and 24. In 2009, this group suffered almost 92,000 nonfatal injuries. According to CDC data for 2007, this group suffered 2,916 homicides, or 79% of all homicides in this age group.

According to the CDC, in 2005 63,715 individuals under the age of 30 were hospitalized for assault related injuries. The medical cost of these injuries exceeded $1.2 billion, and the work loss cost of these injuries exceeded $4.2 billion. Yet we know that only one in 10 victims of assault who present to the emergency department are hospitalized. In 2005 903,856 persons under the age of 30 were seen in emergency departments and released for assault related injuries. The medical cost of these assaults was $1.39 billion and the work loss cost was $2.78 billion.

We also know that violence is a chronic recurrent problem. Sims and colleagues documented in Chicago that 44% of victims with a penetrating injury suffered a recurrent penetrating injury in the subsequent 5 years. This study also showed that the mortality rate at 5 years from all causes in this cohort was 20%, and in 70% of the deaths substance abuse was listed as a contributing cause on the death certificate.

these services should be reimbursed by Medicaid and private insurers. Effective intervention would not only decrease medical costs but could conceivably decrease costs in the criminal justice system by decreasing retaliation and other illegal behaviors.

While there are many strategies to intervene in the cycle of violence, identification in an emergency department and hospitalization presents a unique opportunity to intervene with a population at highest risk. A 1989 study found hospital readmission rates for youth for recurrent violent injuries are as high as 44% due to assault and 20% due to homicide over a 5-year follow up.[1] Since then, other studies of retrospective chart reviews have noted similar rates.[2] Without intervention, hospitals discharge violently injured patients to the same violent environments where they were injured, without a prescription for how to stay safe and with community pressure to seek revenge. Too often, this results in a revolving door of violence, causing even more injuries, arrests, incarcerations, and, sadly, deaths. In 1996, The American Academy of Pediatrics (AAP) published report pointing out that, while "it has been routine to treat victims of child abuse, suicide attempts, and sexual assault via multidisciplinary care protocols, ... no care guidelines exist that address the unique needs of" violently injured adolescents.[3] Two years later, the U.S. Department of Justice's Office for Victims of Crime took the next step by recommending that hospital-based counseling and prevention programs be established in communities grappling with gang violence.

Emergency departments are resource rich settings for identifying young victims of violence, collecting data to help craft best practices, and intervening. According to "Children's Exposure to Violence: A Comprehensive National Survey," clearly more needs to be done at all levels of policy and practice to identify young people at risk from

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[1] Sims, D. W., B. A. Bivins, (1989). "Urban trauma: a chronic recurrent disease." J Trauma 29(7): 940-946.

[2] Reiner, D. S., J. A. Pastena, (1990). "Trauma recidivism." Am Surg 56(9): 556-60.

Poole, G. V., J. A. Griswold, (1993). "Trauma is a recurrent disease." Surgery 113(6): 608-11.

Morrissey, T. B., C. R. Byrd, (1991). "The incidence of recurrent penetrating trauma in an urban trauma center." J Trauma 31(11): 1536-8.

Goins, W. A., J. Thompson, (1992). "Recurrent intentional injury." J Natl Med Assoc 84(5): 431-5.

Claassen, C. A., G. L. Larkin, (2007). "Criminal correlates of injury-related emergency department recidivism." J Emerg Med 32(2): 141-7.

[3] American Academy of Pediatrics, *Adolescent Assault Victim Needs: A Review of Issues and a Model Protocol*, Pediatrics, Vol.98, No.5, 1996:991- 1001.

profound, affecting mental and physical health and altering their interactions with others. In addition, as experts in the field explain, *"[t]he health and human service systems that serve boys, young men and their families are fragmented, do not share common knowledge or language, compete for limited resources, and are under stress."* When these victims interact with staff in these stressed systems, trauma-related issues can negatively affect service access and success.[10]

In 1998, the U.S. Department of Justice's Office for Victims of Crime (OVC), in response to an American Academy of Pediatrics' report on youth violence, *"recommended that hospital-based counseling and prevention programs be established in medical facilities that provide services to gang violence victims."*[11] The OVC also reported that health care and criminal justice systems respond less sympathetically to violently injured youth, particularly African-American male victims of gun violence, than to other crime victims. They noted that, *"[w]hatever the reason for the disparate treatment of these victims, we must not ignore them. Assumptions about the blameworthiness of young African-Americans and Hispanics shortchange a large segment of the population and perpetuate racial stereotyping."*[12]

Hospital-based programs have started to change the traditional approach to working with this vulnerable population. Today, the National Network of Hospital-based Violence Intervention Programs (NNHVIP), founded in 2009, connects 16 member programs from Boston, Chicago, Oakland, Philadelphia, and other cities across the country to continue improving services.[13] NNHVIP supports the notion that there is a

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[9] Bonderman J. 2001. Working with victims of gun violence. OVC Bulletin, U.S. Department of Justice, Office for Victims of Crime.
http://www.ncjrs.gov/ovc_archives/bulletins/gun_7_2001/welcome.html

[10] Rich, Corbin, Bloom et al. (2009) Healing the hurt: Trauma-informed approaches to the health of boys and young men of color. The Center for Nonviolence and Social Justice, Drexel University.
http://www.calendow.org/uploadedFiles/Publications/BMOC/Drexel%20-%20Healing%20the%20Hurt%20-%20Full%20Report.pdf

[11] *New Directions From the Field: Victims' Rights and Services for the 21st Century* at the Office for Victims of Crime site.

[12] Bonderman J. 2001. Working with victims of gun violence. OVC Bulletin, U.S. Department of Justice, Office for Victims of Crime.
http://www.ncjrs.gov/ovc_archives/bulletins/gun_7_2001/welcome.html

[13] NNHVIP 16 member programs are in these cities: Antioch/Richmond, CA, Baltimore, MD, Boston, MA, Camden, NJ, Chicago, IL, Cincinnati, OH, Davis, CA, Indianapolis, IN, Las Vegas, NV, Milwaukee,

As the Network expanded the decision was made to relocate the NNHVIP headquarters from Youth Alive! to a setting where a more diverse range of shared resources would be able to sustain the work. The NNHVIP Steering Committee solicited proposals from its member organizations and ultimately selected to relocate the leadership to Philadelphia, under a shared collaboration between the Center for Nonviolence and Social Justice (CNSJ) at Drexel University, the Philadelphia Collaborative Violence Prevention Center (PCVPC) at Children's Hospital of Philadelphia (CHOP) and the Firearm Injury Center at the University of Pennsylvania (FICAP). In transferring the leadership of the NNHVIP to this Philadelphia collaborative, the Steering Committee recognized that these three organizations have a proven track record of collaboration in youth violence prevention science, practice, and policy. Each brings independent and complementary strengths to this collaborative.

Existing programs that are part of the NNHVIP have developed a range of best practice interventions to engage victims of interpersonal violence in an array of health, human service, education/ employment training services. Frontline field staff of these hospital-based programs help young victims of violence access, engage in, and navigate health and human services as well as criminal/juvenile justice systems before and after they leave the hospital. Such programs have been found effective in linking violence survivors with community-based services and reducing re-injury and criminal activity.[14]

While each of these programs produces positive outcomes,[15] they have identified barriers both external to and within their own programs to providing more positive outcomes, such as "vicarious trauma" experienced by staff members. Within hospital-based violence intervention programs, lack of knowledge about trauma and

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[14] Liebschultz H et a.. 2010. A chasm between injury and care: Experiences of black male victims of violence. Journal of Trauma 69(6):1372.

[15] Becker MG et al (2004) "Caught in the Crossfire: the Effects of a Peer-based Intervention Program for Violently Injured Youth." *Journal of Adolescent Health:* 2004; 34:177-183.

[16]Cooper, Carnell MD; Eslinger, Dawn M. MS; Stolley, Paul D. MD. "Hospital-Based Violence Intervention Programs Work." *The Journal of Trauma: Injury, Infection, and Critical Care*: September 2006 - Volume 61 - Issue 3 - pp 534-540.

[17]Shibru, Daniel MD, MPH; Zahnd, Elaine PhD, Becker, Marla MPH, Bekaert, Nic MSW, Calhoun, Deane MA, Victorino, Gregory P MD, *Benefits of a Hospital-Based Peer Intervention Program for Violently Injured Youth,* Journal of the American College of Surgeons 2007;205: 684–689.

can often mimic the traumatic experiences that have proven so harmful to the clients served.[19]

Again I fully believe that such interventions are effective and are a critical component of healthcare for this vulnerable population. The greatest challenge to the success of these programs is the lack of funding support. I also fully believe that healing is possible by addressing the trauma that our young men and boys have encountered.

[21]Rich, J, et al (2009). *Healing the Hurt: Trauma-Informed Approaches to the Health of Boys and Youth Men of Color.* Center for Nonviolence and Social Justice at Drexel University Schools of Public Health and Medicine, Philadelphia. (p. 21)

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OF THE NATIONAL ASSOCIATION
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**EDUCATION COMMITTEE TESTIMONY
BEFORE THE HOUSE DEMOCRAT POLICY COMMITTEE
JUNE 13, 2013**

The Education Committee of the Pennsylvania State Conference of NAACP Branches is grateful to the House Democratic Policy Committee for holding public hearings on Youth Violence as a Public Health Epidemic. We commend the members for intensifying the advocacy for violence prevention, and we are pleased to participate in this event as the Committee seeks to understand this tragic scourge that for too long has plagued the Commonwealth of Pennsylvania to the extreme. Pennsylvania must develop a clear and attainable vision for a violence prevention agenda that is appropriate for the circumstances at hand. It is our hope that these hearings will leverage increased political will and increased resources to address the victimization of youth.

Nearly thirty years ago, former Surgeon General C. Everett Koop declared violence as a public health issue to which the science of public health should be applied. The violence increased. Thirteen years ago, former Surgeon General David Satcher issued a report declaring youth violence as a public health epidemic. He called on Federal, state, local and private entities to invest in research with the aim to develop intervention programs.

As defined by the Centers for Disease Control and Prevention (CDC):

> Violence is the intentional use of physical force or power, against another person, group, or community, with the behavior likely to cause physical or psychological harm. Youth violence refers to harmful behaviors that can start early and continue into young adulthood. The young person can be a victim, an offender, or a witness to the violence. Youth violence includes various behaviors. [It] typically includes persons between the ages of 10 and 24, although pathways to youth violence can begin in early childhood. Some violent acts—such as bullying, slapping, or hitting—can cause more emotional harm than physical harm. Others, such as robbery and assault (with or without weapons) can lead to serious injury or even death... Acts of violence can disrupt the learning process and have a negative effect on students, the school itself, and the broader community. Examples of violent behavior include:
>
> - Bullying
> - Fighting (e.g., punching, slapping, kicking)

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- Weapon use
- Electronic aggression
- Gang violence [1]

A meta-study of universal school based violence and aggression prevention programs was reported out in the August 2010 publication of the CDC Morbidity and Mortality Weekly Report (MMWR). The Report yielded the following conclusions.

> U.S. schools provide a critical opportunity for changing societal behavior because almost the entire population is engaged in this institution for many years, starting at an early and formative period. ... this opportunity is difficult to overestimate. The potential benefits of improved school function alone are notable. The broader and longer term benefits in terms of reduced delinquency and antisocial behavior are yet more substantial. Universal school-based violence prevention programs represent an important means of reducing violent and aggressive behavior in the United States. The findings of this review suggest that universal school-based violence prevention programs can be effective in communities with diverse ethnic compositions and in communities whose residents are predominantly of lower SES or that have relatively high rates of crime.[2]

Because of the conclusions drawn in this MMWR, in preparation for today's Hearing, PA NAACP Education Committee spoke with a number of school administrators, counselors, teachers and students concerning youth violence in general and the school's role in violence prevention.

Input from the administrators was consistence across socioeconomic settings both urban and suburban. Among other things, the administrators shared the following.

- They cannot address the needs of the victims of youth violence, chaotic homes, or community violence without the school counselor as a resource.
- School counselors deliver the anti-bullying programs.
- School counselors coordinate school-wide support for distressed students.
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[1] Centers for Disease Control and Prevention (Available on-line June 6, 2013) http://www.cdc.gov/violenceprevention/youthviolence/schoolviolence/index.html;

[2] CDC Morbidity and Mortality Weekly Report. August 10, 2007. (Available on-line June, 10,2013) http://www.cdc.gov/mmwr/pdf/rr/rr5607.pdf.

- There is no predicting who among the school staff may become the trusted person for a child.

- Schools need after school programs to engage students in positive opportunities that build social skills, life skills and self esteem.

Input from school counselors was consisted across socioeconomic settings both urban and suburban. Among other things, they shared the following:

- They need time with students dedicated to:
- Grief groups
- Divorce groups
- Anger management groups
- Life skills and social skills groups
- Problem solving skills

Input from students was consistent across socioeconomic settings both urban and suburban. Among other things they shared the following.

- Children learn to be violent from the adults around them.
- Peer pressure is a form of bullying.
- Guns need to be controlled and no one should have a gun in a school building.
- Schools should have afterschool programs that interest the students that attend them.
- Schools have to have counselors and even therapists. There have to be grief groups, anger management groups, problem solving groups and social skills groups.
- Police should monitor areas where youth frequent - not to arrest people, but to prevent misbehavior.
- Sometimes family difficulties or fear of other things interferes with the ability to focus in class or to make sense of what is being taught.

Clearly, we must all be concerned about the physical, emotional, social, and economic consequences of youth violence. Homicide is a leading cause of death among youth aged 10–24 years in the United States. As well, violence on the whole results in many nonfatal injuries among youth. For example during 2001

alone over 700,000 young people aged 10–24 years were treated in emergency departments for nonfatal injuries sustained from assaults.[3]

At the same time, as we grieve over the loss of lives and of human potential caused by murder; and while we are aware of the horrific and boundless psychological and emotional trauma stifling our society because of these occurrences; youth violence encompasses much more than homicide and occurs across every ethnicity and both genders. It is often interpersonal. It is often self-directed. We must be clear that we are referring to acts such as date rape, cyber-assaults, intimate partner violence, all forms of bullying, and to suicide as we hold these discussions. Furthermore, we must be aware that witnessing violence is an indirect form of victimization that can also result in lasting trauma.

We must be aware and acknowledge the link between the level of adversity experienced by youths and the acts of violence that concern us. Among the social determinants of violence are poverty, economic inequality, unemployment, poor adult monitoring, and social norms.[4] These social norms are often related to attitudes concerning gender, class, and/or ethnicity.[3]

As well, there is evidence of a strong relationship between levels of violence and factors which can be modified through just and fair policies and laws. These factors include: economic inequality, access to fire arms, access and harmful use of alcohol, poor monitoring and poor parental supervision of children.[5]

The Office of Juvenile Justice and Delinquency identifies six areas of concern that serve as predictors to the propensity for violent behavior. These include anti-social activities, academic performance, attitudes and beliefs, relationship with family, relationship with friends, self-concept, and social and cultural enrichment. In an effort to forestall the potentially negative impact of the powerful combination

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[3]Centers for Disease Control and Prevention (Available June 6, 2013) (http://www.cdc.gov/ViolencePrevention/youthviolence).

3 Global Campaign for Violence Prevention, Violence Prevention Alliance. Plan of Action 2012 - 2020

[5] Global Campaign for Violence Prevention, Violence Prevention Alliance. Plan of Action 2012 - 2020

of these social determinants, Congress passed the Juvenile Justice and Delinquency Prevention Act of 1974 which created JUMP, the Juvenile Mentoring Program.[6] The Office of Juvenile Justice and Delinquency has provided in its publications, evidence informed materials concerning mentoring as a powerful deterrent to the committing of acts of violence by adolescents.

