

Good morning, everyone. Thank you for joining us today. My name is Sharron Fletcher, and I work in the Office of Victims of Crime, and I'm your host today for a Vision 21 talk engaging with experts on trending topics. Before we get started, I want to make sure everyone can hear us. If anyone is having technical issues, please email us at [ovcwebcast@ovcttac.org](mailto:ovcwebcast@ovcttac.org).

OVC in collaboration with OVC's Training and Technical Assistance Center, or OVC TTAC, hosts the new online series Vision 21 talks engaging with experts on trending topics, which includes our four inspiring talks. Inspired by OVC's Vision 21 recommendations to support strategic change in the victim assistance field, these virtual sessions provide innovative and relevant information about transformational victim service topics. Our topic today is "Supporting Male Survivors of Violence." I'm excited to be here and I hope you are, too, because we have what I believe is a very meaningful discussion planned.

I want to start by giving you a little bit of history about how this topic came to be selected. I'm going to guess that everyone here has heard about Vision 21. Mostly because my colleagues are in the audience. In May 2014, OVC developed Vision 21, which is essentially a strategy to change the way we respond to victims in our country through a comprehensive and systemic approach to ensure that every crime victim receives the best responses and services. In other words, Vision 21 is really OVC's plan to move the victim service field forward in the future recognizing multiple areas of needs in the field as well as how the field continues to change. It drives what we do at OVC every single day. The final report for Vision 21 contained a number of key findings, one of which was the need to expand victim services to reach underserved and unserved victim populations, specifically young men of color, African-Americans, and Latino young men. Our goal at OVC is to reach every victim. Reaching underserved populations and providing them with services that work best for them is one of our primary focuses.

The reason that OVC is uplifting this specific underserved population is African-American and Latino young men are more likely to become victims of violent crime, specifically homicide. There are numerous statistics that have shown this to be true; however, despite these troublesome statistics, the victim service field and other allied professionals to serve crime victims have been slow or often even reluctant to recognize and serve these victims. We have also learned from years of research and practice about the harmful effects of trauma and violence on our communities, especially those communities that experience higher levels of crime and violence.

In the interest of time and because most of this will be covered by our panelists, I won't go over all of the research, but I will summarize by mentioning that when people are exposed to violence, which includes both directly experiencing violence and witnessing violence, it causes trauma. This trauma can manifest itself in different ways for each individual. Signs of trauma include difficulty managing emotions, difficulty learning, and other behaviors that others might find erratic. Even riskier behaviors such as substance abuse and criminal activity. The need

to address this trauma that is experienced by crime victims, especially those that are most likely to become victims and that statistics show to be victimized at higher rates than other segments of the population make connecting victims and supportive services an important step in a survivor's healing process. We know that connecting young men of color that have been harmed by violence with services and support can prevent both retaliation and reinjury. Breaking this cycle of violence is important not just for the individual victim but for us all because we all want and deserve to feel safe in the communities where we live and work.

Some of the points I have mentioned align with recommendations from the Attorney General's Task Force on Children's Exposure to Violence, which some of you may know is Defending Childhood. OVC recognized this overlap in 2015 and began working with our partners at the Office of Juvenile Justice and Delinquency Prevention, which is the office in the department that leads the Defending Childhood Initiative. And we also reached out to our partners at the National Institute of Justice to develop the Supporting Male Survivors of Violence Initiative.

This important initiative has three parts. First, it's working in 12 demonstration sites across the country to implement a variety of programs to reach and serve boys and men of color harmed by violence. Second, it's providing dedicated technical assistance support to the demonstration sites through the Healing Justice Alliance, or HJA. HJA is actually a partnership of organizations that includes Youth Alive!, the National Network of Hospital-based Violence Intervention Programs, Cure Violence, and the Berkeley Media Studies Group. Each of these organizations have been in the trenches for years working to improve services for these young men and change the narrative about who deserves to receive services. And lastly, we are evaluating the programs funded to help increase the evidence base to show what types of programs and interventions best serve boys and men of color harmed by violence. The Research Triangle Institute, which some of you may know as RTI, is the organization leading the national level valuation effort.

With all of this in mind, we have organized today's session to continue the conversation about reaching the survivors and their families and connecting them to much-needed services and support. I'm very excited to get this panel going, so now I will give the floor to Anne Marks who will serve as a moderator for this session and is Executive Director of Youth Alive! which as I just mentioned is part of the Healing Justice Alliance. Thank you.

Thank you, Sharron. Thank you to the Office of Victims of Crime and the Office of Justice Programs for hosting us here today. It is incredibly gratifying to be at a moment where this is the topic of importance and interest for this group. Sharron described a lot of the Healing Justice Alliance and what it is we do, so I won't restate that, but I will state the value behind why the Healing Justice Alliance exists. It's because of programs like the ones you are about to hear from and individuals like the ones you are about to hear from who understand there is no justice unless there is healing. I would encourage you that every time you see the word "justice," insert "healing" in its place and think how that

might feel if we are really serving victims. We should be here in the Office of Healing Programs. When we look at young men, black men, brown men, we should remember they are disproportionately victims of violence in need of healing. I am gratified to be here on the panel today with these tremendous healers. First, you're going to hear from Sherman Spears, who was the founder of Caught in the Crossfire, the first hospital-based violence intervention program. Then you will be hearing from Dr. John Rich, who is the Co-Director for the Center for Nonviolence and Social Justice at Drexel University in Philadelphia. And then you will hear from Dr. Ted Corbin, who is also a Co-Director of the Center for Nonviolence and Social Justice as well as the Medical Director for the Healing Hurt People Program. And after him, will be Kenton Kirby, who is the Director of Trauma Support Services at Crown Heights Mediation Center in Brooklyn.

We are going to go hopping around the country from Oakland to Philadelphia to New York, and after that we are going to take some questions both here in the room and from those of you who can email in your questions. We hope to have a very rich discussion about how and why violence is really a health issue and how programs like these can help create healing. With no further ado, Sherman?

Good morning, everyone. My name is Sherman Spears. I'm the founder of the hospital-based intervention program Caught in the Crossfire, and thank you, guys for giving me the opportunity to participate in this discussion today on how to support young men affected by violence. I would like to start off and say that I myself found myself at the age of 19 a young victim of male violence. Because of that, I had a lot of healing and discovery to go on about myself. When I woke up in the hospital after being a multiple gunshot victim, I woke up thinking that my life had traumatically been turned upside down and I had all kinds of questions and fears about what life would be now, especially since it resulted in my permanent paralysis and being in a wheelchair. I had at the time I had no experience with people being paralyzed or living in a wheelchair and so all of this was all new to me.

