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

Introduction

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

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

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

In-depth interviews with African American men who are victims of violence show that symptoms of trauma combine with the so-called “code of the street” to compel traumatized victims to self-medicate with drugs, arm themselves and sometimes seek to retaliate, all to reestablish a sense of safety (Rich & Grey, 2005). This dynamic is not limited to African
American men but resonates with other men of color who find themselves facing a limited horizon of life possibilities in communities that they see as hostile. Despite this knowledge, the criminal justice system remains the dominant model for addressing youth violence.

**The central role of trauma**

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

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

**The Emergency Department as locus of intervention**

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

According to “Children’s Exposure to Violence: A Comprehensive National Survey,” more needs to be done at all levels of policy and practice to identify children at risk from exposure to violence and to coordinate the delivery of services to these children. This study mentions the need to involve emergency room physicians, nurses, and social workers in responding to the needs of these youth and in connecting with other service providers in the young person’s life to coordinate services (Finkelhor, Turner, Ormrod, Hamby, & Kracke, 2009). Another study that looked at repeated exposure to violence concluded that the multiplicity of interrelated risk factors mandated a comprehensive approach to violence recidivism and called for hospital-based
intervention strategies that address the complex needs of this population (Cooper, Eslinger, & Stolley, 2006).

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

**Portals of Care**

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

**Where They Go**

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

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

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

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

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

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

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

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

African Americans are also impacted by the diagnoses and treatments they receive. Specific to mental health services, African Americans are over-diagnosed with psychotic disorder, like schizophrenia, and under-diagnosed with affective disorders, like depression and anxiety (Baker & Bell, 1999). African Americans are also more likely than whites to be prescribed older
generation/less commonly prescribed anti-depressants which have more side effects and are less efficacious (Melfi, Croghan, Hanna, & Robinson, 2000). Already less likely than whites to seek mental health services (U.S. Department of Health and Human Services, 2001) misdiagnosis and suboptimal medications can lead to continued or increased symptoms and erode trust in treatment.

**Trust**

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

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

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

Communication appears to be at the root of mistrust, Keating stated, “Perceptions that physician communication was less supportive, less partnering, and less informative accounted for black patients’ lower trust in physicians” (2004). Studies have shown that Black patients reported less positive communication, and that physicians engaged in less participatory decision making with black patients (Tarrant, Stokes, & Baker, 2003) (Fiscella, et al., 2004).
While perceived racism is often cited as potential reasons for mistrust and under-utilization of health services, studies show conflicting results on the value of racial or ethnic similarity between patient and physician (Cook, Kosoko-Lasaki, & Obrien, 2005). One study showed a patient’s rating of a doctor’s care and effort is higher when of the same race (Cooper, Roter, & Johnson, 2003). Another study showed patients do not have a preference for physicians of the same race, but rather nonverbal behavior was associated with both satisfaction and trust (Aruguete & Roberts, 2002). Another study showed that the race of the physician was not as important as establishing trust as was language and cultural barriers (Jacobs, Rolle, Ferrans, Whitaker, & Warnecke, 2006). Overall, race appears to be less important than the development of interpersonal trust, which is a variable process among individuals.

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

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

**PTSD**

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

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

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

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

**PTSD Symptomology in BMoC**

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

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

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

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

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

Screening Tools

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

Other screens include Brief Anxiety Inventory-Primary Care (BAI-PC), a subset of the 21-item Beck Anxiety Inventory. One benefit of this screen is that the seven item screen also screens
for other disorders. Short Screening Scale for PTSD, also a seven question screen was designed for use by all trauma victims. Primary Care PTSD Screen (PC-PTSD), a four item screen, was designed for medical settings and is in use for military veterans. It does not offer a list of possible traumas. Startle, Physiological Arousal, Anxiety, and Numbness (SPAN) is a shorter version of the Davidson Trauma Scale with only four items. The Short Post-Traumatic Stress Disorder Rating Interview (SPRINT) has eight questions that measure intrusion, avoidance, numbing, and arousal, among other things. SPRINT is useful for measuring changes of symptoms over time and can be used to measure "global improvement". The Trauma Screening Questionnaire (TSQ), a 10 item screen, was designed for all kinds of trauma and is intended to be used 3-4 weeks after the event to allow time for normal recovery (National Center for PTSD, 2007).

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

**Interventions/treatment**

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

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

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

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

**SBIRT**

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

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

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

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

Benefits and Challenges in ED context

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

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

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

Screening Tools

Like PTSD, a number of pre-existing screening tools are in use for SBIRT; the tools vary in length and some may be more efficient than others, depending on population and environment (Higgins-Biddle, Hungerford, & Cates-Wessel, 2009). Screening tools include: AUDIT, a 10 question assessment; Binge question, a single question; Cut down, Annoyed, Guilty, Eye-opener (CAGE), three questions; and Car, Relax, Alone, Friends, Forget, Trouble (CRAFFT), a six
question instrument; can all be used independently or grouped with consumption information and/or blood alcohol content. (American Public Health Association and Education Development Center, Inc., 2008; Higgins-Biddle, Hungerford, & Cates-Wessel, 2009). In some cases, such as AUDIT, the abbreviated version – already validated for its efficacy- is used to keep the screening short. This shortened time frame is beneficial to emergency room personnel and patients whose primary concern is treatment for injury or illness and not for interventions.

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

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

**Brief Interventions/Treatments**

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

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

For the abstainers and low risk drinkers, the intervention is actually intended to prevent increased drinking over time through education. Providing praise for current drinking habits and basic information about standard drink sizes and recommended intake is all that is necessary for this group  (Babor & Higgins-Biddle, 2001). For those who are screened as moderate risk, simple
advice is provided, while for moderate-to-high risk simple advice plus brief interventions are provided. The final Zone goes beyond the brief intervention structure and requires a referral to a specialist (Lawson & Flocke, 2009; Cunningham, et al., 2009).

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

**Conclusion**

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

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

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

Although beginning to gain some traction through the adoption of the term Complex PTSD to distinguish it from the more commonly known and diagnosed PTSD, there is still limited research on how continuous exposure to violence and violent surroundings without expectation
of a change in environment impacts individuals and the best way to treat such cases. One study, in Kosovo, sited success in treatment with continued protection after continued exposure to violence but that intervention was not brief and does not fit easily into the SBIRT model.

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

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

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

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

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

**Future Research**

Considering the current gaps in research as starting points, it is important to give more attention to complex PTSD, and more specifically, what that looks like in relation to community violence- and within a population of young BMoC.
There is also a gap in research related to PTSD and how it might be treated in the context of the criminal justice system where people have high rates of trauma exposure and risk, by nature of the criminal justice system, being further traumatized. This is significant because BMoC are disproportionately represented in the criminal justice system.

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

(n.d.).


February 12, 2013