During September of 2011, 300 violence prevention experts from over 60 countries agreed to a set of policy, legal, and program delivery goals and to a plan of action. Developed by the Violence Prevention Alliance for the Global Campaign for Violence Prevention, the plan presents goals which are: to increase the priority of evidence-informed violence prevention as a global public health and development issue; to build the foundation for violence prevention; and to implement violence prevention strategies. This plan is intended to support the achievement of these goals by the nations of the world.

What are the recommendations of the Global Campaign for Violence Prevention?

According to the Global Campaign for violence Prevention, evidence informed violence prevention strategies include:

- Parenting support and resources for high risk parents.
- Preschool education and early family support,
- Life skills training for high-risk children and adolescents,
- Changing of social and cultural norms that support violence along with strengthening non-violent norms,
- Reduction in access to and harmful use of alcohol,
- Implementation of evidence informed measures to reduce risk of firearms-related deaths and injures,

- Services and resources for both victims and perpetrators aimed at mitigating the consequences of violence and reducing its recurrence.

The Global Campaign asserts that interpersonal violence can be prevented. This is doable, they say, if we will tackle: "economic and gender inequalities, firearm and alcohol availability, poor schooling and unemployment, parental abuse and neglect, and dysfunctional families."[7]

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[6] Office of Juvenile Justice, Bulletin October, 2009.

[7] Global Campaign for Violence Prevention, Violence Prevention Alliance. Plan of Action 2012 – 2020. p. 6

Any approach to violence prevention must be evidence-informed and must include:
A focus on prevention,
Enhanced services for victims and perpetrators of violence,
A focus on human rights such that the vulnerable are included in decision-making,
A life course perspective that recognizes the need for prevention and intervention at all stages of development,
An intersectoral approach across agencies, levels of government and civil society organizations.[8]

The PA NAACP through its Education Committee stands with the current recommendations from the Pennsylvania's Commission on Children and Families. This Commission was established by Executive Order in 2003 to support the Governor's Cabinet on Children and Families. Its role is to "to assist, advise, and make recommendations for actions to the Governor and Children's Cabinet on various cross system issues, and one of the priority areas was to help improve the delivery of state and local services to children and families".[9]

We agree with the Commission's declaration that, "Reducing youth violence is critical to the well-being of youth and all citizens of the Commonwealth".[10] Shockingly, while there are states in this country where very few youth homicides occur, over the years, Pennsylvania has repeatedly ranked number 1 of the 50 states in the rate of youth homicides. Youth homicides are not a normal condition in all regions of the country.

What is the Pennsylvania's Commission on Children and Families recommendation to address Youth Violence?

The Commission has recommended an approach that is comprehensive in its application. They call for "strategies to prevent, intervene early, intervene on the streets (after-school and community-based programs) and in schools, mobilize communities, and strengthen law enforcement and gun laws".

Specifically, for prevention strategies, the Commission states:

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[8] Ibid.
[9]

Govenor's Commission for Children and families. Recommendations. (Available on-line June 9, 2013) http://www.pachildren.state.pa.us/portal/server.pt/community/pa_children/371

- We recommend permanent prevention innovation funding for communities to implement locally agreed to programs from a menu of proven or promising programs.
- We recommend that the Governor and the General Assembly support proven programs that prevent youth violence.
- We recommend the Commonwealth support programs that focus on improving the conditions of youth of color, particularly African American males.
- We recommend extending the use of the "Restorative Justice and Practices" approach, informing decision makers and citing the successful implementation in Pennsylvania communities and schools.

Specifically, for intervention strategies, the Commission states:

- We recommend that the state promote the use of and disseminate information about proven programs and best practices for programs that aim to intervene at the early signs of violent or anti-social behavior.

Specifically for the street interventions, meaning community based programs and in-school and after-school interventions, the Commission states:

- The State should fund and encourage proven and meaningful street intervention efforts that divert youth from violence, promotes inter community peace and helps youth contribute to the well-being of their community rather than destroy or detract from the best interests of the community.

Specifically for Community Mobilization, the Commission states:

- We recommend that the state provide funding for creative local Youth Crime Prevention Councils that engage community leaders to understand and address these problems.

- We recommend that the state promote the establishment of school and community partnerships to prevent youth crime.

- We recommend that the state advocate for restoration of state funding (Safe Schools Act, Office of Juvenile Justice and Delinquency Prevention) to at least the levels initially legislated as well as federal funding (Safe and Drug-Free Schools and Communities Program, SDFSC) that has helped schools establish safer school environments.

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Specifically in the way of Sound Law Enforcement and Strengthening Gun Laws, the Commission states:

We recommend that the Governor and General Assembly enact legislation to address the growing statewide trend of violence caused by handguns.

How are state law makers positioning Pennsylvania to deal with the homicides, suicides, physical assaults, rapes, cyber-assaults and social conditions that plague our youth?

The House Democrat Policy Committee hearings on youth violence as a public health epidemic have come at a crucial time. As is clear from the evidence based conclusions presented by the Global Campaign for Violence Prevention; firearms, alcohol, and poor schooling are causative factors in the perpetration of violent acts. The relationship among firearms, alcohol and self-violence and suicide is especially noteworthy given that Pennsylvania has a formal suicide prevention plan. Hence the current discussions in the Pennsylvania General Assembly about firearms regulation, about liquor privatization, and about school funding, aligns perfectly with discussion about violence prevention.

The evidence shows that in order to prevent violence you must have firearms regulation. You must control access to alcohol. You must have early childhood education. You must have good schooling. Universal school based programs work. These understandings must inform the policy and law that you create as law makers.

It will be a sad footnote to history if this present legislatures' claim to fame is that the policies and laws you created supported and facilitated the continuing slaughter of the children under you watch and keep.

Thank you for this time. I am happy to answer questions pertaining to this topic.

Respectfully submitted on behalf of the PA NAACP Education Committee,

Joan Duvall-Flynn, Ed.D.

Mission The Mission of the Father's Day Rally Committee, Inc. (FDRC) is to promote positive action and interaction among individuals to prompt more aggressive hands efforts toward resolving a range of problems confronting African Americans communities in Philadelphia and the Delaware Valley..

How Since 1989 the FDRC has been committed to reducing violence in the minority communities affected by a myriad of social ills. Men working together at the grassroots level can launch a meaningful attack on the negative attitudes which contribute to the destruction of families and neighborhoods.

So we are encouraged by this legislation because it recognizes one of our long held beliefs that youth violence is Pubic Health Issue, and more recently it has reached epidemic levels.

When we consider the threatening situations that confront those public servants on the front lines, like our police and military, we honor and take care of them because of the physical and mental trauma they experience. We recognize that their dangerous daily engagements create a great need for professional medical and psychological services. These are our fellow citizens who are in what we rightfully call a dangerous line of work.

Now let's consider those citizens who through no fault of their own live in dangerous communities, communities in which they face the very same traumas. Those who hear gun shots and teach their young to drop to the floor in their own home, those who have lost a love one or a friend through violence, those who have witnessed an act of violence, and those who have been physically injured by violence. They need your help and this legislation represents a first step. Thank you.

Youth Violence as a Public Health Epidemic

Testimony by Dorothy Johnson-Speight, MHS, LPC

Founder & Executive Director, Mothers In Charge

Good morning. My name is Dorothy Johnson-Speight. I am the Founder and Executive Director of Mothers In Charge. Mothers In Charge is a grassroots community-based organization working to reduce violence in our community. I founded the organization in May of 2003 after the death of my only son, Khaaliq Jabbar Johnson, who was shot to death over a parking space. Mothers In Charge is a group courageous mothers that are working on the front lines every single day to address the issue of gun violence, especially among our youth.

Although it's been several years since Khaaliq was murdered, not a day goes by that I don't think of him. To have a loved one murdered is a pain that there are no words to adequately explain or describe. There are many of us that live with this kind of pain across this country. But more importantly, today, there are so many of us that live in fear—live in fear that our children, especially our male children, will not live to see 25.

I was always aware of those awful stats—those numbers that say African American males 14 to 24 may not live to see their 25th birthday. I actually remember when my son Khaaliq turned 24 that June. I thought, "Wow, he made it. He beat the odds." Six months later, at the age of 24 ½, Khaaliq was dead. Shot to death. This is a pain that I live with every single day. I live with the pain, but I also live to make a difference every single day so that other mothers and fathers and families don't have to live with this.

In Philadelphia last year, there were 334 homicides. Of that 334: 293 were male; 239 were black; and 104 were between the ages of 14 and 24.

What we must remember is that violence affects us all directly or indirectly. Unfortunately, I am not alone in experiencing this pain and trauma—not even close. Many more will suffer and many more will die if we do not take collective action. We must not sit mute on this issue.

As Representative Ronald Waters has stated, the prevalence of violence in our communities is truly an epidemic. Every day when you turn on the news, without fail, there are reports about killings, shootings, or even massacres and mass shootings. The biggest threat to our citizens is not from abroad or from terrorists. The biggest threat comes from within our borders, from our own youth who have become accustomed to using violence, leaving behind a trail of victims and broken families. Our government has poured trillions of dollars into our military to fight foreign wars when, in reality, there is a war to be fought here at home, on this soil.

This senseless killing has gone unchecked for too long and threatens to devastate our communities on physical, social, emotional, and economic levels. I started Mothers In Charge to combat the spread of this epidemic of violence. We had hoped to go out of business—we don't want more mothers, sisters, grandmothers, aunts to need our services because they have lost a loved one senselessly—because someone had access to a gun and no reservation about using it to take human lives.

A report by the "Law Center to Prevent Gun Violence" cites that gun violence leaves over 100,000 people injured or killed every year in communities nationwide. Our phone rings each day with calls from families devastated by youth violence seeking support. People die by guns every single day. Those that survive are left to deal with physical and emotional scars that will last a lifetime—and I know personally about those emotional scars.

Youth violence is perpetrated both by and against young people. According to the Center for Disease Control (CDC), homicide is the second leading cause of death among 15- to 24-year-olds. In this age group, homicide is the number one cause of death among African Americans and the second leading cause of death among Hispanic Americans. The CDC reports that of homicide offenders in 2000, approximately 47% were 24 or younger, and 9% were younger than 18. This is truly a health epidemic. And it is not some incurable disease—it's homicide.

We need to change the way we approach violence among our youth, which is predominantly reactive. The damage has already been done, whether a life is lost or a life is changed forever as our youth are incarcerated, locked away with little hope for a future. What we desperately need is to support policies and identify effective programs that will prevent youth violence. Mothers In Charge has taken an active role in these efforts through violence prevention, advocacy, and intervention.

We will never win the fight against violence unless we stop focusing on individuals and start looking at the broader social and economic factors that promote and sustain cultures of violence. We need to realize that none of us are safe until we work collectively and on a large scale to prevent violence at its source. It's clear that we need to change our strategy, which has been primarily reactionary and focused on punishment and criminal justice. Punishment alone is not effective in addressing the problem. We need to make efforts to stop crime by investing in prevention. The Institute of Medicine recommends a public health approach to violence, which involves three elements: a focus on prevention; a focus on scientific methodology to identify risks and patterns, and extensive collaboration to address the problem.

It is also important to realize that there is a cost of violence that extends well beyond its impact on victims and their families—for example, there is a great financial burden on local economies who are left to foot the bill for medical costs for those who are treated in emergency departments for injuries related to violence. Not to mention the impact on communities of losing what should be their most precious gifts, our youth. Our youth 14 to 24 that are dying, and too many in our community, too many in society are mute on this devastating issue.

I thank Ronald Waters and those elected officials that see the importance of this issue and are working to make a difference. At Mothers In Charge, we stand ready to support these efforts, and we will do anything in our power to reduce violence and save our youth and communities.

Pennsylvania House of Representatives
Democratic Policy Committee Hearing
on Youth Violence as a Public Health Epidemic
Harrisburg, Pennsylvania
June 13, 2013
Testimony of © Betty Lee Davis, Ph.D., LCSW

Good Morning, Pennsylvania House Democratic Policy Committee

I am Dr. Betty Lee Davis, and I am deeply honored and grateful to be here today. Before beginning my testimony, I would like to thank the Pennsylvania House of Representatives, and you as members of it, for its nearly unanimous support of House Resolution 191, declaring youth violence a public health epidemic and supporting the establishment of Statewide trauma-informed education. That is a landmark achievement. I thank Representative Waters for carrying forward the message brought to the House in the testimonies given by Dr. Joan Duvall-Flynn and me in the summer, 2011, that provided the information for the Resolution. I thank the House Education Committee, Pennsylvania Legislative Black Caucus, House Health Committee, and House Democratic Policy Committee for moving it forward.

I am a Licensed Clinical Social Worker at the Ph.D. level with many years of experience providing behavioral health services to children, adolescents, families, individual adults, and couples in a variety of behavioral health settings and range of capacities with evolving expertise in trauma-informed behavioral health care and demonstrated commitment to the establishment of policy requiring that youth violence be treated as a public health epidemic and Statewide trauma-informed education.

Testimony Introduction

By the color of my skin, I represent the majority. In my heart and through a lens created by the stories of heart wrenching grief of mothers and others at Mothers In Charge, a violence prevention and advocacy organization, where I provide grief support to those who have lost a loved one to murder in the City of Philadelphia, I speak for the minority. I thank Mothers In Charge Founder and Director, Dorothy Johnson-Speight, for opening the door to Mothers In Charge to me, for the endless opportunities to grow and develop in my understanding of and knowledge about the consequences of youth violence and homicidal grief on individuals, families, and the community and for the many ways she has inspired me. I am pleased to say that she is here to give testimony today.

After years of providing what might be considered *palliative* care to those suffering the anguish that accompanies homicidal grief and advocating for violence prevention, I realized that to bring the relief that victims of youth violence need to heal more fully, I needed to move beyond *service* and *advocacy* to *activism*, as activism goes *beyond providing care and empowering others* to *changing the status quo.* I am here today to appeal to you, Democratic Policy Committee, to *change the status quo* that has allowed the youth violence epidemic to go untreated for over three decades, despite three former Surgeon Generals declaring it a crisis and public health epidemic, and to generate policy that will allow communities permeated by

violence to heal. I am here to appeal to you to let the Commonwealth take the lead in putting a stop to youth violence by creating policy acknowledging youth violence as a public health epidemic and requiring public health intervention for its treatment.

Summary of House of Representatives Education Committee Informational Meeting and Pennslyvania Legislative Black Caucus Flashmob Hearings Testimonies

As a Pennsylvania State Conference NAACP Branches Education Committee Member, I was invited by its Committee Chair, Dr. Joan Duvall-Flynn, to give testimony before the Education Committee of the House of Representatives at its Informational Meeting at Temple University in July, 2011 and within weeks, before the Philadelphia Delegation of the Pennsylvania Legislative Black Caucus at its Flashmob Hearings at St. Joseph's University in August, 2011. I thank Dr. Flynn for including me on her education advocacy journey and for being my policy-activist mentor. Her testimonies are well known to the Pennsylvania General Assembly, and as surely as the sun rises, she is, or will be, here to give testimony to you today.

For your reference, I have submitted the full text from those testimonies in this testimony's appendix. What follows is a condensation of those testimonies into a summary of key elements, presented in the present tense as the testimonies were then.