You would think that in that situation that there would be someone or some organization that could come in and tell me how life would be and what to expect and what kind of support systems that would be in place for me. But as I quickly discovered, there were none. At that time, when I had my injury, there was no such things as services for victims of violence. And so everything was a discovery basis for me. To be here today to try and talk to you guys about how we can provide support for male victims of violence is a great honor for me. Through my own injury, what I realized is that when you wake up and you are in the hospital and you are a male and you have been victimized, that all of your preconceived notions about yourself change. We are raised as males to believe that we are strong and if we show fear that that's a sign of weakness. To reach out for help, that's a sign of weakness. More often than not, we turn in on ourselves and become closed off and reclusive and not open to the services of social services that are presented to us. At that time, our only concern is how do I go on and who do I trust? Because once you're a victim of gun violence you are very mistrustful of everybody and everything.

What I found out, the only thing that helped me heal was that I was getting an opportunity to become part of a change. Unlike most victims of violence, I was given an opportunity to work within my injury and to use that injury to try and help other people. Because of that I was able to heal and because of that I was able to develop the Caught in the Crossfire program. As for the Caught in the Crossfire program, it was really created to serve a need that I did not find for myself. What we do in the Crossfire is when someone is injured in our community, someone is immediately dispatched to the bedside to be there to be that supportive person and let the victim know that you are not alone. That if you need help, there is a helping hand, and we are here to help and support you.

When I was in the hospital, you would think your friends and your family would come and they would be supportive of your healing process. More often than not because they have no idea how to be supportive, the conclusion that they come to is the only way that I can support you is by going out and victimizing someone else. That very thought process is why there is recidivism and one person hurts another person and so on and so on. Unless we can come to the point where we can let males know that when you are victimized that there is a certain level of mental trauma and mental health that you need to heal, this scenario keeps playing itself out over and over again. I think that one of the things that was apparent to me is that when I did try to reach out for services, there was almost a preconceived notion that I must have played some part in my victimization. More often than not, that is not true. I believe that even if it is true, if you are a victim of violence you need help to be healed. Because if you're not healed, it's going to be more harmful to your community than anything else. I'm not sure if you guys understand, but there is terminology in the medical field of treat and street. Which means that victims of gunshot violence, the all doctors can do is stabilize you and then send you back out in the same environment that you were victimized in in the first place with no more understanding of how to avoid that or deal with your victimization than you had when you came in.

Just a small story, one of the doctors that I work with would tell me how, he is a trauma surgeon, how he would get a victim on the table and when he takes off his clothes in order to operate on him he would find the same bandages on him from when he was there recently. That in itself tells us that if young male victims of violence do not get services, the recidivism rate, it's not going to stop. Also the recurrence of sending someone else there is not going to stop. By providing services to the victim not only do we help heal them but we can help heal our community. Because someone has to be there to tell these young people that enough is enough. That we believe in you and that we will be here to support you through your healing process.

Those kind of programs are the only things that are really going to make a difference in our community. I would like to encourage you guys that are in a funding position or in a program position to really think about what it is that we can do to help these unserved populations because if we do nothing then nothing will change. Until we take it seriously regardless of what the circumstances were that brought a man into this

position, we as a community, as a nation have to be there to say we support you and we believe in you and that we know that given opportunity that there can be change. Going forward, I think that we have to try and restructure our thinking and restructure the way that money is dispersed. Because the only persons that are seen worthy of receiving help is domestic violence and alcohol violence, and even prisoners coming out of jail receive more support and more programs and more benefits than the young males that are out there trying to survive. Most of these males given the opportunity would make a change for the positive and be productive citizens in our society. But we have to give them that chance and that opportunity without having preconceived judgment on why they were victimized or how deserving they are of our help. Thank you.

[Applause]

Thank you, Sherman. I am moved by the commitment and the action that you spurred in the setting of having been traumatized and victimized. I think that speaks to something we talk about that often young people come out of these experiences with a survivor mission. That they want to make a change in community so that others are not traumatized. I want to build on what Sherman said by talking about the lens of trauma. How is it that if we take what we know about trauma, the science of trauma and adversity, and apply it to the lives of young people, we see a different set of solutions in front of us? We often think about that and the way that Sherman was talking about it, we see a young person who has been injured we may come with a particular preconceived notion that it was their own fault, they got themselves shot, they were doing something that they shouldn't have been doing. But when we take the lens of trauma and apply it to these young people, we often find that their actions are coming out of their past trauma, or the experience of trauma that landed them in the hospital. I will talk a little bit more about how we begin to bridge the disconnect between our preconceived notions and what these young people are experiencing.

Perhaps the starting context for thinking about trauma is to think about stress. Stress is a common word, a word we are mostly familiar with, but to provide a specific definition we think about stress as the set of changes in the body and the brain that are set into motion when there are overwhelming threats to physical or psychological well-being. Many of us on a day-to-day basis encounter what we talk about as stress, but not all stress is the same. We might think about stress as in some cases being positive. When we are faced with a challenge, perhaps it's an exam or school studies that have to be overcome, we think about a sports competition, maybe a musical recital. Those are often experiences that are short-lived. In the end, you come out of it stronger. Then many of us are familiar with what we might call "tolerable stress." These are more intense: the loss of a job, illness in the family, perhaps the death of a family member. These are short-lived, but with adequate support you are unlikely to cause long-term problems.

More recently, we have come to understand a concept called "toxic stress." Toxic stress is the kind of sustained adversity that was studied in the Adverse Childhood Experiences Study or that victims of repeated sexual abuse or violence or child abuse experience. These are sustained.

Children, particularly, are unable to manage the stress by themselves. In the long run, it will cause, can cause disruption to the physical body and to the mind. We often are faced with different types of stress, and we in health and justice are thinking about how to study these and understand them, so we can intervene most effectively.

But posttraumatic stress disorder is a different type of stress, and it is well-defined in the literature. It was initially noted in people returning from war in Vietnam. There are four main components of posttraumatic stress. The first is hyperarousal or hyperactivity. That is a jumpiness, a sense of never feeling safe, inability to sleep. It is a kind of revved up state where the body's normal fight or flight response is put into overdrive. And it occurs in people who have experienced extreme trauma. There is re-experiencing, or intrusive symptoms. This includes nightmares, flashbacks, and what we often call "body memory," that is a feeling in your body, potentially pain or another sensation that's associated with what you experience. These are often brought on by triggers: being somewhere near what happened to you or seeing someone else violently injured. The one we don't talk about as much as emotional numbing. This is the loss of the ability to feel. The loss of the ability to feel fear or love. And it can be very disruptive to relationships, very disruptive to families. Finally, what is termed negative alteration in cognition and mood, and this is difficulty concentrating or depression.

Young people who have been victims, young men of color often display all these in the aftermath of injury or because of witnessing violence. Yet in hospital or health care settings or social settings, it's often misinterpreted, that is a young person who doesn't have much expression, who may not make eye contact, who may be jumpy is often interpreted as well, he must've had something to do with it. He must be guilty. So what you have is a person who is suffering in a health care environment and instead of a healing intervention we treat them and we street them. We know from research that young people experience high rates, so in Healing Hurt People that you will hear about in a moment, when we looked at young people who had come through as victims of violence, 75 percent of these young people met full criteria for posttraumatic stress. Even those who didn't meet full criteria, many of them suffered from re-experiencing or hyperarousal or avoidance. We're seeing the epidemic levels of trauma and stress in young people. We're also seeing very high levels of adverse childhood experiences. That is experiences of childhood neglect, abuse, or family disruption with substance abuse, mental illness, violence in the family, or incarceration of a family member.

In the original study that defined adverse childhood experiences—you'll see here in the blue—in the original study, 13 percent of the people, mostly an insured population in Southern California, 13 percent had experienced it four or more adversities in their lives. In the clients that we see, people who have been victims of violence, 50 percent have experienced four or more. And in the original study, 64 percent had experienced at least one; among the people that we see, young victims of violence, 100 percent.

You might well ask what is the relationship between posttraumatic stress and violence? Let me detail for you something that we have learned in in-

depth interviews and studying young people and talking to them gathering their stories. Let's say a young person comes in with an injury. As a result, they develop posttraumatic stress. They are jumpy. They are not able to sleep. They feel unsafe all the time, having nightmares and flashbacks. No one has explained to them in the hospital that this will happen to them. They have no context, and they think they are going crazy. Young people often turn to something in their environment to treat their distress like marijuana or alcohol. What happens to someone who turns to marijuana or alcohol? If you are trying to get a job and they urine test, you're not going to be able to get a job. If you are on probation, you will be remanded if you have drugs in your urine. So what happens, a young person who was trying to self-treat can find themselves in deeper trouble or cut off from opportunity.

It is no secret to us as well that young people don't trust the police, often because they have been targeting young people of color in particular. If you don't trust the police and you don't feel safe, many young people turn to weapons as a way to protect themselves. Ill-advised, but we understand in the context of trauma that that may be all they see as an opportunity. We know that the risk of incarceration or death is elevated when you have PTSD and you have a weapon. We know that for younger people who have been victims of violence, if you follow them for five years and studies have done this, 45 percent of them have been shot or stabbed again, and 20 percent of those young people are dead. It's a very high-risk experience to be a victim of violence.

We also know it's not only the health care system and the hospital that encounters young people who have been victims. The truth is they are encountered by the police, often at the time that they have been injured. They may be in school. They may be involved in health care. Any number of these systems is touching them and at any point a system that touches you can either help you heal or it can re-traumatize you. And so we have an opportunity working together as many of the programs serving male survivors of violence are doing to not only focus on the health care environment, which is a potent and powerful moment, but also to focus on these other systems and working together.

The term we use collectively here and amongst our partners is trauma-informed practice. Trauma-informed practice is an approach that recognizes the psychological, not just the physical, wounds but also the deep wounds of trauma that these young people are left with. It also recognizes that early childhood adversity and stress can change your body and even put you at risk for chronic disease. That is well-known. So when we are talking about treating trauma, we're talking about preventing violence, but we're also talking about easing the burden and disparity of chronic disease that affects disproportionately people of color and especially men of color. A framework for thinking about the needs of victims of trauma—and Sharron, you made reference to this earlier—comes from the Sanctuary Model. This nonlinear conceptual framework supports the idea that people who have been traumatized need to reestablish safety, physical, psychological, social, and moral safety. They need support managing their emotions. They need help dealing with loss: the losses that come not only from losing friends or losing function in your body but also the loss that comes when you have to choose one path over

another. And then finally, victims of trauma need to be able to see a future. Because one of the most potent effects of trauma is to cut off your ability to see paths into the future, a brighter future. This is the framework that undergirds Healing Hurt People and undergirds many of the programs in the initiative that are looking at how to help young people heal. And with this, I am going to turn it over to my colleague Dr. Corbin to talk about Healing Hurt People.

Good morning. Thank you, John, thank you, Sherman, thank you, Anne and Kenton, who will follow me up. John set the tone for how we developed Healing Hurt People in Philadelphia based on the model that Sherman developed in California, Caught in the Crossfire. I'm just going to walk you through what this actually entails in identifying and working with young victims of interpersonal injury. I myself, I am an emergency medicine physician, and it's unfortunate that we see so many young people come through as victims of interpersonal injury. I'm based in Philadelphia, population of about 1.1 million people, we have five level one trauma centers that tend to these victims of interpersonal injury. At our hospital, Hahnemann University Hospital, which is the affiliate of Drexel University.

This is the schematic in which we work in terms of how we see the young person that comes through the emergency department. You will see if you start up in the left-hand corner you see someone that's violently injured. The hospital does a great job of stabilizing the person. To what Sherman said earlier, in these days of medical practice it is upon us to get the patients out as quickly as possible. For every one person that is shot, stabbed, or assaulted, they are admitted, and then nine people are treated and discharged. And so again, there is an opportunity to have a healing presence and purpose for that young person when they are identified as a victim of interpersonal injury.

At Hahnemann, we have that opportunity in that we have a skilled social worker as well as the community health worker peer—and I will talk about them in a minute—that really identifies these young people and works with them to heal from the trauma that they have experienced. There is a lot of pre-work in gaining trust with the young people because again, as Dr. Rich mentioned, there's a lot of mistrust both in the health care system as well as the justice system. We're really trying to deconstruct the notion that our young people have that we are in fact there to help them heal from the trauma they have experienced. You see at the bottom, and I'm not going to go through detail, but you can look at this schematic and see where our social workers and our community health worker peers work with the individuals who have been the victims of interpersonal injury.

There is an assessment that happens, there is case management and navigation of the systems, there is mentoring. We also have a S.E.L.F. group, which is essentially a peer group that works with the individuals who have experienced interpersonal injury. And then for our younger population, we have a more trauma-specific treatment, which is child-family traumatic stress intervention, which is working with the young person as well as a caregiver or a parent and the licensed social worker. What we actually provide is in these different quadrants we work with to

help the person heal from their physical wounds in a myriad of ways. Their social health by helping them navigate different systems within the city that they sometimes don't access because they don't know that they are available to the individual. We also work with them in terms of their behavioral health as well. All these things are all extremely important in us helping them heal. And then finally, we work with them around their family health as well because we know that helping just one person heal is not as good as helping the family heal as well.