> Youth are killing each other in a war on the street as a cry for help with society's doors closed to them and guns flowing freely on the streets, keeping open the revolving prison door. (www.facesofcouragebook.com). These youth are injured, not bad (www.sanctuarymodel.com). They are demoralized (Frank, 1961; Frank and Frank, 1991). They are suffering from chronic social breakdown, from soul sickness. *Flashmob* is taking their cries to another level—to the level of the powerbrokers. Youth are killing each other in a cry for help, and no one is listening to their cries. No value is assigned to their lives. If they take their cries into the community of the power brokers, maybe someone will hear, if not to assign value to their lives, to protect commerce. *And indeed, someone did hear.* These hearings were scheduled within two weeks of their crossing the power line. A manifestation of institutional racism (Davis and Speight, 2008), youth violence was declared a public health epidemic over twenty years ago by two Surgeon Generals (www.surgeongeneral.gov/library/youthviolence/report.html), but it has not been treated like a public health epidemic. Very specific, universal protocols go into place when there is an epidemic. Emergency measures are taken to contain the epidemic and prevent its spread. Victims of violence develop Post Traumatic Stress Disorder (PTSD). It is a medical disorder (American Psychiatric Association, 1994). PTSD is medical terminology for *shell shock.* © (Davis, 2011). These youth are in *shell shock* © (Davis, 2011). Communities permeated by violence are in *shell shock* © (Davis, 2011). Children and adolescents in communities permeated by violence are going to school in shell shock. Unlike adults who relive trauma through flashbacks with PTSD (American Psychiatric Association, 1994), children and adolescents relive trauma through behavioral reenactments (American Psychiatric Association, 1994). They do to another what was done to them or what they witnessed. That is how violence spreads. They are reenacting the homicides surrounding them by killing each other. It is contagious. It is a universal

psychological mechanism of defense, grounded in psychoanalytic theory. The public health system has not responded to youth violence as a medical disorder. It is a medical disorder that requires a trauma-informed, medical response. This epidemic is a perfect, naturalistic research design. It is not the adults who are killing each other. They are having flashbacks (American Psychiatric Association, 1994). They become disabled, frozen, and immobilized. Just as PTSD theory states. It is the youth who are killing each other. They are doing behavioral reenactments. This epidemic requires a universal, trauma-informed, public health, medical response.

As Dr. Flynn and I were walking down Broad Street across from Temple University after the first of these testimonies, I heard someone hollering my name, "Dr. Betty, Dr. Betty, " which is how I am known at Mothers In Charge. I turned and saw two women running after me, one was a new volunteer at Mothers In Charge, and she said, "Dr. Betty, this is my sister. We have just been to the funeral home. Her son was shot and killed." After we had spent some moments with them listening to their anguish, as we were leaving, I turned to Dr. Flynn and said, "If this is not a sign of an epidemic, to have two women, one whom I hardly know and the other I didn't know, running after me on the street calling out for help in their anguish, I don't know what would be. Right after this testimony about youth violence as a public health epidemic. This is almost Biblical."

What I saw as I developed the first testimony crystallized and became even clearer to me in the second. In the second, I restated and refined what I came to see in the first and expanded its calls to include a verbal charge to the Philadelphia Delegation to call on the public health community to intervene in the youth violence epidemic. I said there are three leading, public health youth violence and trauma authorities right here in Philadelphia. I charged the Delegation to call on them. These were education advocacy testimonies, and I called on them to create a commission to study childrens' educational needs using Sandra Bloom's Sanctuary Model TM (www.sanctuarymodel.com). Whether or not they did, I don't know, but what I do know from events I have attended and announcements on my email, is that the public health community is moving, and it is moving fast. That is good news. I am pleased to say that those three leading authorities are here to provide testimony today. They are Doctors Rich, Corbin and Bloom.

Flurry of Activity—All Good News

Locally, in the Spring, 2012, Philadelphia Magazine published an article on youth violence in Philadelphia, likening its effects to the PTSD experienced by war veterans. In August, 2012, the Philadelphia Inquirer announced that Dr. Bloom would be addressing 500 principals in the Philadelphia School District. In February, 2013, one of Dr. Corbin's "Healing Hurt People" patients was interviewed in a documentary, "This American Life," by Chicago reporter Alex Kotlowitz, demonstrating that the PTSD symptoms that war veterans experience and what children exposed to violence experience are the same. In March, 2013, Dr. Rich presented a powerpoint entitled "Viewing Urban Violence through the Lens of Trauma: A Public Health Approach to Healing." In May, at Mothers In Charge first national conference, the Commissioner of Behavioral Health in the City of Philadelphia presented a new community-based intervention for trauma model.

Nationally, early in 2013, the Report of the Attorney General's National Task Force on Children Exposed to Violence was released based on hearings and testimonies conducted and collected during 2012 from around the nation. Its recommendations focus on "ending the epidemic of children exposed to violence." In April, 2012, the Johns Hopkins University School of Medicine, the Johns Hopkins Bloomberg School of Public Health and Department of Mental Health held it "First Annual Symposium on Childhood Sexual Abuse: A Public Health Perspective." Also, in April, 2012, the Institute of Medicine held a workshop on "The Contagion of Violence." In November, 2011, Dr. Bloom presented a powerpoint on "Childhood Trauma and Public Health" at the United Way's *Healthy Parenting Initiative*, expanding her focus on trauma associated with physical and sexual abuse in residential treatment, the schools, and the workplace to include violence and the community. Internationally, in November, 2011, Dr. Bloom and Dr. Corbin were on a panel entitled "Trauma-Informed Approaches to Public Health Problems: Lessons from the City of Brotherly Love" at the Annual Meeting of the International Society for Traumatic Stress Studies.

This is all very good news.

Reconceptualizing the Youth Violence Epidemic as a Medical Disorder in an Untreated Public Health Epidemic

Youth exposed to violence are at risk for Posttraumatic Stress Disorder (American Psychiatric Association, 1994). Those exposed repeatedly or to multiple forms of violence are at risk for developing complex stress disorder. Posttraumatic Stress Disorder is a medical disorder classified as a behavioral health disorder. Its treatment requires trauma-informed behavioral health intervention. Until now, the primary youth violence intervention has focused on law enforcement. While law enforcement is still necessary to ensure safety, law enforcement is not the primary intervention for treating a medical disorder. With posttraumatic or complex stress disorder, the overuse or improper use of law enforcement can be harmful rather than helpful, as it involves the risk of re-traumatizing already traumatized youth.

Conceptualizing youth violence as a medical disorder, confirmed by its classification in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders Edition IV, leaves no room for questioning the need for intervention. How can a bacterial epidemic, like tuberculosis, be allowed to go untreated? It can't. Failure to treat a medical disorder creates liability. Failure to treat youth violence as the medical disorder it is, after being declared an epidemic by three Surgeon Generals, not only two, since 1979, creates social. medical liability.

What positioned me to see reconceptualize the youth violence epidemic as a medical problem was a case that I had in my community-based, clinical practice in the months preceding the testimonies in the summer of 2011. It was the case of a twelve year old male who had been exposed to domestic violence while his mother was living with his father whom she had left several weeks before the referral. He and his sister were adjusting well in their new environment living with mother and her parents with court ordered supervised visitation with father away from his home. The domestic violence exposure involved another family member's violence toward mother and father. Two months later, the court lifted the supervised visitation and he and his sibling began visiting father in the trauma environment which led to an immediate

regression. When I consulted with the psychiatrist initially about the change, he thought it was a self-calming technique taught to developmentally disabled children, which he was, until I arrived one day and he refused to come out of his grandparents bedroom. I normally wouldn't go to the bedroom but on this occasion, it was necessary. I found him very disheveled in his appearance and disorganized in his talk until reenacted a trauma scene with his father being thrown against the wall. Then, it became clear. He was going into dissociative states. Increasingly, he would go into states where he walked and talked like the abuser and his talk was marked by violence. Dissociative states are a common defense mechanism used in posttraumatic stress disorders. When in those states, he was taking on the identity of the abuser. When I confirmed this with the psychiatrist, I provided that information to the family. I said that the court had lifted the supervised visitation and sent him back into the trauma environment which was like sending him back into an environment where he had contracted a disease, putting him at risk for getting the disease again. Months had passed since the supervised visitation had been lifted. The judge ordered emergency assessments and told her that they would return to court after the assessments for the judge to decide whether to allow unsupervised visitation or return to supervised visitation. They went for the assessments and no court date was set to return. The grandmother, who carried out certain tasks as his mother also had a developmental disability, contacted the lawyer with this new diagnositic information. The lawyer had them back in court within days. A new judge orderd a return to supervised visitation. At this point, I adapted Sandra Bloom's Sanctuary Model TM to use with him and the family. Very quickly, he restabilized.

From this clinical experience, I learned the power of correctly applying the use of a medical disorder to effect corrective action. That is the lens that I brought to my testimonies that enabled me to see the power inherent in applying the correct diagnosis to the youth violence epidemic to effect change at the community level and to call for policy intervention to secure public health treatment of it. Establishing how to treat it as a medical disorder in a public health epidemic will require the coming together of a wide range of perspectives with multiple levels of intervention but getting the diagnosis correct is the first step. Treatment interventions will flow from there.

Project Rescue and Restore SM—Three Levels of Youth Violence Epidemic Community Intervention: Immediate, Intermediate, Long Term

The youth violence epidemic requires a three step intervention at the community level levels of intervention: (1) immediate/emergency intervention, (2) intermediate trauma treatment, and (3) long term policy. Establishing policy is the desired but long term response to an epidemic in need of immediate/emergency interventions and intermediate trauma treatment to reduce or eliminate the wave of casualties during the long term policy process. Project Rescue and Restore SM is a response to that need at the immediate/emergency and intermediate trauma treatment intervention levels while the longer term policy intervention moves through the legislataive process.

Through its nearly unanimous adoption of House Resolution 191 declaring youth violence a public health epidemic and supporting the establishment of a Statewide trauma-informed education system, the Pennsylvania House of Representatives has taken an unprecedented step to raise awareness of youth violence as a public health epidemic requiring

the application of the public health epidemiological model to its treatment. By shifting the focus from viewing youth violence as a reflection of "bad behavior" in communities permeated by violence to a "social ill," untreated posttraumatic stress disorder in adults or complex stress disorder in youth, it redirects the primary intervention from law enforcement to medical treatment.

Support of the Resolution is a landmark achievement and a first step toward establishing policy for a more effective response to treating youth violence. These hearings are a laudible second step. Local, Statewide and national statistics document the failure of treating youth violence by law enforcement alone; however, the legislative process is slow. If this first step succeeds in achieving its desired end to effect policy requiring that the public health epidemiological model be applied to youth violence, it will take time for it to achieve its desired goal. In the meantime, hundreds of lives continue to be lost to the war on the streets in this wave of youth violence in the Commonwealth and around the nation.

Since August, 2011, when I first conceived of Project Rescue and Restore SM, an estimated 568 lives have been lost to homicide as causalities of an untreated epidemic in the City of Philadelphia alone. Add to that, the number of causalities from similar communities around the nation, and the tragic figure is astounding. Despite three Surgeon Generals declaring violence as a public health epidemic beginning almost 35 years ago, focusing specifically on youth violence in 2000, there was no policy put into place to support the declarations which has left it untreated at the national level as a public health epidemic. Without policy to support the declarations, youth violence has continued to spread, as epidemics do, with the number of causalities rising daily and nationally exceeding the number of casualities lost in recent wars.

Two models were employed that were highly successful in achieving a reduction in the rate of homicide: (1) the Boston Model described in Murder is No Accident (Prithrow-Stith, Spivak, 2004) with no juvenile homicides for almost three years and (2) the Child Development and Community Policing Program which was a collaborative partnership between the Yale Child Study Center, New Haven Police Department, and clinicians and other social service agencies (personal communication, Marans, 2007). Both of these programs were highly effective in responding to youth violence at the community level but no longer exist. Without policy to keep successful programs in place, valuable treatment resources and more lives are lost.

Getting the victim to safety is the first requirement in trauma treatment (Marans, 2007; Gentry, 2013). In communities permeated by violence, nowhere is safe. Even with other levels of trauma treatment in place, healing cannot begin until safety is secured.

Method

Create Safety

1. Federal Declaration of War Zones Meeting Youth Violence Epidemic Criteria—Presidential use of Executive Order in State of War to Restrict Guns, Employ Law Enforcement to Protect Witnesses
2. Deployment of the National Guard or Homeland Security, with trauma-informed consultation to avoid community retraumatization, to Create Safety in War Zones

Apply Public Health Epidemiological Approach

1. Federal Declaration of Public Health Epidemic—Surgeon General Applying Public Health Methodology to Posttraumatic/Complex Stress Disorder Spreading Violence through Violence Reenactment Resulting from Childhood Violence Exposure and Adverse Childhood Experience in War Zones

Intervene at Three Levels of Community Intervention: Immediate, Intermediate, Long Term

1. *Immediate*-Emergency Medical Intervention for Victim; Emergency Trauma Intervention for Victim, Family, Immediate Community
2. *Intermediate*—Establish trauma units without walls for victims in war zones based on VA trauma unit model
3. *Long Term*—Create violence intervention/prevention policy across systems and funding streams to support it

Pennsylvania Democratic Policy Committee Charge

1. Transform War Zones into Safe Zones (Waters, personal communication, 2013) Protecting the public from bacterial epidemics does not require long term policy process. Emergency measures are put into place once an epidemic is declared. As a legislative body, appeal to the President to declare communities permeated by violence meeting established criteria as War Zones and use the power of his office in time of war to order gun restrictions in those communities to get guns off the streets and provide witness protection through law enforcement (Domzalski, personal communication, 2012). The youth violence epidemic has characteristics of war and of an epidemic with an interactive effect. One causes the other.
2. Develop a bill declaring youth violence a public health epidemic and create a commission to study the effective treatments of it at the community level and create a framework for interventions.
3. Consult with former City of Philadelphia Health Commissioner, John Domzalski, regarding the use of law enforcement in a War Zones to restrict guns and protect witnesses.
4. Let the Commonwealth of Pennsylvania lead the way putting policy into place that declares youth violence a public health epidemic and requires the public health epidemiological model using behavioral health interventions, including the more recent biological findings regarding the impact of trauma on the brain, as a focus of its treatment while also, taking steps to address causes related to the social structure

Respectfully Submitted,

Betty Lee Davis

Betty Lee Davis, Ph.D.,LCSW
Youth Violence Public Health Epidemic and
Trauma Informed Education Activist

Notes

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"Schools as Sanctuaries"—Stanwood, Mark and Doolittle, Gina

(www.facesofcouragebook.com) "IN UNISON: The Collective Voice of Mothers In Charge—An Interpretation by Betty Lee Davis, Ph.D."

SUBMITTED BY © Betty Lee Davis, Ph.D., LCSW

Pennsylvania State Conference NAACP Branches: Education Committee

Testimony before the Pennsylvania General Assembly

August 23, 2011

Good Morning, Pennsylvania Legislative Black Caucaus Coalition and Philadelphia Delegation.

I am Dr. Betty Lee Davis, and I am honored to be here today. I am a member of the Pennsylvania State Conference of NAACP Branches Education Committee and take this opportunity to speak out for the youth of the Commonwealth of Pennsylvania and call for a *trauma-informed, universal safe, quality education* throughout the Commonwealth in response to the recent *flashmob activity* in Philadelphia.

I am a Licensed Clinical Social Worker at the Ph.D. level with many years of experience working with children, adolescents, and their families in a variety of behavioral health settings and range of capacities. In recent years, I have provided grief support and other services to Mothers In Charge, a violence prevention, advocacy organization composed of mothers and others who have lost a loved to violence in the City of Philadelphia. After providing what might be considered *palliative* care to those suffering the anguish that accompanies homicidal grief and advocating for violence prevention, I have come to see education advocacy as the natural, next step for me in supporting those who have lost a loved one to homicide as families and youth experience this epidemic of pain and trauma.

Testimony Introduction

By the color of my skin, I represent the majority. In my heart and through a lens created by the stories of heart wrenching grief of mothers and others at Mothers In Charge, where I provide grief support to those who have lost a loved one to murder in the City of Philadelphia, I speak for the minority.

Just this past weekend, a call to action came from within the community of color in Philadelphia to challenge a youth curfew instituted in response to the *flashmob* activity by youth of color in the powerbroker district in the heart of Center City, when, in contrast, no curfew was placed on white youth in a similar youth mob action after the Phillies won the world series. Violence is not to be condoned under any circumstance. Violence must have consequences, but for a City plagued by violence to heal, the consequences must be trauma-informed and must not re-traumatize victims of violence.