In Philadelphia, we were given the opportunity to replicate Healing Hurt People at the different level one trauma centers in Philadelphia. We started at our hospital, Hahnemann, which I mentioned. We also mentioned we have a children's site, our St. Christopher's Hospital for Children, which is based in the north part of our city. Unfortunately, we see a lot of victims of interpersonal injury there. We have since been able to replicate the program at Einstein Medical Center, Temple University Hospital as well as Penn Presbyterian Medical Center.

And so in doing that, we also saw the opportunity to have a natural experiment. We recognize as we develop these programs we want to make sure that we are doing a good job at helping the young people that we are serving as well as making sure that the fidelity is in place as well as evaluating how the program actually works. We took the opportunity at this natural experiment. In doing so, we took advantage of—as we ramped up the program at these different sites, we also took an opportunity to collect information from a control group. And then as we ramped up, we collected information from the control group, and then once we started the program we collected information from the intervention group. You can see this is the schematic of the data collection that we are doing in evaluating the program. At the bottom, you'll see we are looking at re-injury in terms of hospital revisits, and then also we are looking at arrest rates. Most importantly, that we are interested in, the more proximal things you will see on the sides in terms of depression, PTSD, drug, and alcohol use.

This is another schematic as to how we rolled out this natural experiment in collecting information from the different institutions. It also allowed us to be as rigorous as a randomized control design, worked with the timing of the replication. We wanted—we ameliorated the ethical consideration withholding the program for which we knew had some impact on the lives of the individuals. To give you a sense of some of the preliminary data that we have found, we see looking at baseline we see that 78 percent of our participants report poor sleep quality, 55 percent of the participants have met full criteria for provisional PTSD, 45 percent met or exceeded the cutoff for major depression. In terms of some preliminary trends, we also see at baseline sleep quality is very poor. But then working with the program, they get better, as well as provisional PTSD in our intervention group, we see there is some improvement in those that are involved in the program.

Finally, in looking at how we can make the program better in working with young people, with the support of OVC we were able to work with and develop community health workers. And in doing that, we recognize for a long time that community health workers are valuable assets to any type

of health care program. But specifically, in this setting, young people that have lived experiences, that have graduated and done their own healing work, we then incorporated them into our program to connect to the young people that are victims of interpersonal injury. We also recognize the opportunity through the Affordable Care Act how we can get reimbursed for the services of those young people that are providing as community health worker peers. Lastly, on one of the slides you saw that we do have this—we bring together different agencies to talk about a patient that's involved in Healing Hurt People, and it's an opportunity to figure out how these different sectors can in fact improve provisional services to the victims of interpersonal injury, identify policy level barriers, and create trauma-informed systems.

Lastly, I'm going to share with you one of our community health worker peer's story. This is a young man who was the victim of multiple gunshot wounds. He enrolled in the program and did his own work and did his healing with the help of Healing Hurt People, and now he's one of our community health worker peers, staffing the emergency departments on Saturday nights and Friday nights, the peak time that we see interpersonal injury. I'm just going to let you hear his story.

Safety is the condition of being safe. Freedom from danger, risk, or injury. My definition of safety was being around my friends holding guns, but little did I know that my definition of safety was about to change. November 23, 2011, I was shot while someone was trying to mug me. Being out there selling drugs, I knew it would eventually get me shot. I just didn't think it would happen how it did. I was walking out of an apartment complex when I saw a shady figure at the entrance to the complex. At that exact moment, I knew my fate. I tried to play it cool by walking past him, but he grabbed my arm and put a gun on my side and forced me to the back of the apartment complex. Thinking of how to get away, I grappled with the gunman. I threw him to the ground, and the gun went off. I was shot three times that night.

Safety was now a top priority. Having nightmares every night made me feel like I needed to have a gun on me. In my dreams, I would always get shot. The only way I knew how to stay safe was to have a gun and stay around people with guns. Time went on, and I was back to the same bad habits. Back to the block. Safety was on the brain, so I stopped hustling in the apartment complex. I went to the next safest place, the corner. But being on the corner made me more on edge and put me at greater risk for something that happened to me again. Back then, safety was just having a chance to escape danger. August 30, 2012, I was shot again on the corner I was hustling on. Not again, I said to myself as I was laying on the ground. I could not feel my right leg and thoughts running through my head were I would rather die than to be in a wheelchair the rest of my life. Once in a while, I go back to the spot where I was laying, and I see myself on the ground in pain. I talk to myself that is lying on the ground shot and bleeding, trying to comfort myself I tell myself, you're going to be okay. It will be all right.

A month in the hospital gave me a lot to think about how I was going to stay safe. I thought the only place I could be safe was the hospital. Today, I stay safe by being around people who support me and my future. I

stay away from the neighborhood where I was injured. I go to school. I participate in Healing Hurt People program as a client and an intern. I'm making safety decisions that allow me to have a better future. This is what safety means to me now.

The Office for Victims of Crime has allowed us to develop this community health worker peer project. Lastly, I just want to add that it's really about changing our narrative. Changing the conversation, recognizing the humanity of young people that we are working with. That all people are deserving of all the services that we have to offer. And then finally, I also just want to say that it's so important that we recognize that many of the young people that we encounter that we are working with, it's not just about the posttraumatic stress, it's about the sustained traumatic stress that they are enduring and how we can help them heal or give them tools to manage those issues. With that, I am going to turn it over to Kenton.

Hello, everybody. Before I kind of jump in, I just want to say just listening to these amazing programs out there inspires me to continue in this work. I am from the Crown Heights Community Mediation Center. I run a program called Make It Happen, and it's a community-based program to work with young men of color between the ages of 16 and 24 who have been directly/indirectly impacted by violence. I say directly/indirectly because there are young men who had been shot and assaulted but also people who have witnessed it. People who were the aggressors in those situations.

There is a mantra I always hear. Hurt people hurt people, right? In our program, we recognize the fact that we are engaging with a population that has mistrust of traditional mental health services. That mistrust is completely justified based on systemic racism, historical trauma, community trauma and their own individual history of trauma. Our program—the foundation is working with these young men around their definition of masculinity, how they have been socialized, and how that socialization has been a way to stay safe but also the whole trauma history and that impact that they have to deal with. How do we do this? We do individual therapy. We do group work. We do case management. We work with these young men. We don't expect them to sit in our office, in our space and talk to me about their trauma history or their level of victimization when they don't know where they going to get their next meal, if they don't know where they are sleeping that night. They may be leaving my office and have to know that they got to go back to a territory where they may actually be a target for any sort of violence. Truly understanding what these young men's experiences are out there in the world and providing that service for them.

I'm a social worker by trade, so meeting the client where they are at is not just something that we figuratively say. We literally meet them where they are at. For example, one of the questions that we'll ask in our intake is this neighborhood, this is where our programming is, are you okay to come over here? Yes or no? And we work with them from there. In our program, we take a similar approach to ACT. It's an acronym for Assertive Community Treatment, so this is a population that may have a history of not following through with traditional mental health services,

so you go out and work with them. With that approach, we are able to build trust with these young men. We also identify the fact that recovering from any sort of pain is a process. You may take five steps forward in healing, and then you may take two steps back. You may have been an aggressor in that relapse, and it's very important for our program to stick with you. That's where the advocacy part comes in. Whenever our young men, a lot of our young men are connected to various systems of oppression, the criminal justice system, child welfare system, anything, and it's our charge is to stay with them through that. We will go to court with our young men. There some sort of transitional object whenever they are faced with these large systems—someone from the program's representing them and portraying them in a light where you are recognizing their humanity. You don't use words like noncompliant, uncooperative. If you don't show up to our program, the first thing we ask is what happened, are you okay? A lot of times, people don't ask those questions to these young men.

The other part of the program is we really want to help these young men build on their emotional intelligence because if you think about—I will give an example. Let's say a little boy is learning how to walk, right, and he falls flat on his face. He's about to cry. What do you think everyone says around him? Stop crying, boy. Get up, boy. Try to walk that off. So if you think about primary attachment and like your zero through five when it comes to child development, that's your first lesson in how to navigate the world as a man. You've already had your emotional—your emotions are supposed to be under control, and you got to only show happiness or anger. When a kid gets at school age, and he is in school and he maybe is embarrassed by something, so he flips a table over or throw a chair. That kid is labeled as oppositional defiant. Is labeled a problem. Those labels follow you all the way through until unfortunately many of our young men get caught up in the criminal justice system. And those things come back and bite in the butt when they are done. In our program, our groups are around breaking down that definition of masculinity and trauma history. And hopefully, in the hopes of improving their emotional intelligence.

A lot of times when I check in with the young men in our program, I go, how are you today? I never let them say I am good. I want more than that. What do you mean you are good? Tell me more. I feel by doing that over and over again, it gets them to start thinking a little bit more about what their real emotions are. Because when you live in communities where you are impacted by violence, you're seeing it, you are targeted by it, you are participating in it all around trying to stay safe, where's the space for you to actually check in with yourself? Who are you? A lot of young men I work with always say they have to be on point. When I think of being on point, that is being hypervigilant, hyper aroused to your environment because that's all about being safe. And those are all traumatic reactions. Really breaking down what that emotional intelligence is for these young men so we do these [unintelligible] groups around masculinity and trauma. Because we're lucky to be with these wonderful partners, we adopted a self-group, so we run self-programming with our young men, which is great because they can now facilitate the group themselves. It's getting them to start thinking about the future. Because you know at the end of the day, their safety is

about trying to get from moment to moment. And we did something this summer which I was very proud of. We took some of our participants that have been in the Make It Happen program, trained them to be care facilitators. We spent the summer, they were learning about how to run groups. They call themselves junior social workers. They learn how to run groups. I took them around the city to see different resources out there. Because it's very important when you are out in the community and they come across somebody in their lives that may need help or some sort of healing that is not connected to our program or a hospital-based program, these young men have the tools that they can extend it to them.

Another part of the program that we really pride ourselves on is whenever we make referrals out of our program, we make sure we have seen the programs, we make sure we vet them. Because we're all about building trust to young men, and if we send them out someplace and it doesn't turn—they are not treated, they're not honored, they're not valued, they're not validated in their experiences, then I lose my own buy-in with these young men, and I didn't do my job. Every referral that we send our young men to is measured, we connect with the people and we do a soft handover to them. That's how we have pretty good buy-in. In the past 18 months, we've had about 107 young men through the program, and we've only had two new arrests in our program. So it's just administrative data, but you know it speaks to the need for the program, the desire for the program. The groups are 10 weeks, and a lot of young men still stay connected to the program. A lot of times, these young men, they look at therapy and say oh no that's a white person's problem. When they are sitting with me and we're talking about all the struggles and the challenges in trying to navigate the world that is actually unsafe for them to begin with based on all the systems. I sit there and go you know we just spent 45 minutes talking. You know this was a therapy session, right? But they're like oh wow yeah, but you are a different Ken, and you are cool. Like anyone else on the staff is cool. Wouldn't it be great if you had—most people when they go to therapy, they can pick and choose what therapist they want. It's really about the fit. It's really about that. You have that privilege to say that. You're not a right fit for me. Our young men should have the same exact rights.

Want to show you guys a story with one of my participants. His name is John. I have permission to share his story. He came into the program about two years ago. I will let him share his story.

The show I usually go into is basically like a safe house. Everything is all right in that shell. It's also lonely in there. I used to get bullied a lot, and they used to call me 'blackie' because of my complexion. I was the quietest one inside school, and yet I'm the one getting picked on.

I met John about a year and a half ago, just kind of getting to know John and realizing he's had a history of being targeted because of his skin color. The fact that his family lives in poverty, and maybe he doesn't have the most expensive sneakers or the clothes. He mentioned struggling, really struggling with people walking behind him. Imagine living in New York City with that being something that triggers you.

That's part of the anxiety that came over me. I really want to explode. Everybody in there they made fun of me.

In the City of New York, the statistics around young men of color in incarceration is kind of glaring. Of the city jail population, 58 percent of that population are young men of color between the ages of 19 and 24. So that right there shows that there is some serious systemic issues that are impacting the lives of these young men. The Make It Happen program is a program directed at young men of color between the ages of 16 and 24 who have been directly impacted by community violence. We discuss the intersections between what healthy masculinity looks like for these young men and the history of trauma they have dealt with. We run programming in some non-secure detention centers, we have researchers that work with us. We form relationships with the King's County District Attorney's Office.

Whenever I go there, Make It Happen, I have to speak up, talk to people. It makes me open up more, and Make It Happen, I started doing it in school. It was out of my comfort zone at first, but after a while I got used to it, I was like oh this has been cool.

We want our young men to challenge their definition of masculinity. Because a lot of times that definition is intertwined with their own trauma history.

I was this worthless person, and Make It Happen was a big impact to me to try to open up more and try to make friends a whole lot better.