Youth curfews may well be needed; however, the use of curfews and community mobilization to *protect the powerbroker community* in response to a *single episode* of youth

violence, when youth violence is almost a *daily occurrence* in *communities of color* with no similar "emergency intervention" put into place, only reinforces the view that it is not their lives that are of value, but commerce. In communities of color in the City of Philadelphia, blood overflows on the streets. Youth are *killing each other in a cry for help* in a society that has failed them, with under-resourced schools and employment doors closed to them and guns flowing freely on the streets, keeping open the revolving prison door.

The youth are crying for your help Legislators. This time *in unison* as *flashmobs*, taking their cries for help into the *community of the powerbrokers* with the hope that, if killing each other has served only to reinforce their experience that society assigns little value to *their* lives, maybe, *flashmobs* will call attention to their cries where they will be heard—in the *community of the powerful.*

This Epidemic : A War on the Streets

To set the stage for my testimony, I would like to read an excerpt from a piece that I was inspired to write for Mothers In Charge first book, *Mothers In Charge: Faces of Courage,* entitled "IN UNISON: The Collective Voice of Mothers In Charge—An Interpretation by Betty Lee Davis, Ph.D.":

> We are mothers wailing at the senseless slaughter of our children. We are mothers riveted by rage. We are mothers aching in our hearts, minds, bodies and souls. *We are Mothers In Charge.*
>
> One by one, we just keep coming, hundreds of us since our grief support meetings began. Meeting after meeting, with every new member, our heads shake in disbelief at the retelling of our story. Each of our stories is unique, but the theme is the same—the senseless murder of our children. *Ours is the Refrain of Mothers In Charge.*
>
> *"Will the floodgates ever close?" we wonder. "Not until the war is over," we answer. "War? What war?" you ask. "There is no war in Philadelphia,.." "Yes", we answer," There is a war in Philadelphia. The war is on streets. Semi-automatic rifles reserved for war flowing freely on the streets declare it, if no one else has." We are the Voice of Mothers In Charge.*
>
> Nobody seems to have *really* noticed, at least not enough to stop it, only we, mothers screaming at the horror of our children being brutalized on the streets, lost to institutions that have failed them. *Ours is the Scream of Mothers In Charge.*
>
> Bought and sold on the streets like bags of candy filled with poison by youth too young to comprehend life's sacredness, guns are only the *symptom* for a generation of our youth. A broken educational system. A broken employment system. A broken economic system. A broken moral system. All are roads leading our youth to the most dangerous dintersection along the "cradle to prison pipeline," the intersection between poverty and race.*

> In this land where opportunity exists for *some, but not all*, society has failed our youth. In a *cry* for help with so many doors closed to them, young black males are killing each other. When society fails to protect them and give them equal opportunities to "learn, grow and flourish,"** all of our children are sacrificed, some as victims, others perpetrators. *All are Children of Mothers In Charge.*
>
> (www.facesofcouragebook.com)

This Epidemic: A Manifestation of Institutional Racism

The Founder and Director of Mothers in Charge, Dorothy Johnson-Speight, often begins her talks with "No one is safe until we are all safe." No one is safe until we are all safe, but some of us are safer than others walking outside of our homes into our communities, and most of us do not have to hit the floors of our homes dodging bullets coming through our windows, as some members of Mothers In Charge do.

Early in my work with Mothers In Charge, as I listened to the stories of those suffering from severe, homicidal grief, a grief unlike any other, and learned more about the needs of black youth entering the juvenile justice system, I saw quickly that this is not a universal problem scattered equally across the social strata. The mothers grieving their loved ones lost to homicide are almost all African American, living primarily in African American communities, in relatively close proximity to where the homicides occur, in the City of Philadelphia. It did not take long for the lights to go on. Very soon, I realized that this is a problem with its roots deeply embedded in our society. This problem is a contemporary manifestation of institutional racism. I was so troubled, and outraged, that I was moved to develop what I observed into a presentation, entitled "The Youth Violence Epidemic as a Contemporary Manifestation of Institutional Racism: Mothers In Charge as an Organizational Antidote," which I invited Ms. Speight to do with me at the Pennsylvania Chapter of the National Association of Social Work's Annual Conference that Spring. (Davis and Speight, 2008)

Demoralization

In his seminal work, *Persuasion and Healing*, (1961), Jerome Frank, well known psychiatrist and psychologist and Professor Emeritus of Psychiatry at the Johns Hopkins University School of Medicine until his death in 2005, coined the concept "demoralization." In its third edition (1991), he and his daughter, Julia, also, a psychiatrist, wrote:

> Dictionaries define demoralize 'to deprive a person of spirit, courage, to dishearten, bewilder, to throw a person into disorder or confusion.' Typically, they are conscious of having failed to meet their own expectations or those of others, or being unable to cope with some pressing problem. They feel powerless to change the situation or themselves and cannot extricate themselves from their predicament. This situation has been conceptualized as a 'crisis' if acute (Korchin,1975) and as the 'social breakdown syndrome' if chronic (Gruenberg, 1974) (see Chapter 12)." Features of demoralization are anxiety, sadness, hopelessness, and low self-esteem. Social support and a sense of community are essential in healing from demoralization.

While those who are demoralized may look to be depressed, they are suffering from *oppression* caused by *externally imposed* situations or conditions.

This Epidemic: Educational Disparity

The cause of the youth violence epidemic is complex. Educational disparity is an extremely significant factor as it not only closes the employment door, but when underfunded, stymies exposure to the possibilities of life. Today, youth who do not have a diploma are at high risk for unemployment but most certainly will face under-employment. Youth who are unemployed are at-risk for taking to the streets. With education, employment and economic doors closed to them, these youth are demoralized and left to the streets, where guns flow freely, to feed the revolving prison door.

Communities Plagued by Violence

The City of Philadelphia is plagued by murder. It is like a trauma unit over run with victims. Everyone is suffering from some form of trauma resulting from this epidemic, if not from *primary trauma* associated with the violent death of a loved one, from *secondary trauma* resulting from exposure to violence permeating the community. What the members of Mothers In Charge are experiencing is *primary trauma,* and it is complicated by *secondary trauma* and *re-traumatization* because they cannot escape the chaos that surrounds them in their community. Not everyone lost a loved one in 9/11, but a whole country was traumatized. That is secondary trauma. Not everyone in Philadelphia has lost a loved one to homicide, but the whole community is reminded daily about homicides through the news, teddy bear memorials, candlelight vigils, victims lying dead on the street, and sirens and bullets roaring through its neighborhoods. That is secondary trauma. Students are reminded that they are unsafe every time they face metal detectors, security guards, and the police. That is re-traumatization.

As recently as a few weeks ago, I spoke with a member of Mothers In Charge whose story I wrote about the murder of her brother for *Mothers In Charge: Faces of Courage*. She said when I called that she was not doing so well as she had heard twelve shots a little while before my call. After the sounds stopped, she said that she opened the door to see what was happening. On the ground, across the street in front of her house, she saw a boy lying dead. She said, "He could have my son." To her left was another boy on a stretcher being put into an ambulance, only to die a short time afterwards. When I saw that member two weeks later at an event, she said she had not left the house since that day. She said that she didn't know what the reason was, but that she just couldn't go outside. I asked if she thought if it had anything to do with what she saw. She said she had not thought about it, but as she thought about it, she thought it was probably the only explanation. That is re-traumatization.

A few days later, in a different, rural community where the children are white and where I provide clinical services, a grandmother told me that when she went to her grandson's school for a conference, she was greeted by a girl being taken out on a stretcher, assaulted by a female peer. The grandmother said that there were security officers "coming out of the woodwork." The grandmother was troubled by what she saw as her own granddaughter had been the victim of an unprovoked assault in her neighborhood by a female peer, several years previously. That is re-

traumatization. Her granddaughter had never been violent, but after the assault, she began assaulting female peers in school unprovoked or at the least sign of provocation, for which she was expelled on multiple occasions and referred to an alternative program. Her granddaughter had been exposed to domestic violence in her home and violence in her neighborhood. She was the *victim of assaul,* and she became the *perpetrator of assaults*. That is behavioral reenactment.

I could not get these stories and the images that they brought to my mind off my mind for days. They kept popping into my mind. When I think of them now as I write, I am still troubled by them. That is secondary trauma.

Take these two stories and magnify them thousands of times over. These are the stories that children carry to school and which can only be addressed by a universal, public delivery environment.

This Epidemic: A Public Health Problem

Webster defines *epidemic* as "prevalent and spreading rapidly among many people in a community at the same time; widespread; said especially of a contagious disease." (Webster, 1960). Those suffering from a contagious disease need treatment, and the disease needs to be contained to prevent its spread. The youth violence epidemic has been declared public health problem (www.surgeongeneral.gov/library/youthviolence/report.html) A problem affecting the public's health is a medical problem. Medical problems require medical treatment, not law enforcement, to heal. That does not mean that there are not situations where law enforcement is required, but law enforcement is not the primary treatment for a medical problem.

Post Traumatic Stress Disorder

Post Traumatic Stress Disorder (PTSD) is the medical condition associated with violence. It is a mental health condition, and the treatment of it must correspond to the diagnosis. Not everyone exposed to violence meets all of the symptom criteria of PTSD, but many, if not most, will experience some of the symptoms. When violence affects the whole community, many of its members are experiencing at least some of its symptoms, and the intervention needs to be at the community level.

Post Traumatic Stress Disorder Criteria

To acquaint you with the symptoms that many, if not all, children are experiencing when they walk through the school building doors in communities permeated by violence, I have selected symptoms most relevant to this testimony form the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders IV (1994):

A. Exposure to a traumatic event in which both of the following were present:

Experienced, witnessed, or was confronted with an event or events that involved

actual or threatened death or serious injury, or a threat to the physical integrity of self or others.

Response involved intense fear, helplessness, or horror. In **children**, this may be expressed instead by disorganized or agitated behavior.

B. Traumatic event is persistently reeexperienced in one (or more) of the following ways:

Recurrent and intrusive distressing recollections of the event including images, thoughts, perceptions. In **young children**, repetitive play may occur in which themes of the trauma are expressed.

Recurrent distressing dreams of the event. In **children**, dreams may be frightening without recognizable content.

Acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes,including those that occur on awakening or when intoxicated). In **children**, trauma-specific behavioral reenactment may occur.

Intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.

Physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.

C. Persistent avoidance of stimuli associated with trauma and numbing of general responsiveness (not present before the trauma), as indicated by three (or more) of the following:

Efforts to avoid thoughts, feelings, or conversations associated with the trauma.

Efforts to avoid activities, places, or people that arouse recollections of the trauma

Inability to recall an important aspect of the trauma

Markedly diminished interest or participation in significant activities

Feeling of detachment or estrangement from others

Restricted range of affect (e.g., unable to have loving feelings)

Sense of a foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span)

D. Persistent symptoms of increased arousal (not present before the trauma), as indicated by two (or more) of the following:

Difficulty falling or staying asleep

Irritability or outbursts of anger

Difficulty concentrating

Hypervigilance

Exaggerated startle response, hyperarousal

E. Duration (symptoms in B, C,and D).is more than 1 month.

Disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Acute: if duration of symptoms is less than 3 months
Chronic: if duration of symptoms is 3 months or more

With delayed onset: if onset of symptoms is at least 6 months after the stressor

Historical Context of PTSD—*Shell Shock* © (Davis, 2011)

The research underlying the concept of Post-Traumatic Stress Disorder is rooted in the Veterans Administration. To put this concept into words that most everyone, if not everyone, will know, Post-Traumatic Stress Disorder is the mental health terminology for what the lay community knows, at least those of a certain era, as *shell shock*. We have all experienced the consequences of war, whether it be World War II, the Koren War, the Vietnam War, or any of the more recent wars. Many of us, if not all or most, know someone who was in a war and know something about their experience on returning home, which includes the risk of going on a *shooting spree* and killing someone else or themselves, in response to a flashback where their home environment is confused with the front lines or overreacting to a minor irritation due to being in a state of *hypervigilance* or *hyperarousal* where a violent reaction is reflexive. That served the veteran well on the front lines but not in the home environment.

Youth and Communities Plagued by This Epidemic in *Shell Shock* © (Davis, 2011)

Now, think of the children and adolescents living in these communities driven by chaos as being in *shell shock* in an undeclared *war on the streets* and think of the *whole community* as being in shell shock. How does that affect your thinking about what an education system needs to provide for children and teens coming to school everyday in *shell shock*? What did the Veterans Administration do for war veterans? It created special treatment units for their care, and it established a very specific protocol to protect them and those around them.

What is the education system doing to care for the children, teens and the school, all in *shell shock*? Putting in metal detectors, security guards and the police. That is like surrounding veterans returning from the frontlines with the enemy. How would they respond? Like they were on the frontlines. They would shoot them. How are the children and teens responding to the implementation of security measures that remind them that they are unsafe? I refer you to the *Zero Tolerance Report* published by the Youth United for Change with the support of the Advancement Project with current research findings about the effectiveness of the use of law enforcement in treating a medical disorder. The findings show that children are being pushed out of school and being criminalized, not helped.

(http://www.advancementproject.org/sites/default/files/publications/YUC%20Report%20Final%20-%20Lo-Res.pdf)

Prevailing Rule of Trauma ©) (Davis, 2011)

In the place of flashbacks, children and adolescents respond to trauma through behavioral reenactments. In a community plagued by violence, children reenact the trauma created by the violence by traumatizing each other. When there is a violence epidemic, the whole community is plagued by violence reenactments. Psychologically, we all live, not by the Golden Rule, but by the Prevailing Rule of Trauma, "*Do unto others as you have been done unto.*" That is how we are made up psychologically. Like an antibiotic, it protects us emotionally. It takes us out of a position of *being acted upon* to *acting upon* and out of a situation of *being helpless and powerless* to *being in control.*

Behavioral Reenactments and Children and Youth

Trauma, by definition, involves the sudden and unexpected with no time in advance to prepare emotionally for it. In trauma, anxiety *follows* the event rather than preceding it, which gives warning and some time to prepare. Flashbacks in adults and behavioral reenactments in children and teens help to work through the anxiety that follows trauma by reliving it with the hope of a different outcome. Trauma puts everyone in a state of *hypervigilance*, always on the lookout, and *hyperarousa*l, always on guard, ready to defend against an attack.

Education System Response to *Shell Shocked Youth*

Instead of preventing what it is that metal detectors, security guards and the police are installed to prevent, they re-traumatize already traumatized children and adolescents and produce the violence they are intended to prevent. It is called *reactivity*, or in education language, the *Pygmalian effect*. Not only do children and adolescents entering the school environment suffer from the traumatic stress effects of a community permeated by violence, but so do all whose job it is to care for them, at home and at school.

Injury, Not Pathology

Early on in my work with members of Mothers In Charge, I came to see that what members coming for grief support presented was not *pathological.* They were not mentally ill. Their hearts were aching, and their spirits were broken. Shock and sorrow permeated all of their being. What they presented in their grief was not caused by a mental disorder. It was caused by a shocking, life-altering event that robbed their loved one of life. They were injured, like someone run over by a truck or ambushed. I thought that the interventions needed to be based on a rehabilitation model, not a pathology model.

A Trauma Informed Education System

Several years later, I discovered the work of Sandra Bloom, MD, Co-Director of the Center for Nonviolence in the Department of Public Health at Drexel University, and her Sanctuary model, which evolved out of research at the Veterans Adminstration with war

veterans. I was pleased to learn that she shared the view that trauma victims are *injured* and that traumatized children and teens who are misbehaving in school are "*injured, not bad.*" She has a developed of trauma-informed framework that can be implemented in a variety of settings, including the school.