This history of being targeted or bullied put him in a shell. Now he has a voice. He started to develop into an adult, and that's all I wanted for him. That's all he wanted for himself.

I think Make It Happen was the best thing for me, especially in my social life.

Accountability is important for things that you do, but you can still hold someone accountable, but also validate their experience. That is a restorative approach to helping people. One thing I noticed that helped me grow through all the pain and obstacles in my life was that there were people out there that took an interest in me. When you feel safe and you feel validated, by validated meaning you're supported, you can do anything. You can really move forward.

Before I close, I just want to share one thing about that video. He mentions the shell. That was how he stayed safe. That shell was actually -if you have noticed, he is actually taller than me. When I first met him, I thought he was shorter than me because he literally scrunched down and wore a hood over his head, so he literally created a shell for himself to survive the world that he was in. It took a while before I realized that wait, you're actually taller than me. That young man has finally had the opportunity to get control in his life. He has learned a lot, and it's a work in progress. We are proud of him and proud of all the young men that come through our program. Thank you.

[Applause]

Sherman, John, Ted, Kenton, those were really inspiring presentations and definitely appreciated that. There is information that you see on the screen now for people to start asking questions. I should not say start because you guys have already got it started with some questions coming in, so thank you for sending those in. I also want to give the panelists an opportunity to ask each other any questions and share any responses you would like with each other. I will answer one question first. If you don't mind me taking the privilege of answering it myself, which is a question about defining what hospital-based violence intervention is. There really four key components to a hospital-based violence intervention is. How it looks depends on the community where it is taking place. It is the notion that there is a golden moment to intervene with a victim immediately after an injury, a violent injury has occurred. You need to do so as soon as possible after that. To explicitly address retaliation prevention as well as long-term healing. To have the person who is approaching the survivor to be someone who is—comes from a community, shares experiences, connection with that person. To provide services not just in the hospital but post-discharge in the community as well, to get on that path. Not just treat and street, but then treat and then treat in the street. That is the concept there. And I do want to add that Kenton's program is part of Cure Violence model, which is a related model, so for people interested in that model as well, it is based on the notion that violence is contagious. To interrupt and address violence when it occurs and also before it occurs to identify and resolve conflicts using street-based conflict mediation from credible messengers in the community. That's a quick summary of those models. Gentlemen, is there any questions you have for each other or comments you want to share before we get into some of these other questions? Okay, great. Sherman, why is it effective when someone like you goes to visit someone in the hospital?

I think the reason why it's effective when I go into the hospital is because our youth grew up apprehensive and mistrustful of the system of authority. They find their comfort and sense of identity among their peers in their community. Statistics show that when they are injured, they are most likely injured by someone that looks like them or someone they know. Once again, there is another level of mistrust. When they are injured and wake up in the hospital, they have probably a medical team that have nurses and doctors looking after their physical health. They are probably approached by police and investigators that are looking into their legal health. More often than not, we are the first person that comes in that is concerned about their mental health. After you are shot and laying there, and you were thinking about your life and what it means and how can you change and how do you move forward, systematically there is really no one there to answer those questions. The first thing that we do when we come in, I let them know that I know you are confused and scared. I am not with the police and I'm not with the hospital. I'm here to work with you to come to an understanding of helping you deal with how you are feeling at this point and helping you move forward past your injury. Because when you are mistrustful of everything and everyone around you, and the doctors and the police are coming in, your first instinct is to close yourself off. Me myself, when I was in the hospital and they would come and talk to me, my response was to pull the blankets

over my head and not talk to anyone. That got me labeled as being depressed. It wasn't that I was depressed it's that I was mistrustful of these people that were coming in and trying to be evasive into my world and what was going on. And I did not identify with them.

But I know for a fact that is one of the few times that a young male is questioning how do I change my life? How do I keep this from happening to me again? And when we come in, and we tell them hey, I understand that you are scared, I understand that you are fearful. This doesn't have to be the end for you. You can use this opportunity to change your life around, and we are here to help connect you with the services that you need to make that happen. Young people can pretty quickly determine whether or not you are genuine and whether or not you are genuine about wanting to help them or is it just a spiel that you're bringing to them as another person trying to trick them into telling you what's going on.

I think it's effective because they know when we come in that we are generally concerned about their mental state. Because when their friends come in, your friends want to support you because they love you, but the problem is they don't know how to express or demonstrate that love, so often that frustration becomes the only way I can show you I love you is to go and injure the person that hurt you. I think most people know if I send you out to attack my perpetrators, there is always the injury that you may get killed and I lose my loved one. You could go to jail and I lose my loved one. Or worse yet, you kill the person that shot me and now their loved ones are looking for us. When we go in, our whole thing is let us help you move forward. Let us help you get the support you need. In turn, what I want from you was to help me talk to your friends and family about not seeking retribution for your injury. A deal gets struck, not like solidified, but unspoken deal gets struck up that I'll help you move forward and you'll help me start to curb the cycle of violence in our community, and together we can heal both.

Thank you Sherman. I think Kenton referenced the phrase, of course it's the name of Ted's program, Healing Hurt People, the idea that hurt people hurt people, and I think one of the things that we forget is that healed people heal people. I think you are a great example of that. I have a question for you, Ted that came in and I want to encourage—if there's anybody here live as well, just to give me a signal and we'll take your questions as well. This question came in from the Reverend Wayne Sylvester Daley, and he wanted to know what direct support services are offered to the victim's family, parents, siblings, and friends, through your program?

Sure. Thank you for that question. With regard to the family, we have one thing that's unique and interesting about many hospital-based violence intervention programs is that the work doesn't stop in the hospital. These are skilled—we call them community intervention specialists that go into the home to follow-up appointments, to court. There is a case management aspect to that which in some instances is the carrot. While they are doing those case management things, they also infuse behavioral health counseling, talking about issues of trauma. Right down to do you have heat in your house? Do you have food? Because something that also goes neglected is the food insecurity that accompanies the young person

as well as their families. There's a myriad of services that are provided, or at least acknowledged, so that we can start to get to the bottom of figuring out, establishing a plan to help the individual heal as well as their family. Because we recognize that in some instances the person is only as good as their family's going to be. It goes hand-in-hand in some of those instances when we're providing the behavioral health counseling, we might identify that the mom, or in some instances the father need that assistance as well. School is also important in all this. We touch on these different systems that are connected to the individual as well as connected to the family.

Thank you. I don't know if anybody else wanted to add anything on that topic, but if not I will move on. John, this is a question from Cheryl Greene [ph] in St. Louis. Have the men you have interviewed elicited signs—and she puts this quotes—of “fatalism ideology”?

I'm going to interpret that as young people who don't believe they will see the future, and, therefore, don't have anything positive in the future to weigh their current behavior against. I think we can take a trauma perspective on that. I think that young people who have lived in communities where they have seen a lot of violence, and they have lost friends to violence, do develop a kind of coping mechanism that has them think a lot about what would I do if this happened to me? When we interview young people they say when they are shot or stabbed they have a script in their minds of how they are going to escape and what they are going to do to stay safe. There is a trauma perspective on this that trauma itself can cut off your ability to see the future. The reason I think it's important to think about this in the context of healing from traumatic events, is if we decide these young people simply have a fatalism mentality, it doesn't tell you what to do about it. If we understand it's a consequence of trauma, then we also understand that helping them heal from the trauma it reestablishes their ability to see the future. That's not only true for the young people but it's true for any of us who go through a traumatic experience. We need someone—we need a supportive community to help us reestablish our ability to see the future. I think we have an opportunity and to the work that Kenton and Ted and Sherman have talked about that's what's happening is help young people heal, help them reestablish helpful community and to be able to see a future that in many ways they aspire to anyway. Because despite sometimes these expressions of fatalism, if you really engage young people, what would you really like to be doing, often they are able to talk about that. They are able to talk about a future that is viable and safe and often related to family and work.

Thank you. So I think while we're talking about the future part of self, there's actually another question I have about self that I'd love to hear from you, John, as well as Kenton, maybe you can start with this question from Erika Bitar in Williamson County. We have discussed self-intervention, but do you have thoughts on interventions like target, TFCBT, seeking safety, PCIT, and other types of interventions that were discussed actually at a trauma-informed care summit in Austin, Texas, last week?

I feel all those evidence-based models are effective. I personally think it's very important to be eclectic in our approach. Trauma looks different from one young man to the next. Being able to borrow a little bit from TF CBT, borrow a little bit from motivational interviewing, I feel as service providers it is very important for us to really sit in the space with our clients and know that this is not a cookie-cutter story. You can't just throw an evidence-based model at this particular client because maybe that's not going to work. Once again, I go back to the fact that mental health services is mired in white supremacy and racism. It's a racist system, too. I admit I am part of that as a clinician. So being able to say take bits and pieces of strategy to try to help these young men heal is what really is my approach. I do feel some of those things can help, but just bits and pieces in my opinion.

There is a question here, it would be great if you could get a microphone. Thanks.

Thanks. The question I have is particularly in your program, Kenton. What, in your 10 weeks, how long does it take you to start to see some breakthroughs in the young men you mentioned? How long does it take to get to a point where they can verbalize where they really are and then to see a change?

That's a good question. In our program, it really depends on the young man. At some point, whether they are actually actively appear to be actively engaged in the programming, whether they are talking a lot or they're not, doesn't appear to be actively engaging, in a corner with their hood on all day, but they're still participating in it, they're still taking in some of the information, so at some point, maybe by the end of the program, by the end of the 10 weeks, I am seeing some change. Change is hard. Changing my diet is a struggle. Imagine changing in the context of traumatic events. So I would say after 10 weeks, but also with other individual counseling but also the buy-in. They really have to buy into the program to really effect-see any change.

Great. Thank you.

Hi, I'm Tuyet Duong with OVC and I'm a language access fellow, and I want to speak to your point about institutionalized racism. What are the policy interventions with regards to institutionalized bias that you all are folks in the same orbit working on to make sure that especially federally funded entities that have to comply with Title VI of the Civil Rights Act are making sure they serve everyone equally and have provide equal access for everyone?

I think this might be a good time to remind all the people from states across the country who are listening to this right now that one of the most important changes to VOCA, is that it's now accessible to people who have been involved in the justice system. If your state isn't providing services, adequate services, to people who have touched the system, who have been incarcerated, then your state is out of compliance. I don't think we need to emphasize, and I certainly couldn't emphasize any better than these gentlemen have today the importance of providing services to young men of color who we know due to institutional racism are

disproportionately incarcerated and need services as much or more than anyone. I would leave that to you guys to also add your thoughts on this topic.

Also the HR hiring practices. Hiring a team that looks like America. I am working on issues of immigration status and culture and language. If you want to talk about some of the other barriers as they apply to other immigrant and newcomer communities that would be great, too.

I will start a little bit. I think it's really an important question. It highlights the fact that we embrace the notion that culture is important. That racism is a key determinant of how these young people feel about themselves and how the systems serve them. Also this notion of intersectionality. That these young people are more than one thing. There's a view that young men of color, here is what they need they need violence prevention. We know these young people are not just one thing. Some young people are not at high risk for re-injury or retaliation, but they are at high risk for having school disruption that will send them off of an academic path that was very promising in the beginning. I think much of our work begins within the individual institution to change the views of providers who are providing care and often provide at least unkind care to young people by assuming they know who they are. That often entails providing trauma-informed education to residents, medical students, physicians, nurses in the institution as we orient them to the work of the program.

And one very powerful intervention is to bring a young person who was been a patient and been treated back later to meet the providers who provided the care. Because often there is no connection to what that individual's life was. They are seen only when they were horizontal and in pain, often as any of us would be agitated or scared. To bring the person back and say here's where you were helpful to me. Here's where you weren't so helpful. Here is where I didn't understand what was happening to me. Those are more organic ways in which we are trying to alter the setting. I think there is room at the policy level funders requiring that those who are funded pay attention to implicit bias, institutional racism, realizing that some of these are LGBT youth who have been victims of violence. We cannot enter into this complicity of the stereotype that's propagated widely about the young people. There are many different strengths and challenges, and we have this moment of opportunity in partnership with others in the community to allow for these young people to heal and be safe.

To add on that, in our program, we also get feedback from our participants. We have done focus groups. What has worked for them, what hasn't worked, what they feel they need. Another element of the program is we wanted to start bringing the conversation around working with this population to the larger audience. We hosted a conference in Brooklyn called Paving the Way to Healing and Recovery. The purpose of that conference was to get service providers that are working with this population, people that are interested in working with this population, and we wanted to get some of the young men's voices out there, too, to start that conversation. You go to most of these conferences, and everybody talks about how wonderful their programs are. Our intention was

to say this is what we're doing and this is where we are falling short, what information can we get from the brain trust here, including the young men, to improve our services? And in fact, if we don't actually have the capacity to work with this population, we will get out of the way and let others take lead. We've done this two years in a row, and we have had great turnout. We want to continue that conversation.