In her paper, "Creating Sanctuary in the School" (www.sanctuaryweb.com) she calls for the school to *shift* its thinking from viewing traumatized children and teens as "bad" to seeing them as *injured* and to change the question when they misbehave from "What is wrong with you?" to "What has happened to you?" and "How can I Help?" She said that the shift to the injury model "in *no* way" implies an "abdication of responsibility" but rather a "sharing of responsibility" where "punishment is used only to the extent that it serves the purpose of providing the child with an alternative learning experience that does not automatically reenact the previous traumatic experience." It is designed to provide a "corrective emotional experience." She wrote:

> Punishment must never be violent or traumatic, if it is, we simply deepen the problem instead of correcting it. Any situation that places the child's body in a state of hyperarousal and overwhelming emotion increases the likelihood of a traumatic response. Children who have responded to injury by engaging in 'bad' behavior are reenacting their traumatic relationships with caregivers [in a community context, with the community]...the key in strategizing how to handle 'bad' kids is figuring out how *not* to do what it is they are cueing us to do.

Selected *Sanctuary* TM Concepts for a Trauma-Informed Education System

The following quote extracts selected aspects of her paper, that combined, provide an introductory glimpse into a trauma-informed education system:

> One of the basic assumptions about the educational system is that the job of the school is to educate children. But generally, this education is confined to the traditional three R's. The trauma model clearly illustrates why limiting education is this way is hopeless. Traumatized, overstimulated children cannot learn their schoolwork in the hyperaroused state which inevitably accompanies and follows trauma. They cannot calm themselves down and tend to overreact to even minor stimuli...The normal process of educating children cannot proceed until a sense of physical and psychological safety is established in the school...Now that many schools have metal detectors to ascertain which students are carrying guns, physical safety is no longer just assumed...Some schools are beginning to consider the importance of other kinds of safety as well—psychological, social and moral safety...Few people kill because they cannot read, write, or do sums, but they do perpetrate against others within a context of emotional literacy...If we cannot teach children how to get along with other people and feel better about themselves, the other educational skills are almost irrelevant." (www.sanctuaryweb.com)

Call to Action—Children's Defense Fund

> *The pipeline is not an act of God or inevitable; it is a series of human choices at each stage of our children's development. We created it, we can change it.* We know what to do. We can predict need. We can identify risk. We can prevent damage. We can target interventions. We can monitor progress. In so doing, we can guarantee returns on public investments and control costs to children and society. We can train professionals and create programs that heal and nurture. We can adapt and replicate strategies that work in communities across our nation and incorporate them into policy. We can restore hope and build on child strengths and resiliency. We can wrap buffers around our children's fragile places, bind up their wounds and prepare them with spiritual anchors inside to better weather the storms of life. We have the knowledge and the experience to do this. It is not impossible or futile as countless inspiring stories of children and youth beating the odds tell us every day attest. What it takes is a critical mass of leaders and caring adults with the spiritual and political will to reach out and pull children at risk out of the Pipeline and *never* let go and who will make a mighty noise until those in power respond to our demands for just treatment for children. This will not happen unless we come together and do the hard work to build a movement to save all our children and nation's soul.
>
> Marian Wright Edleman
> Childrens Defense Fund Report
> *America's Cradle to Prison Pipeline*

Call to Action

1. Reorient your view to look upon youth attending school in communities plagued by violence as *injured*, not bad
2. Create policy for all school districts to put into place a *universal education system* that requires that *all children be screened for trauma* and that its *education system be trauma- informed.*
3. Create a Commission to study the trauma-informed, educational needs of all the Commonwealth's youth using the Sanctuary model as a trauma framework (www.sanctuaryweb.com)
4. Review "Schools as Sanctuaries" for Sanctuary models used in three southern New Jersey schools (www.sanctuaryweb.com)
5. Create policy to generate the laws, regulations, and funding needed to provide a trauma-informed education system across the Commonwealth that is responsive to the needs of demoralized youth who are suffering from *social breakdown syndrome* (Frank and Frank, 1991) struggling to survive in communities plagued with violence

6. Create policy and provide funding to require u*niversal trauma screening for all students* across the Commonwealth to determine their trauma needs and to establish the level of trauma-informed intervention needed by each school in each district across the Commnonwealth using a trauma-informed framework based on the Sanctuary model
7. Review the Adverse Childhood Experiences study(www.sanctuaryweb.com) funded by the Center for Disease Control as a model to guide the development of a screening instrument for use in the education system as a screening protocol
8. Create policy and provide funding for *universal, safe quality education* for *all* of the Commonwealth's youth, not only some, to regulate and monitor a Commonwealth-wide, trauma-informed education system from a central source that requires that all schools, not only some, follow the same trauma-informed education system protocol

Pennsylvania Legislature Charge

As Legislators, you are in a position to do something about their cries, to pay attention to them. You can create policy to develop a trauma-informed response their needs, to give them equal opportunities, and to lift them out of the valley of despair. They are *my* children. They are *your* children. They are *all of our* children.

Humanity calls out for social justice, not only from those grieving a loved one lost to murder, but all of humanity, whose charge it is to be our children's keeper.

Let all children know that you care. Let all children know that the Commonwealth cares. Give each and every child the universal public school support that will position them to succeed in this world. Provide trauma-informed policy to heal and protect them and make the City of Philadelphia, and the Commonwealth, *a safer place for all, not only some.*

Respectfully Submitted,

Betty Lee Davis

Betty Lee Davis, Ph.D., LCSW
Member, Pennsylvania State Conference of
NAACP Branches Education
Committee

Notes

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"Schools as Sanctuaries"—Stanwood, Mark and Doolittle, Gina

(www.facesofcouragebook.com) "IN UNISON: The Collective Voice of Mothers In Charge—An Interpretation by Betty Lee Davis, Ph.D."

Three Central Points

1. Youth are killing each other in a cry for help with society's doors closed to them and guns flowing freely on the street, keeping open the revolving prison door. These youth are injured, not bad. They are demoralized. They are suffering from chronic social breakdown, from soul sickness.

2. *Flashmob* is taking the cries to another level—to the level of the powerbrokers. They are killing each other in a cry for help, and no one is listening to their cries as no value is assigned to their lives. If they take their cries into the community of the power brokers, maybe someone will hear, if not to assign value to their lives to protect commerce. *And indeed, someone did hear.* That is why we are gathered in this room today.

3. This epidemic was declared a public health problem twenty years ago by the Surgeon General, but it has never been treated like a public health problem. Very specific, universal rotocols go into place when there is an epidemic. Emergency measures are taken to contain the epidemic and prevent its spread.

   Victims of violence develop Post Traumatic Stress Disorder (PTSD). That is a medical problem. PTSD is medical terminology for *shell shock* © (Davis, 2011). The youth are in *shell shock.* Communities are shell shocked. Unlike adults who have flashbacks with PTSD or shell shock, children and adolescents relive trauma through behavioral reenactments, that is, they do to another what was done to them or what they witnessed. They are reenacting the homicides surrounding them by killing each other. It is a universal psychological mechanism of defense. This epidemic is a medical problem. The public health system has not responded to it like a medical problem. It needs a trauma-informed, medical response. This epidemic is a perfect, naturalistic research design. It is not the adults who are killing each other. They are having flashbacks. They become disabled, frozen, and immobilized. Just as PTSD theory states. It is the youth who are killing each other. They are doing behavioral reenactment. This epidemic requires a universal, trauma-informed, public health, medical response.

SUBMITTED BY © Betty Lee Davis, Ph.D., LCSW

Pennsylvania State Conference NAACP Branches: Education Committee

Testimony before the House Education Committee of the Pennsylvania General Assembly

July 28, 2011

Good Morning, Pennsylvania House Education Committee.

I am Dr. Betty Lee Davis, and I am honored to be here today to represent the Pennsylvania State Conference of NAACP Branches Education Committee and to have this opportunity to speak out for the youth of the Commonwealth of Pennsylvania in support of *universal safe, quality education* for *all* of the Commonwealth's children, not only some.

I am a Licensed Clinical Social Worker at the Ph.D. level with many years of experience working with children, adolescents, and their families in a variety of behavioral health settings, including on-site, school-based mental health services in a suburban county in the Commonwealth and coordinating a home-school behavioral health services program in the City of Philadelphia. In recent years, I have provided grief support and other services to Mothers In Charge, a violence prevention, advocacy organization composed of mothers and others who have lost a loved to violence in the City of Philadelphia.

Through my work with Mothers In Charge, I have become very aware of the youth violence epidemic that is taking the lives of young black males who are killing each other in a *cry for help* with so many doors closed to them. After providing what might be considered *palliative* care to those suffering the anguish that accompanies homicidal grief and advocating for violence prevention, I have come to see education advocacy as the natural, next step for me in supporting those who have lost a loved one to violence. By acting at the structural level to advocate for *universal safe, quality education* for *all* the Commonwealth's children, not only some, I am taking a step that may help to spare the loss of yet another life by eliminating the education system as one, among others, of the social conditions underlying the violence epidemic that is robbing society, Philadelphia and this Commonwealth, in particular, of its youth.

The Youth Violence Epidemic

To set the stage for my testimony, I would like to read an excerpt from a piece that I was inspired to write for Mothers In Charge first book, *Mothers In Charge: Faces of Courage,* entitled "IN UNISON: The Collective Voice of Mothers In Charge—An Interpretation by Betty Lee Davis, Ph.D.":

We are mothers wailing at the senseless slaughter of our children. We are mothers riveted by rage. We are mothers aching in our hearts, minds, bodies and souls. *We are Mothers In Charge.*

One by one, we just keep coming, hundreds of us since our grief support meetings began. Meeting after meeting, with every new member, our heads shake in disbelief at the retelling of our story. Each of our stories is unique, but the theme is the same—the senseless murder of our children. *Ours is the Refrain of Mothers In Charge.*

"Will the floodgates ever close?" we wonder. "Not until the war is over," we answer. "War? What war?" you ask. "There is no war in Philadelphia,.." "Yes", we answer," There is a war in Philadelphia. The war is on streets. Semi-automatic rifles reserved for war flowing freely on the streets declare it, if no one else has." We are the Voice of Mothers In Charge.

Nobody seems to have *really* noticed, at least not enough to stop it, only we, mothers screaming at the horror of our children being brutalized on the streets, lost to institutions that have failed them. *Ours is the Scream of Mothers In Charge.*

Bought and sold on the streets like bags of candy filled with poison by youth too young to comprehend life's sacredness, guns are only the *symptom* for a generation of our youth. A broken educational system. A broken employment system. A broken economic system. A broken moral system. All are roads leading our youth to the most dangerous intersection along the "cradle to prison pipeline," the intersection between poverty and race.*

In this land where opportunity exists for *some, but not all*, society has failed our youth. In a *cry* for help with so many doors closed to them, young black males are killing each other. When society fails to protect them and give them equal opportunities to "learn, grow and flourish,"** all of our children are sacrificed, some as victims, others perpetrators. *All are Children of Mothers In Charge.*

(www.facesofcouragebook.com)

The Youth Violence Epidemic as a Manifestation of Institutional Racism

The Founder and Director of Mothers in Charge, Dorothy Johnson-Speight, often begins her talks with "No one is safe until we are all safe." No one is safe until we are all safe, but some of us are safer than others walking outside of our homes into our communities, and most of us do not have to hit the floors of our homes dodging bullets coming through our windows, as some members of Mothers In Charge do.

Early in my work with Mothers In Charge, as I listened to the stories of those suffering from severe, homicidal grief, a grief unlike any other, and learned more about the needs of black youth entering the juvenile justice system, I saw quickly that this is not a universal problem scattered equally across the social strata. The mothers grieving their loved ones lost to homicide are almost all African American, living primarily in African American communities, in relatively

close proximity to where the homicides occur, in the City of Philadelphia. It did not take long for the lights to go on. Very soon, I realized that this is a problem with its roots deeply embedded in our society. This problem is a contemporary manifestation of institutional racism. I was so troubled, and outraged, that I was moved to develop what I observed into a presentation, entitled "The Youth Violence Epidemic as a Contemporary Manifestation of Institutional Racism: Mothers In Charge as an Organizational Antidote," which I invited Ms. Speight to do with me at the Pennsylvania Chapter of the National Association of Social Work's Annual Conference that Spring. (Davis and Speight, 2008)

Demoralization

In his seminal work, *Persuasion and Healing*, (1961), Jerome Frank, well known psychiatrist and psychologist and Professor Emeritus of Psychiatry at the Johns Hopkins University School of Medicine until his death in 2005, coined the concept "demoralization." In its third edition (1991), he and his daughter, Julia, also, a psychiatrist, wrote:

> Dictionaries define demoralize 'to deprive a person of spirit, courage, to dishearten, bewilder, to throw a person into disorder or confusion.' Typically, they are conscious of having failed to meet their own expectations or those of others, or being unable to cope with some pressing problem. They feel powerless to change the situation or themselves and cannot extricate themselves from their predicament. This situation has been conceptualized as a 'crisis' if acute (Korchin,1975) and as the 'social breakdown syndrome' if chronic (Gruenberg, 1974) (see Chapter 12). Features of demoralization are anxiety, sadness, hopelessness, and low self-esteem. Social support and a sense of community are essential in healing from demoralization.

While those who are demoralized may look to be depressed, they are suffering from *oppression* caused by *externally imposed* situations or conditions.

The cause of the youth violence epidemic is complex. Educational disparity is one among multiple factors, but it is a significant factor as it closes the employment door. Youth who do not have a diploma are at-risk for unemployment. Youth who are unemployed are at-risk for taking to the streets. With education, employment and economic doors closed to them, these youth are demoralized and left to the streets, where guns flow freely, to feed the revolving prison door.

Communities Plagued by Violence

The City of Philadelphia is plagued by violence. It is like a trauma unit over run with victims of violence. Everyone is suffering from some form of trauma resulting from the youth violence epidemic, if not from *primary trauma* associated with the violent death of a loved one, from *secondary trauma* resulting from exposure to violence permeating the community. What the members of Mothers In Charge are experiencing is *primary trauma,* and it is complicated by *secondary trauma* and *re-traumatization* because they cannot escape the violence that surrounds them in their community. Not everyone lost a loved one in 9/11, but a whole country was traumatized. That is secondary trauma. Not everyone in Philadelphia has lost a loved one to

homicide, but the whole community is reminded daily about violent homicides through the news, teddy bear memorials, candlelight vigils, victims lying dead on the street, and sirens and bullets roaring through its neighborhoods. That is secondary trauma. Students are reminded that they are unsafe every time they enter a school building fortified with metal detectors, security guards, and the police. That is re-traumatization in a community plagued by violence.

As recently as a few weeks ago, I spoke with a member of Mothers In Charge whose story I wrote about the murder of her brother for *Mothers In Charge: Faces of Courage*. She said when I called that she was not doing so well as she had heard twelve shots a little while before my call. After the sounds stopped, she said that she opened the door to see what was happening. On the ground, across the street in front of her house, she saw a boy lying dead. She said, "He could have my son." To her left was another boy on a stretcher being put into an ambulance, only to die a short time afterwards. When I saw that member two weeks later at an event, she said she had not left the house since that day. She said that she didn't know what the reason was, but that she just couldn't go outside. I asked if she thought if it had anything to do with what she saw. She said she had not thought about it, but as she thought about it, she thought it was probably the only explanation. That is re-traumatization.

A few days later, in a different, rural community where I provide clinical services, a grandmother told me that when she went to her grandson's school for a conference, she was greeted by a girl being taken out on a stretcher, assaulted by a female peer. The grandmother said that there were security officers "coming out of the woodwork." The grandmother was troubled by what she saw as her own granddaughter had been the victim of an unprovoked assault in her neighborhood by a female peer, several years previously. That is re-traumatization. Her granddaughter had never been violent, but after the assault, she began assaulting female peers in school unprovoked or at the least sign of provocation, for which she was expelled on multiple occasions and referred to an alternative program. Her granddaughter had been exposed to domestic violence in her home and violence in her neighborhood. She was the *victim of violence*, and she became the *perpetrator of violence*. That is behavioral reenactment.

I could not get these stories and the images that they brought to my mind off my mind for days. They kept popping into my mind. When I think of them now as I write, I am still troubled by them. That is secondary trauma.

Take these two stories and magnify them thousands of times over. These are the stories that children living in communities, and a society, plagued by violence live with every day. These are the stories that they bring with them to school daily as victims of community violence.

The Youth Violence Epidemic as a Public Health Problem

Webster defines *epidemic* as "prevalent and spreading rapidly among many people in a community at the same time; widespread; said especially of a contagious disease." (Webster, 1960). Those suffering from a contagious disease need treatment, and the disease needs to be contained to prevent its spread. The youth violence epidemic has been declared public health problem (www.surgeongeneral.gov/library/youthviolence/report.html) A problem affecting the public's health is a medical problem. Medical problems require medical treatment, not law enforcement, to heal. That does not mean that there are not situations where law enforcement is required, but law enforcement is not the primary treatment for a medical problem.

Post Traumatic Stress Disorder (PTSD) is the medical condition associated with violence. It is a mental health condition, and the treatment of it must correspond to the diagnosis. Not everyone exposed to violence meets all of the symptom criteria of PTSD, but many, if not most, will experience some of the symptoms. When violence affects the whole community, many of its members are experiencing at least some of its symptoms, and the intervention needs to be at the community level.

To acquaint you with the symptoms that many, if not all, children are experiencing when they walk through the school building doors in communities permeated by violence, I have selected symptoms most relevant to this testimony form the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders IV (1994):

The person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others.
The person's response involved intense fear, helplessness, or horror. In *children*, this may be expressed instead by disorganized or agitated behavior.

Recurrent and intrusive distressing recollections of the event including images, thoughts, perceptions. In *young children*, repetitive play may occur in which themes of the trauma are expressed.
Recurrent distressing dreams of the event. In *children* dreams may be frightening without recognizable content
Acting or feeling as if the traumatic event were recurring (a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes). In *children,* trauma-specific behavioral reenactment may occur.
Intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event
Physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event

Markedly diminished interest or participation in significant activities
Feeling of detachment or estrangement from others
Restricted range of affect (unable to have loving feelings)
Sense of a foreshortened future (does not expect to have a career, marriage, children, or a normal life span)

Difficulty falling or staying asleep
Irritability or outbursts of anger
Difficulty concentrating
Hypervigilance
Exaggerated startle response, hyperarousal

Duration is more than 1 month
The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

The research underlying the concept of Post-Traumatic Stress Disorder is rooted in the Veterans Administration. To put this concept into words that most everyone, if not everyone, will know, Post-Traumatic Stress Disorder is the mental health terminology for what the lay community knows, at least those of a certain era, as *shell shock*. We have all experienced the consequences of war, whether it be World War II, the Koren War, the Vietnam War, or any of the more recent wars. Many of us, if not all or most, know someone who was in a war and know something about their experience on returning home, which includes the risk of going on a *shooting spree* and killing someone else or themselves, in response to a flashback where their home environment is confused with the front lines or overreacting to a minor irritation due to being in a state of *hypervigilance* or *hyperarousal* where a violent reaction is reflexive. That served the veteran well on the front lines but not in the home environment.

Now, think of the children and adolescents living in communities plagued by violence as being in *shell shock* and think of the *whole community* as being in shell shock. How does that affect your thinking about what an education system needs to provide for children and teens coming to school everyday in *shell shock*? Add to that a Commonwealth with gun laws that allow guns to flow freely on the streets into a *shelled shocked community*. That is a combustible mix. What did the Veterans Administration do for war veterans? It created special treatment units for their care, and it established a very specific protocol to protect them and those around them. Imagine what would happen on those units if guns were among the choices on the menu. It would be a combustible mix.

What is the education system doing to care for the children, teens and the school, all in *shell shock*? Putting in metal detectors, security guards and the police. That is like surrounding veterans returning from the frontlines with the enemy. How would they respond? Like they were on the frontlines. They would shoot them. How are the children and teens responding to the implementation of security measures that remind them that they are unsafe? I refer you to the *Zero Tolerance Report* published by the Advancement Project with current research findings about the effectiveness of the use of law enforcement in treating a medical disorder. The findings show that violence is increasing, not decreasing.
(http://www.advancementproject.org/sites/default/files/publications/YUC%20Report%20Final%20-%20Lo-Res.pdf)

Children, Adolescents, and Post Traumatic Stress

In the place of flashbacks, children and adolescents respond to trauma through behavioral reenactments. In a community plagued by violence, children reenact the trauma created by the violence by traumatizing each other. When there is a violence epidemic, the whole community is plagued by violence reenactments. Psychologically, we all live, not by the Golden Rule, but by the Prevailing Rule of Trauma, "*Do unto others as you have been done unto.*" That is how we are made up psychologically. Like an antibiotic, it protects us

emotionally. It takes us out of a position of *being acted upon* to *acting upon* and out of a situation of *being helpless and powerless* to *being in control.* Trauma, by definition, involves the sudden and unexpected with no time in advance to prepare emotionally for it. In trauma, anxiety *follows* the event rather than preceding it, which gives warning and some time to prepare. Flashbacks in adults and behavioral reenactments in children and teens help to work through the anxiety that follows trauma by reliving it with the hope of a different outcome. Trauma puts everyone in a state of *hypervigilance*, always on the lookout, and *hyperarousa*l, always on guard, ready to defend against an attack. Instead of preventing what it is that metal detectors, security guards and the police are installed to prevent, they re-traumatize already traumatized children and adolescents and produce the violence they are intended to prevent. It is called *reactivity*, or in education language, the *Pygmalian effect.* Not only do children and adolescents entering the school environment suffer from the traumatic stress effects of a community permeated by violence, but so do all whose job it is to care for them, at home and at school.

A Trauma-Informed Education System

Early on in my work with members of Mothers In Charge, I came to see that what members coming for grief support presented was not *pathological.* They were not mentally ill. Their hearts were aching, and their spirits were broken. Shock and sorrow permeated all of their being. What they presented in their grief was not caused by a mental disorder. It was caused by a shocking, life-altering event that robbed their loved one of life. They were injured, like someone run over by a truck or ambushed. I thought that the interventions needed to be based on a rehabilitation model, not a pathology model. I developed a program proposal and began to look into ways of doing it, but funding did not allow.

Several years later, I discovered the work of Sandra Bloom, MD, Co-Director of the Center for Nonviolence in the Department of Public Health at Drexel University, and her Sanctuary model, which evolved out of research at the Veterans Adminstration with war veterans. I was pleased to learn that she shared the view that trauma victims are *injured* and that traumatized children and teens who are misbehaving in school are "*injured, not bad.*" She has a developed of trauma-informed framework that can be implemented in a variety of settings, including the school.

In her paper, "Creating Sanctuary in the School" (www.sanctuaryweb.com) she calls for the school to *shift* its thinking from viewing traumatized children and teens as "bad" to seeing them as *injured* and to change the question when they misbehave from "What is wrong with you?" to "What has happened to you?" and "How can I Help?" She said that the shift to the injury model "in *no* way" implies an "abdication of responsibility" but rather a "sharing of responsibility" where "punishment is used only to the extent that it serves the purpose of providing the child with an alternative learning experience that does not automatically reenact the previous traumatic experience." It is designed to provide a "corrective emotional experience." She wrote:

> Punishment must never be violent or traumatic, if it is, we simply deepen the problem instead of correcting it. Any situation that places the child's body in a state of hyperarousal and overwhelming emotion increases the likelihood of a

> traumatic response. Children who have responded to injury by engaging in 'bad' behavior are reenacting their traumatic relationships with caregivers [in a community context, with the community]...the key in strategizing how to handle 'bad' kids is figuring out how *not* to do what it is they are cueing us to do.

The following quote extracts selected aspects of her paper, that combined, provide an introductory glimpse into a trauma-informed education system:

> One of the basic assumptions about the educational system is that the job of the school is to educate children. But generally, this education is confined to the traditional three R's. The trauma model clearly illustrates why limiting education is this way is hopeless. Traumatized, overstimulated children cannot learn their schoolwork in the hyperaroused state which inevitably accompanies and follows trauma. They cannot calm themselves down and tend to overreact to even minor stimuli...The normal process of educating children cannot proceed until a sense of physical and psychological safety is established in the school…Now that many schools have metal detectors to ascertain which students are carrying guns, physical safety is no longer just assumed…Some schools are beginning to consider the importance of other kinds of safety as well—psychological, social and moral safety…Few people kill because they cannot read, write, or do sums, but they do perpetrate against others within a context of emotional literacy…If we cannot teach children how to get along with other people and feel better about themselves, the other educational skills are almost irrelevant." (www.sanctuaryweb.com)

Call to Action

In communities plagued with violence and education systems that fail them, *shell shocked youth,* as victims and perpetrators, are carrying out what society is programming them to do: with education, employment, and economic doors closed to them and guns flowing freely into their hands, they are killing each other in a *cry for help* in an undeclared war on the streets. Nothing else has gotten the attention of the society whose charge it is to care for them. Maybe killing each other will, but it hasn't yet.

This is your opportunity, Legislators to respond to their cry and to give them the care they need by starting with the education system, and as a companion to it, by changing the laws that allows guns to flow freely into their hands on the streets.

What I am proposing in this testimony is that as Legislators, you begin to look upon children and youth attending school in communities plagued by violence as *injured*, not bad, and that a *universal education system response* to *communiies in shell shock* be put in place that requires that *all children be screened for trauma* and that *education system be trauma- informed.*

What action can you take? Create a commission to study the trauma-informed, educational needs of all the Commonwealth's youth and require that the findings of the Commission generate the laws, regulations, and funding needed to provide a trauma-informed education system across the Commonwealth.

1. Create legislation that would support the implementation Bloom's concept of "sanctuary in the school" to produce a trauma-informed education system that is responsive to the needs of demoralized youth who are suffering from *social breakdown syndrome* (Frank and Frank, 1991) struggling to survive in communities plagued with violence. Refer to "Schools as Sanctuaries" for Sanctuary models used in three southern New Jersey schools (www.sanctuaryweb.com).
2. Pass legislation that would require u*niversal trauma screening for all students* to determine their trauma needs and to establish the level of trauma-informed intervention needed by each school in each district across the Commnonwealth using a trauma-informed framework based on the Sanctuary model. Review the Adverse Childhood Experiences study (www.sanctuaryweb.com), funded by the Center for Disease Control, as a model that could be adapted for use in the education system to develop a screening instrument and screening protocol.
3. Support *universal, safe quality education* for *all* of the Commonwealth's youth, not only some, to regulate and monitor a Commonwealth- wide, trauma-informed education system from a central source that requires that all schools, not only some, follow the same trauma-informed education system protocol.

In closing, I would like to leave you with a call to action by Marian Wright Edleman in the Childrens Defense Fund Report *America's Cradle to Prison Pipeline* (2007):

> *The pipeline is not an act of God or inevitable; it is a series of human choices at each stage of our children's development. We created it, we can change it.* We know what to do. We can predict need. We can identify risk. We can prevent damage. We can target interventions. We can monitor progress. In so doing, we can guarantee returns on public investments and control costs to children and society. We can train professionals and create programs that heal and nurture. We can adapt and replicate strategies that work in communities across our nation and incorporate them into policy. We can restore hope and build on child strengths and resiliency. We can wrap buffers around our children's fragile places, bind up their wounds and prepare them with spiritual anchors inside to better weather the storms of life. We have the knowledge and the experience to do this. It is not impossible or futile as countless inspiring stories of children and youth beating the odds tell us every day attest. What it takes is a critical mass of leaders and caring adults with the spiritual and political will to reach out and pull children at risk out of the Pipeline and *never* let go and who will make a mighty noise until those in power respond to our demands for just treatment for children. This will not happen unless we come together and do the hard work to build a movement to save all our children and nation's soul.

Respectfully Submitted,

Betty Lee Davis, Ph.D., LCSW
Member, Pennsylvania State Conference of
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Committee

Reference List

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IN UNISON

THE COLLECTIVE VOICE OF MOTHERS IN CHARGE

AN INTERPRETATION BY BETTY LEE DAVIS, PH.D.

Shown below are more members of Mothers In Charge. We could not tell all of their stories—they and hundreds more in the organization are an inspiration to us all.

WE ARE MOTHERS WAILING AT THE SENSELESS SLAUGHTER OF OUR CHILDREN. WE ARE MOTHERS RIVETED BY RAGE. WE ARE MOTHERS ACHING IN OUR HEARTS, MINDS, BODIES, AND SOULS. *WE ARE MOTHERS IN CHARGE.*

One by one, we just keep coming, hundreds of us since our grief support meetings began. Meeting after meeting, with every new member, our heads shake in disbelief at the retelling of our story. Each of our stories is unique, but the theme is the same—the senseless murder of our children. *Ours is the Refrain of Mothers In Charge.*

"Will the floodgates ever close?" we wonder. "Not until the war is over," we answer. " War? What war?" you ask. "There is no war in Philadelphia," …"Yes," we answer, "There is a war in Philadelphia. The war is on the streets. Semi-automatic rifles reserved for war flowing freely on the streets declare it, if no one else has." We are the Voice of Mothers In Charge.

Nobody seems to have *really* noticed, at least not enough to stop it, only we, mothers screaming at the horror of our children being brutalized on the streets, lost to institutions that have failed them. *Ours is the Scream of Mothers In Charge.*

Bought and sold on the streets like bags of candy filled with poison by youth too young to comprehend life's sacredness, guns are only the *symptom* for a generation of our youth. A broken educational system. A broken employment system. A broken economic system. A broken moral system. All are roads leading our youth to the most dangerous intersection along the "cradle to prison pipeline," the intersection between poverty and race.*

In this land where opportunity exists for *some, but not all*, society has failed our youth. In a *cry* for help with so many doors closed to them, young black males are killing each other. When society fails to protect them and give them equal opportunities to "learn, grow and flourish,"** all of our children are sacrificed, some as victims, others perpetrators. *All are the Children of Mothers In Charge.*

We have all lost a loved one, a son or daughter, a grandchild, a nephew or niece, a brother or sister, some within the week, some years ago. Like a nightmare set on replay, grief unites us, wrenching, horrific, traumatic grief. Some of us have lost more than one child to violence. With the second nightmare comes a reliving of the first. Our children, of many ages, were just living their lives, going through the course of their day, when life was stolen from them. Some were going to work, some to school or the store; some were playing in the neighborhood or in front of their homes; some were visiting in another neighborhood; some just sitting in their car. For some of us, the war is so real that we hit the floors of our homes daily, dodging bullets soaring through our neighborhood windows. The piercing, gunshot sound is so familiar to many of us that we can name the kind of gun based on the sound as it leaves the barrel for yet another assault. We are exhausted, often immobile, not able to greet the day in our usual way or get on with our usual tasks. With


Sanna Abdullah


Cynthia Austin

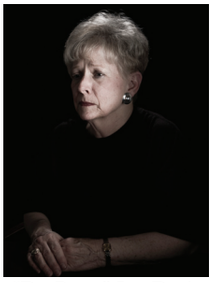

Jane Brevard

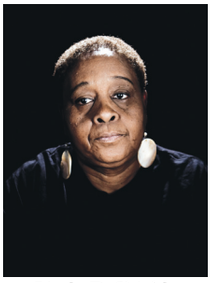

Gloria Bryant


Kimberly Byrd


Bette Clark


Valerie Core


"Dr. Betty" Lee Davis


Linda DeShields


Ruth Donnelly


Beverly Downey


Donna Giddings

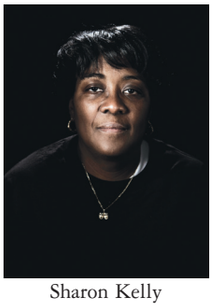

Cheryl Grier


Pat Griffin


Roxann Hargust


Dorothy Johnson-Speight


Delores Jones


Sharon Kelly

the ringing of every bullet, the sound of every siren, the sight of every red, flashing light, or the unending news reports of yet another innocent life gone, the nightmare returns. *Ours is the Plight of Mothers In Charge.*