Great. Thank you. This might be the last question, but we will see how quickly we get it in. This is from Deborah Howard, who is a transition coordinator at a school in Ohio. She works with formerly incarcerated students who are returning to public school, and so she asks how you would train educators to do interventions in the classroom. Oftentimes PTSD as a result of years of exposure to violence plays out in the classroom, and teachers really struggle with how to address it both academically and behaviorally.

I do a lot of work in a couple of schools in Brooklyn. One thing I always recommend to the staff and the social workers is really better collaboration between the social workers and the teachers. Because I get, being a teacher is really challenging, and after a while it can become about managing the classroom, but collaborating with the social worker who's doing social, emotional work with the student, better communication I feel can really help improve teachers' involvement with the students. Also, understanding that people cope differently. Also, be mindful of how maybe a young man flips over—throws a chair, he's not necessarily—it doesn't necessarily mean he is a danger to anybody. He's just upset and when he acts upset, he doesn't know how to express himself because he is lacking that emotional intelligence that we try to build up in our program.

Great. Thank you. Thank you, everyone who submitted questions, and I wish we had more time for them. Hopefully, this is the beginning of a conversation that we can continue. If you are looking for ways to continue this conversation, I would love to direct you to some resources that are available. There is the Youth Alive! Website, among the resources that are available there is information about something we call START, which is a screening tool for awareness and relief of trauma. This was something we developed through a series of focus groups with young men who have been victims of gunshot violence in partnership with the Center for Nonviolence and Social Justice at Drexel University. What it is, it's a brief interview where you can talk to someone in about 20 or 30 minutes about how trauma affected their life and offer them resources. So a quick example, I know, Ted, you mentioned sleep quality, right, being an issue with young people you work with. If sleep quality is a problem, right, which it so often is, not sleeping well, then we offer tools to help support your sleep hygiene. That's an example of something that this tool does. And it's to sort of counter the idea that a lot of interactions with institutions are unsatisfying because you get diagnosed with what's wrong with you but not any help for how to take care of yourself because of what's happened to you. So that's one of the things available on the Youth Alive! website.

The next resource there is the National Network of Hospital-Based Violence Intervention Programs website. Among the resources available,

there are, and I was told, ready for my prop, is this book. This book was developed through a grant from the Office for Victims of Crime, and it's a guide for communities that want to start a hospital-based violence intervention program. So what it does, it talks about various needs you might have as you start it up and give examples from sites all around the country, so you can see it's not one-size-fits-all. And you can think about what works best in your community for who you're working with, and you can download this for free or for a very nominal fee have it shipped to you in this beautiful bound copy.

The Healing Justice Alliance website you can go to for different resources, including recordings of webinars. You can also sign up for a newsletter. In that newsletter, there is information about the latest research on violence and victimization, information about trauma-informed practices, that actually the Center for Nonviolence and Social Justice produces every couple of months. Information on funding. Information about how to communicate in your community about how violence with young men is covered and should be discussed and other topics that are of interest to folks who are interested in something like this today. The Healing Hurt People website has a lot of resources on it, including some connection to resources on trauma-informed care as well as information on Healing Hurt People. What is exciting is in September it will look very different because it's being revamped. Check it out now, and then check it out later, too. For more information about the Crown Heights Mediation Centers, Make It Happen program, there is a resource here as well. Among the things you will find on this website that are exciting is a toolkit that they have developed around responding to trauma around young men of color, adapting the Crown Heights approach for your community. Hopefully, between these resources and the ones that you generate and call to our attention, we can share with each other knowledge and best practices about ways to help male survivors of color.

I want to give each of you a chance to say any final thoughts or statements, but for my part let me just say I am so grateful for your participation in this. We have talked a lot about healing today. We talked a lot about justice. Thinking about the staggering statistic that John shared about how 45 percent of people who are shot or stabbed will happen again. Nearly half the people this happens to will happen again. It strikes me that justice for these young men is at the very least trying to prevent a revictimization, and I think with your outstanding work you have done that. So in our final minute, if you have any closing thoughts you would like to share before we go?

I would like to thank you all for bringing the subject into the forefront and being here to discuss it because I believe if we don't pay attention and make some direct actions to helping those victims that are underserved, which are the male victims of violence, that our communities are going to be much harder to heal and move forward in the healing process. You can't leave those traumatized victims out there alone. If we don't support them we will soon find out that those unresolved feelings and those unresolved mental issues will be something we will all pay for later on. So I thank you guys for starting the discussion and being here today.

I would just echo those, and I would say our work is larger than violence alone. The issue of trauma looms larger in all of our work, and it looms large in every system. While we're talking about in the context of justice and health, we have touched on it in education. We have touched on it in societal and political organization around issues of racial disparities and racism. This is a step forward I think in all of us collaborating to realize these systems have to touch to each other. No single system can do this work. If we change our narrative, this is part of changing the narrative about young survivors of violence who are males of color, and I think that's what gives me the most optimism for the future.

I'm just going to just echo everything that has been said and add that we are grateful for this opportunity to speak on it and get this message out there. The goal is really to make sure that all young people, especially young boys and men of color, receive equitable and appropriate trauma-informed care so they can heal just like anyone.

I want to echo everyone else who has made comments here. I am unbelievably grateful and humbled I am able to do this work. One take away I want to give you guys is to understand that people want to be validated in their experiences and accepted. They also want to feel safe. Working with people and what that safety looks like for them and trying to get them to a place where that safety is actually really is safety. Safety in the community. Safety of their emotional experiences. That's what I would like to throw out there. People want to stay safe and validated and heard. Thank you.

Thank you all for that. What a powerful discussion we have had. I want to thank our presenters for all they shared today. We have of course a lot more work to do, based on our discussion and some of the questions that came up, but I hope you have been inspired by what we have heard to continue this work. The two things I want you all to continue to do and help OVC to do is one, to make sure we continue to change that narrative to ensure that these young men are recognized as victims and connected to services and with that help us in OVC continue our work to ensure that these young men as well as all crime victims are connected to trauma-informed victim-centered and culturally appropriate services when they are harmed. A short note so everyone online will know that the OVCTTAC will have a recording of today's event posted within a couple of weeks on the webinar page. You can visit the webinar page to learn more about the upcoming webinars as well as other archived training sessions that are forthcoming. I want to go back one moment, too, because I forgot one thing. For anyone who has an interest in hearing more or learning more about working with young men of color who were harmed by violence, please feel free to contact Youth Alive! The contact information is for Linnea Ashley, National Training and Advocacy Manager, at Youth Alive! is on the screen now. Please feel free to contact them if you have any questions or interest in learning more about working with this population. With that, thank you and please help me thank our presenters today.

[Applause]