We see the pain in each others faces. We hear it in our voices. The murder of our child is only the first assault for those of us left behind in the wake of this youth-violence epidemic. Many more assaults follow, within the legal system and our search for the perpetrator—often never apprehended—and our appeal for protection from retaliation, which, for some strikes as early as the funeral; with the employment system and its absent or inadequate benefits for post-traumatic stress, costing many of us the temporary loss of income and, for some, the permanent loss of a job and healthcare coverage; with our own family members and friends, who may experience grief in a different way and not understand our needs; with our inability to sleep and new physical symptoms, conditions we are told that come with traumatic grief; and with doubts about spiritual beliefs that have sustained us throughout our lives. *Ours is the Suffering of Mothers In Charge.*

Despite the doubts challenging our beliefs, however, our spiritual beliefs are, also, still part of what sustains many of us, in what is, to the onlooker, often an amazing way. *Ours is the Faith of Mothers In Charge.*

We comfort each other with tissues for our tears and a warm hand for our broken hearts. We feel each others pain. We know the road. We cannot take away each others pain, but we can walk and rest together on the darkened path of traumatic grief. We accept each others need to grieve in our own way, in our own time. We know there is no one way, no right or wrong way, to grieve our child. *That is the Embrace of Mothers In Charge.* Sometimes, there is a break in the cloud, and in an unanticipated moment, we see a glimmer of light for the first time. *That is the Hope of Mothers In Charge.* Our mission is to save the life of another through violence prevention programs so that our children will not have died in vain. *That is the Wisdom of Mothers In Charge.* We give testimonies and go to rallies. *That is the Message of Mothers In Charge.* We attend life celebrations in honor of each others children. *That is the Love of Mothers In Charge.* We gather around our support table with a candle glowing at its center in remembrance of our children. In one moment we may be reeling with pain, only to be followed moments later by the unexpected grace of a smile, as we did this Christmas, when our Founder, in her wisdom, planned a pot luck dinner after our meeting, with *karaoke* as a surprise! Two of us, riveted by sorrow and rage in one moment, joined each other minutes later, inspired by the music, to break into dance and lapse into laughter and an interlude of relief from our grief. Within minutes, the room was filled with dancing. *That is the Beauty of Mothers In Charge.*

We lift our voice in praise of Dorothy Johnson-Speight for her courage in carrying out her vision that led to the creation of Mothers In Charge and of Ruth Donnelly for supporting that vision. We are thankful for all the mothers who opened the way for us by joining Dorothy and Ruth in carrying out the violence prevention mission of Mothers in Charge and in the process, gave us a refuge for our grief and strength for the journey.

We are the Grateful Voice of Mothers In Charge.

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* Children's Defense Fund. (2007). *America's cradle to the prison pipeline: a Children's Defense Fund report* . Washington, D.C.

** Brazelton, B. and Greenspan, S. (2000). *The irreducible needs of children: what every child must have to grow, learn, and flourish*. Cambridge, Massachusetts: Perseus.

Betty Lee Davis, Ph.D. is a Facilitator of the Mothers In Charge Grief Support Group


Karen Lee


Bonnie Lucas


Renée McDonald


Mina Pickney


Brenda Powell


Wanda Robinson


Doris Saunders


Elaine Saunders


Loretta Stivender


Jacqui Tobler


Yvonne Tobler


Tonya Waller


Margaret Washington


Margie Washington


Renata White


Denea Whitest


Angela Williams


Darlene Yancey

Public Hearing Testimony- Youth Violence as a Public Health Epidemic
PA House Democratic Policy Committee

Marla Davis Bellamy, JD, MGA
Executive Director, Philadelphia CeaseFire
Co-Director, Center for Bioethics, Urban Health and Policy
Temple University School of Medicine
marladb@temple.edu-215-707-1262
Philadelphia, PA 19140

Good Morning Representative Waters and members of the House Democratic Policy Committee. It is an honor and pleasure to have an opportunity to speak with you this morning about Youth Violence as a Public Health Epidemic. My name is Marla Davis Bellamy and I am the Co-Director of the Center for Bioethics, Urban Health and Policy at Temple University School of Medicine as well as the Executive Director of the Philadelphia Ceasefire program.

I have traveled this morning with Rasheed Smith who is a Philadelphia CeaseFire participant. And while I understand the importance of hearing from experts, I think it is critical that we spend more time listening to young people like Rasheed who have been engaged in high risk street activity and significantly impacted by youth violence. Rasheed is 20 yrs. old, the father of two and since his release from prison he has been working diligently with our program to change his life and the lives of others around him.

My journey has been somewhat different than Rasheed's. However, our lives are intertwined given the concern that we share about the challenges, injury, and trauma that young people across this nation and commonwealth have experienced due to violence in their homes, schools and communities.

I commend Rep. Waters for stepping forward and embracing what many of our panelists know is a significant problem across the commonwealth. In fact, my introduction to youth violence came about as a result of white paper that I wrote in graduate school which focused on the increase of school violence in rural areas across our state.

So while, I'm sure that our legislators in Phila. grapple with this problem—as the former chief of staff of the pa. department of health, I know first-hand, the problem of youth violence extends well beyond the city of Phila.

However, I think the question becomes what are we doing with the resources that we have to address this problem?

While in Harrisburg, a few years ago, I became aware of a public health violence intervention program that was being funded by the Robert Wood Johnson Foundation called CeaseFire. It was founded by an epidemiologist, Dr. Gary Slutkin who frequently articulates the fact that violence acts like a disease—and can be prevented.

The Chicago CeaseFire model is a structured, deliberate and disciplined violence intervention that was developed in Chicago based on the premise that violence is a public health issue and can be prevented.

We have replicated this model in Phila. and have become one of 16 cities and 5 international countries to do so. We are now a part of what is called the Cure Violence Network. Our presence is felt in Baltimore, New Orleans, Kansas City, New York and Puerto Rico; just to name a few of the sites.

The program is evidenced based and has been evaluated by the Dept. of Justice, Johnson Hopkins, and proven to be effective against homicides and shootings.

The approach includes efforts to heighten community awareness about gun violence and encourage area residents, community, business and faith leaders to work collectively together. While I think most Americans understand the criminal element of violence its somewhat difficult for some to wrap their heads around violence as a public health issue.

Violence is among the most serious health threats in the nation---close to 600 people each week are killed by a gun---Violence is a leading cause of injury, disability and premature death.

Violence is a learned behavior and public health can provide and maintain a focus on prevention of violence before it occurs.

What is a public health approach to preventing violence?
Similar to the public health approach to all other injuries----

a. It involves data collection and analysis
b. Identifying the populations and locations at greatest risk
c. Identifying risk and protective factors
d. Utilizing evidenced based strategies and programs

In Philadelphia, the 22nd police district where our program is based has had the highest number of shootings of any other district in the city. Last year in the 22nd district there were 36 homicides and 165 shootings---which is actually a decrease from the year before.

So how does the program work???

We hire "credible messengers" from the target community---and often times, these individuals are ex-offenders. Think about it this way—if you are having marriage problems—would you go to a marriage counselor who is single?? Or would you go to a counselor that is married and may have similar experiences.

Our team consists of 12 people which include full-time and part time outreach workers and violence interrupters. All are employees of Temple University School of Medicine. For some, this is the very first job.

We saturate the area where gun activity takes place with flyers and posters—We respond to neighborhood shootings immediately and hold a shooting response at least 72 hours after a shooting incident

We have a relationship with Temple Hospital which is where most of our gunshot victims are taken—we work to cultivate a relationship with the gunshot victim and follow him/or her once that person is discharged.

But we spend a significant amount of time working to get out in front and interrupt the violence before it occurs.

Our work is primarily with shooters or what we call high risk individuals—these young people become clients of the outreach team who are required to recruit 15 young people between the ages of 14 and 25. We act like a gnat and stay in the ears of our participants encouraging them to turn their lives around while identifying activities and possible employment opportunities to keep them engaged.

The methods that we use, particularly canvassing is similar to the ones used by public health workers following a disease outbreak.

- Our participants who volunteer to participate, must be a resident of the target area
- Must be between the ages of 14-25
- Have a prior history of offending and arrests
- Be a member of a gang or click
- Have been in prison
- A recent victim of a shooting
- Involved in high risk street activity

We collaborate with everyone from Temple University to the Police Department and faith based leaders.

We also have ongoing support from The Chicago CeaseFire (Cure Violence Team) who provides ongoing training support; data base tracking, weekly conference calls—We have been on the street now for approx.. two year and I am sure wondering is the program working? In calendar year 2012, the 22nd police district saw a 21% decrease in homicides and an 11% decrease in shootings. In the CeaseFire target area within the 22nd there were 56 shootings last year compared to 79 shootings the year before...

Fortunately, PCCD has been a supporter of the program and we also receive funding from the US Dept of Justice—but we need support from every person in this room.

We need to further educate our legislators and state agencies about the program as well as travel to Baltimore or Chicago to learn more about the Cure Violence model.

I frequently hear about the significant reduction in crime in New York City—and while there are multiple efforts that led to that result—there are 10 CeaseFire sites in NY state including 5 in NY City—But here in PA, we need to know across the commonwealth what our state agencies are funding to prevent violence amongst youth--- that includes, health, education, corrections, and welfare. Are we operating in silos or is there some collaboration?

Our program could have an even greater impact in North Philadelphia if we knew from corrections and or parole when the repeat violent offenders were returning home. We could establish a relationship with them while in prison and continue to follow them upon their release. We have to make our youth a priority by action and deed—Our city continues to feel impact of the collapsed building that took 6 lives—and immediately new regulations were put in place to prevent a tragedy like that from happening again---

Over the last two years we have lost 82 lives in our target area.

There have been no new regulations, and no new funding.

However, I am encouraged by today's hearing and believe this is a new beginning and a collective effort to address one of the most critical problems facing our society today.

LEGACY PATHWAYS™

Inspiring Leaders To Build a Legacy Through People, Performance & Profits

Good Afternoon. My name is Joi C. Spraggins and as many of you know I am known by my trademarked name as *"Dr. Joi"* in my motivational speaking engagements, books and articles. I am the founder of Legacy Pathways, LLC, a leadership development, management consulting and supply chain regulatory compliance firm located in Philadelphia and like everyone here today, I have been touched by the violence in our culture.

With a Masters' Degree from the University of Pennsylvania's Fels School of Government and over 25 years' experience, I am recognized globally for inspiring the growth of leaders who leave a legacy through people, performance, profits and collaboration. Today I am here to discuss solutions to violence, particularly youth violence. I am a former City of Philadelphia Police Advisory Commissioner and the former Vice Chairperson of the Police Advisory Commission. I recently became a member of the Pennsylvania Commission on Crime Delinquency Philadelphia Working Group of the DMC and the Philadelphia Minority Youth-Law Enforcement Relations. I have been very involved with and troubled by the ever escalating violence in our society and believe that there are innovative ways of having a positive impact on world peace and those most likely to become involved in violent acts in our communities.

Martin Luther King once said "the ultimate measure of a man is not where he stands in moments of comfort and convenience, but where he stands at times of challenge and controversy."

Today we collectively heard a growing body of evidence and disturbing stories on the high cost of violence and its devastating effects on public safety and public health. I believe we all agree these are very challenging times we are living in. I am honored to be a part of this Policy Committee Hearing and I congratulate all of today's speakers. They have provided an extraordinary insight into the culture of violence. I applaud their efforts to make this a safer society and I am particularly pleased that I share this panel with representatives of Drexel University's Center for Nonviolence and Social Justice and Rutgers University's Center for Behavioral Health Services and Criminal Justice Research. I look forward to working with both of these fine universities to find ways of changing the culture of violence in our communities. Most importantly, we need everyone here today to embrace the core value that youth violence affects each of us in multiple ways and each of us has a role to play to keep our children, youth, communities and our great Commonwealth of Pennsylvania safe.

As part of the solution, in 2007, I developed a Train-the-Trainers program called Tame and Train Your Tongue® that specializes in the field of personal and professional communications, world peace, stress management and conflict resolutions. This evidenced-based training teaches how to transform attitudes and effectively communicate without the drama, as well as, defuse potentially volatile situations.

Why do some youths get involved in violence and others do not? There is no simple answer to this question. According to the American Academy of Pediatrics, exposure to violence and victimization are strongly associated with subsequent acts of violence by victims. When children are asked about the causes of youth violence, they cite violence in the home and bullying at school as the number one and number two causes.

The words we spoke have power. The Tame and Train Your Tongue® methodology provides age-approach critical thinking, problem solving, communication techniques and proven strategies to defuse hostile conversations. We provide methods for resolving conflicts short of violence by maintaining a calm demeanor, listening, using humor and many other tactics to diffuse situations. We examine risk factors associated with an increased likelihood of violence or other harmful behaviors, as well as, explore protective factors and opportunities that buffer youth from harm.

Tame and Train Your Tongue® is a collaborative effort, one in which we include role playing, blended learning training, and a dual approach of increasing and strengthening protective strategies that reduce risk factors and behaviors predictive of violence. Our team of experts is committed to ensuring youth violence avoided today is a triumph.

We have successfully utilized our program in training sessions and strategic planning retreats for professional development for teachers, youth organizations and public safety agencies such as the City of Philadelphia Police Advisory Commission and for the Central Intelligence Agency (CIA) at the National Urban League Black Executive Exchange Program (BEEP) Conference. Tame and Train Your Tongue® is an effective model that can be implemented quickly to help reduce youth violence throughout the Commonwealth and the country.

Legacy Pathways provides this training and stand ready to collaborate and customize our Tame and Train Your Tongue® program to meet the needs of diverse groups and situations. We are interested in working with adults but more particularly with youth by helping them find smarter ways to avoid the violence we have heard and talked about today. This is not an instantaneous, all-encompassing solution but it can save lives and save them quickly. After all, isn't that why we are here today?

Center for
Behavioral Health Services
& Criminal Justice Research

SUBMITTED FOR RECORD

RUTGERS
THE STATE UNIVERSITY OF NEW JERSEY

From the Desk of
Nancy Wolff, Ph.D.
Professor
E.J. Bloustein School of Planning and Public Policy
Rutgers, The State University of New Jersey
Telephone: 732.932.6635

Director
Center for Behavioral Health Services &
Criminal Justice Research
Email: nwolff@cbhs.rutgers.edu

Good afternoon.

My name is Nancy Wolff. I am a professor in the Bloustein School of Planning and Public Policy at Rutgers, The State University of New Jersey and the director of the Center for Behavioral Health Services & Criminal Justice Research, funded by the NIMH. I am a health economist and have conducted research on mental illnesses and criminal justice issues for over 20 years.

For the past decade, I have been conducting victimization research inside prisons. I have asked thousands of incarcerated persons about their experiences with victimization, directly interviewed hundreds about their experiences, and implemented and studied programs that respond to the strengths and difficulties of incarcerated persons who have experienced victimization as adults and children. My testimony today will focus first on what I have learned from listening to incarcerated people as it relates to their early childhood experiences with victimization, emphasizing how childhood victimization is a risk factor for future violence. Next, I will discuss the need to work with children and youth, not fix them, to prevent youth violence. It is my view that any effort to prevent youth violence must begin with and be sustained by trauma-informed strategies. I'm focusing attention on incarcerated people because violent youth are future inmates.

Most people come to prison with a legacy of victimization. Based on data from 7500 incarcerated men and women in New Jersey prisons, half or more male and female inmates reported childhood physical victimization. Slightly less than 10 percent of male inmates, compared to 47 percent of female inmates, reported childhood sexual victimization.[1] If we disaggregate the inmate population by mental disorder, several patterns are observed.

[1] Wolff, N., Shi, J., Siegel, J.A. (2009). Patterns of victimization among male and female inmates: Evidence of an enduring legacy. Violence and Victims, 24(4), 469-484.

First, inmates reporting a mental disorder are significantly more likely to have experienced all types of interpersonal trauma (i.e., sexual, physical, emotional) than their non-disordered counterparts. Second, interpersonal trauma was most likely to occur in childhood (prior to turning age 18). Prior to incarceration, over half of the inmates with serious mental disorder (i.e., schizophrenia or bipolar disorder) reported being hit with an object that left welts or bleeding, being beaten up, and being abandoned. Half or more of female inmates with a serious mental disorder reported experiencing all specific types of sexual victimization, as well as being threatened or harmed with a knife or gun.[2]

Incarcerated persons with histories of childhood abuse are more likely to be victimized inside prison. That is, both male and female inmates who experienced victimization inside prison were significantly more likely to report an experience of victimization in childhood. Roughly two-thirds of male and female inmates experiencing victimization in prison during the past six months reported being physically victimized prior to age 18 compared to roughly half of those who did not report experiencing victimization.[1] In predicting sexual victimization inside prison, most significant was the effect of prior sexual victimization in the community. Inmates who experienced sexual victimization prior to age 18 were approximately three to five times more likely to report sexual victimization inside prison during a six-month time period compared to their counterparts who had no prior sexual victimization.[3] Similarly, inmates who had experienced physical victimization before age 18 were 44 percent more likely to report a physical assault by another inmate, compared to inmates without that characteristic.[4] Here, prior physical victimization included being choked, hit with an object that left welts or caused bleeding, burned with a match or hot object or liquid, threatened or harmed with a knife or gun, and/or beat up. These findings are consistent with the broader victimization literature showing prior victimization is a significant predictor of future victimization.

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[2] Wolff, N., & Shi, J. (2009). Victimization and feeling of safety among male and female inmates with behavioral health problems. *The Journal of Forensic Psychiatry & Psychology, 20*(S1), S56-S77.

[3] Wolff, N., Shi, J., Blitz, C.L., & Siegel, J. (2007). Understanding sexual victimization inside prisons: Factors that predict risk. *Criminology & Public Policy,* 6(3), 201-231.

[4] Wolff, N., Shi, J., & Siegel, J. (2009). Understanding physical victimization inside prisons: Factors that predict risk. *Justice Quarterly*, 2009, 26(3), 445-475.

For incarcerated men, childhood victimization is associated with behavioral health symptoms and psychopathology. Childhood sexual trauma exposure and childhood abandonment were found to be positively correlated with depression and anxiety symptoms, while childhood sexual trauma predicts substance abuse problems among incarcerated males. Likewise, trauma exposure, in general, was positively associated with psychopathology. All types of trauma, experienced in childhood and adulthood, independently and significantly predicted interpersonal and self-regulation problems. Physical trauma and abandonment, in childhood and adulthood, were also positively correlated with aggressive behavior. All types of trauma experiences (with the exception of physical trauma before age of 18) increased the feeling of hopelessness among incarcerated men.[5]

High rates of childhood victimization among incarcerated persons are not surprising as history of violent victimization, high emotional distress, an exposure to violence and conflict within the family are major predictors of youth violence.[6] Researchers have consistently found that early child abuse and neglect increase the risk for arrest as a juvenile, as an adult, and for a violent crime.[7] Over the course of their lifetime, over half (57%) of children and adolescents experience some form of physical assault and bullying. If we look over a 12-month period, two-thirds of children ages 0 to 17 years experienced at least one direct or indirect form of victimization.[8] In an average year, more than 40 percent of children witness an act of violence in their homes, schools, and communities.[9] Rates of victimization are particularly high among children in protective custody. Of those children experiencing maltreatment, two thirds experienced neglect, 14 percent were physically

[5] Wolff, N., & Shi, J. (2012). Childhood and adult trauma experiences of incarcerated persons and their relationship to adult behavioral health problems and treatment. *International Journal of Environmental Research and Public Health,* 2012, *9*(5), 1908-1926.

[6] Center for Disease Control and Prevention. (2013). Youth violence: Risk and protective factors. Retrieved from http://www.cdc.gov/violenceprevention/youthviolence/riskprotectivefactors.html

[7] Maxfield, M.G., & Widom, C.S. (1996). The cycle of violence: Revisited six years later. *Archives of Pediatrics and Adolescent Medicine, 150*: 390-395.

[8] Finkelhor, D., Turner, H.A., Ormrod, R.K., & Hamby, S.L. (2009). Violence, abuse, & crime exposure in a national sample of children & youth. *Pediatrics 124(5): 1-14.*

[9] Finkelhor, D., Turner, H.A., Ormrod, R., Hamby, S.L., & Kracke, K. (2009). *Children's exposure to violence: A comprehensive national survey.* Bulletin. Washington, DC: U.S. Department of Justice, Office of Justice Programs, Office of Juvenile Justiceand Delinquency Prevention. Retrieved from. http://www.unh.edu/ccrc/pdf/DOJ-NatSCEV-bulletin.pdf

abused, 7 percent were sexually abused, and 6 percent were psychologically maltreated.[10] For adjudicated youth inside state-owned or -operated juvenile facilities and state contract facilities, nearly one in ten (representing 1,720 youth nationwide) reported experiencing one or more incidents of sexual victimization by another youth or staff person in the past 12 months or since admission, if less than 12 months.[11]

What all these statistics tell us is that children and youth are victims of violence in their homes, schools, communities, and while under state authority. We also know that being victimized once increases the likelihood of being victimized again.[12] This translates into hundreds of thousands of children who are at higher risk for psychological and behavioral problems because of abuse and neglect. For example, children who were abused are very likely to have poor mental and emotional health,[13] as well as social difficulties[14] in adulthood. These children are also at higher risk for behavioral problems that include delinquency, teen pregnancy, low academic achievement, and drug use.[15] According to a study by the National Institute of Justice, children who experience neglect and abuse are 11 times more likely to be arrested as a juvenile for criminal behavior, nearly three times more likely to be arrested as an adult for violent and criminal behavior, and three times more likely to be arrested for one of many forms of violent crime.[16] The National Institute of Drug Abuse reports that two-thirds of people receiving drug treatment indicated that they were victims of child abuse.[17]

While it is not the case that *all* children who experience or witness trauma will experience long-term psychological and behavioral consequences. We do know, however, that their risk for such

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[10] Office of Juvenile Justice and Delinquency Prevention, (2012). *OJJDP Statistical Briefing Book,* Washington, DC: U.S. Department of Justice, *Characteristics of Child Maltreatment Victims, 2010.* Retrieved from http://www.ojjdp.gov/ojstatbb/victims/qa02102.asp?qaDate=2010&text=.

[11] Beck, A., Cantor, D., Hartge, J., Smith, T. (2013). Sexual victimization in juvenile facilities reported by youth. Washington, D.C.: U.S. Department of Justice, NCJ 241708. Retrieved from http://www.bjs.gov/content/pub/pdf/svjfry12.pdf

[12] Finkelhor, D., Ormrod, R., Hamby, Sh., & Ormrod, R. (2011). Polyvictimization: Children's exposure to multiple types of violence, crime, and abuse. Washington, D.C.: Office of Juvenile Justice and Delinquency Prevention. Retrieved from https://www.ncjrs.gov/pdffiles1/ojjdp/235504.pdf

[13] Silverman, A. B., Reinherz, H. Z., & Giaconia, R. M. (1996). The long-term sequelae of child and adolescent abuse: A longitudinal community study. *Child Abuse and Neglect*, 20(8), 709-723.

[14] Schore, A. N. (2003). Early relational trauma, disorganized attachment, and the development of a predisposition to violence. In M. F. Solomon & D. J. Siegel (Eds.), *Healing trauma: Attachment, mind, body, and brain.* New York, NY: Norton.

[15] Kelley, B. T., Thornberry, T. P., & Smith, C. A. (1997). *In the wake of childhood maltreatment.* Washington, DC: National Institute of Justice. Retrieved from www.ncjrs.gov/pdffiles1/165257.pdf

[16] English, D. J., Widom, C. S., & Brandford, C. (2004). Another look at the effects of child abuse. *NIJ Journal*, 251, 23-24.

[17] Swan, N. (1998). Exploring the role of child abuse on later drug abuse: Researchers face broad gaps in information. *NIDA Notes*, 13(2). Retrieved from www.nida.nih.gov/NIDA_Notes/NNVol13N2/exploring.html

problems are elevated and depend in part on the age of the child when the abuse occurred, the type, frequency, duration, and severity of the abuse, and the relationship between the victim and abuser.[18,19] A recent study exploring the effects of adverse childhood experiences (ACE) on leading health and social problems concluded that:

> *When a child is wounded, the pain and negative long-term effects reverberate as an echo of the lives of people they grew up with—and then they grow up, at risk for taking on the same characteristics and behaviors—thereby sustaining the cycle of abuse, neglect, violence and substance abuse, and mental illness.... Information from the ACE Study suggests that traumatic stressors during childhood and adolescence represent a common pathway to a variety of important long-term behavioral, health, and social problems.... Thus, an integrated rather than a separate or categorical, perspective on the origins of health and social problems throughout the lifespan is needed.*[20]

The lesson most relevant to youth violence from all this research is that troubled youth are very likely to have experienced maltreatment and struggle with its legacy. They may be running away from home to avoid further abuse, developing defensive skills and carrying a weapon to keep people away because they have learned to distrust people, especially those who are bigger than them or who hold authority positions, and using and abusing drugs, love, and fast living to avoid the memories of the harm done to them by people who were suppose to take care of them. In an effort to survive, they are likely to be distrustful of adults, particularly authority figures, hyper-reactive to situations or people who make them feel powerless, quick to run or fight, and predisposed to quitting in part because everything feels so hopeless and in part because they want to avoid being shamed. These youth need safety and understanding. They need a place where they can stop running, hiding, and fighting; a place where a competent, caring adult will listen and help them heal from what has been done to them.

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[18] English, D. J., Upadhyaya, M. P., Litrownik, A. J., Marshall, J. M., Runyan, D. K., Graham, J. C., & Dubowitz, H. (2005). Maltreatment's wake: The relationship of maltreatment dimensions to child outcomes. *Child Abuse and Neglect*, 29, 597-619.

[19] Chalk, R., Gibbons, A., & Scarupa, H. J. (2002). *The multiple dimensions of child abuse and neglect: New insights into an old problem*. Washington, DC: Child Trends. Retrieved from www.childtrends.org/Files/ChildAbuseRB.pdf

[20] Anda, R. The health and social impact of growing up with adverse childhood experiences. Retrieved from http://acestudy.org/files/Review_of_ACE_Study_with_references_summary_table_2_.pdf

With the growing recognition of the prevalence of trauma among people of all ages with health and behavior problems, there is a movement to make care systems more trauma-informed. Trauma-informed care systems recognize that trauma is prevalent among their clients and that environments responding to these clients are often overtly or covertly traumatizing. The goal of a trauma-informed care system is to make the system less traumatizing by engaging people in ways that make them feel safe and, by doing so, the system is more effective (i.e., has better health and behavioral outcomes).[21]

Applying this to troubled children and youth means presuming that every troubled young person has been exposed to abuse, violence, neglect, or trauma, is struggling with its aftermath, and is ashamed to admit the pre-existing or current abuse. With this presumption, trauma-informed staff consistently focuses attention on what has happened to the young person, not on what is wrong with him or her.[22] Pathologizing troubled young people as "bad" or "manipulative" or "evil" is counterproductive as it causes them to become defensive in unhealthy ways. Similarly, the flex of power by staff, exemplified by a harsh, authoritative demeanor, uniforms and jangling keys, and threats of deprivation, will cause the young person to become more protective in aggressive or depressive ways. Systems that use fear and aggressive tactics to control wounded youth inadvertently re-traumatize them and, in response, these youth react by using coping strategies that they perceive as protective, even though they are often self-destructive. To stop the cycle of trauma and violence, we need a more "healing" approach; one that gives wounded youth the opportunity to stop being reactive so that they can start to heal.

If we, as a society, want to lower rates of youth violence, we need to respond calmly and compassionately to the antecedent wounds caused by neglect and abuse in childhood. Often during interviews with incarcerated adults, I am been told that "if someone would have cared enough to ask" or "if someone could have been trusted," things would be different today – "I wouldn't be here." During interviews, I am also told horrific stories of abuse and cruel abandonment; stories that would have been deemed over the top if they were in a fictional story.

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[21] Elliott, D.E., Bjelajac, P., Fallot, R.D., Markoff, L.S., & Glover Reed, B. (2005). *Journal of Community Psychology, 33*(4), 461-477.

[22] Bloom, Sandra (1998). By the crowd they have been broken, by the crowd they shall be healed: The social transformation of trauma. In R. Tedeschi, C. Park, & L. Calhoun. *Post-traumatic growth: Theory and research on change in the aftermath of crises*. Mahwah, NJ: Lawrence Erlbaum.

Yet these were the lives of so many. In the recounting of their life stories, they tell me how they developed themselves in an effort to prevent anyone from ever hurting them again; they learned to fight, bulk up, carry weapons, talk tough … so that no one would "ever hurt me again." Many also said they could not live with the memories of abuse so they found ways to escape into drugs, alcohol, stealing, sex, in hopes that they will find relief. Developmentally, trauma impacts the way wounded people think, the way they feel (or don't feel), and the way they see and interact with others. Yet behind these tattooed and muscle-bound bodies are hurt, injured little boys and girls. When these youth get in trouble, we respond to the externalized protective manifestations of these wounds, which scare us. We react often with harshness; we use the authority of the law to scare them straight. But all that does is start the cycle all over again – they, the wounded, react protectively and self-destructively.

The cycle of trauma and violence must end. There are many trauma-focused programs (e.g., Seeking Safety, Trauma Empowerment Recovery Model, Addiction and Trauma Recovery Integration Model, Sanctuary Model) that would benefit troubled youth (and society) but these youth do not need *just* a program. Trauma-focused programs, even those supported by research evidence, do not work if they are activated by people and in environments that do not internalize the values of a trauma-informed philosophy. Trauma-informed systems must employ staff that understand how trauma impacts human development, that are trained to engage youth in non-threatening, respectful, firm, and trustworthy ways, and that work with the youth to develop and master skills that are life-enhancing and empowering. Similarly, for environments to be healing, they must be safe from abuse, disrespect, judgment, and authoritarian styles of engagement. To reach these young people, to encourage them to let their guard down, we must earn their trust. We must lower our voices and our coercive weapons, and prove our intent to heal, not harm. We must meet them "where they are" -- as people with unique stories and give them the space to come out of hiding and reveal their wounds. As healers, we listen, support, encourage, suggest, guide, and empower. A trauma-informed system of care believes in the youth's potential when he/she cannot, and we, as a society, must also believe in youth's potential even when we cannot see it in their current behavior. We must believe that wounded youth have the potential to be productive, law-abiding members of society and, intervene accordingly, if healing and non-violence are ever to have a chance.

We have, through our policies and practices, failed wounded youth and perpetuated their woundedness. The state's response to their experiences of abuse and subsequent violence is part of the cause of youth violence. We have spent millions of dollars trying to scare youth straight. But they have already been scared through abuse and neglect to violence as a protective shield. More fear will not solve this problem. Fear is the source of the problem. We must address the fear of harm to stop the harm. If we are serious about lowering the rate of youth violence, we need to change how we see these youth, how we engage them, and what we see as the goal. We must see them as the successful adults they can be and help them to get to that place. Our challenge is to step out of a paradigm that has not worked, and to experiment with new approaches that recognize more holistically the effects of violence on violence. Einstein said that "insanity is doing the same thing over and over again and expecting different results." We are trapped by the insanity of our misinformed logic. We cannot scare wounded youth into better behavior; we may, however, be able to earn their trust enough through trauma-informed policies and practices to begin the process of healing. Investing in healing wounded youth is a risk worth public investment, especially in light of the alternative. Thank you.