



YOUTH VIOLENCE: IMPLICATIONS FOR POSTTRAUMATIC STRESS DISORDER IN URBAN YOUTH

An Issue Report from the
NATIONAL URBAN LEAGUE POLICY INSTITUTE

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Violence among youth has become a public health concern due to its epidemic levels in urban communities and large central cities. These areas are also where minorities and the poor are over represented (Stein, 2003). With the increased availability of guns, illicit drugs, and the proliferation of gangs, many researchers have categorized violent urban areas as “war zones” (Skurulsky, 2000). For example, the average annual violent crime rate in urban areas is 74% higher than the rural crime rate and 34% higher than suburban areas (McCart, 2007). The prevalence of violence in urban communities has a direct impact on the mental health of its youth. This issue brief will examine the prevalence of violence in urban communities, its effect on the mental health status of urban youth - in particular the rates of Posttraumatic Stress Disorder (PTSD) in this population; community and government interventions aimed at mental health and violence prevention and finally, next steps for addressing mental health in urban youth.

Prevalence of Violence in Urban Communities

Numerous studies have documented the immense amount of young people who have witnessed and or been victims of violence. African American males are the main perpetrators and victims of violence in urban areas and have the highest risk for being victims of homicide (Datner, 2004 and Scott, 1998). The studies listed in the following chart illustrate the alarming statistics on urban youth witnessing and being victims of violence.

Summary of Youth Violence Studies

Author(s)	Study Results
Buka (2001)	Forty-Seven percent of low-income African-American youth have witnessed a murder and 56% have witnessed a stabbing.
Smith and Tolan (1998)	Results from the Chicago Youth Development Study (CYDS) showed 80% of inner city adolescent boys reported exposure to violence in their lifetime and 56% of these boys reported seeing someone get beaten up.
Bell and Jenkins (1993)	In a study of children in Chicago, 75% had witnessed a robbery, stabbing, shooting and/or a killing.
Osofsky (1993)	Ninety-Eight percent of children studied in New Orleans had witnessed violence and 51% had been a victim of violence.
Fitzpatrick and Boldizar (1993)	Seventy percent of youth surveyed in the DC area were victims of violence; 85% witnessed a violent act; and 43.4% witnessed a murder.
Uehara (1996)	1,035 African Americans ages 10-19 were surveyed; 75% witnessed a violent act and 46.5% had been a victim of violence.
Shahinfar (2000)	In a study of children in Head Start, 57% of the student's parents stated that their child witnessed mild levels of violence and 8% witnessed severe levels of violence. However, when the students were surveyed, 37% reported being a witness to severe violence.
Gladstein and Slater (1998)	Twenty – three percent of patients at an adolescent health care clinic in Baltimore had witnessed homicide and one out of every ten children at a clinic in Boston City Hospital witnessed a shooting or stabbing before the age of six.
<i>Indicators of School Crime and Safety in 2005</i>	Thirty-five percent of students in urban schools reported being in a fight away from school; 43% of black students reported being in a fight away from school. 17% of students in urban schools reported carrying a weapon. Black and Hispanic students in urban schools were more likely to report fearing for their safety in school and away from school. Students in urban areas were more likely to avoid certain places in school. Students ages 12-18 were victims of about 1.3 million non fatal crimes while they were away from school.
Bell (1991)	In a survey of inner city high school students, 75% reported witnessing shootings, robberies, and stabbings and 46.5% had been victims of such acts.
Singer (1994)	Seventy-five percent of the students surveyed had experienced, witnessed, or been threatened by physical violence during the past year; 50% had witnessed a shooting in the past year.
Freeman (1993)	Forty-seven percent of children surveyed in an urban school could describe a violent event they witnessed.
Durant (1994)	Eight-four percent of the students surveyed in inner city communities were involved in a violent event.
Berman (1996)	In a survey of students at a Miami Dade County area high school, 86.5% reported witnessing a beating or mugging and 41.6% witnessed a murder.
Shakoor and Chalmers (1999)	In a survey of urban elementary and high school students and almost half reported being directly victimized; 75% reported witnessing a robbery, stabbing shooting or homicide.

Effects of Community Violence on Mental Health

Researchers are now beginning to document the effects of violence on the mental well being of children and adolescents. Research suggests a link between violence exposure and psychological problems (Scott, 1998). Many children living in chronically violent areas can develop a pathological adaptation to their surroundings. These adaptations can lead to developmental impairments such as personality disorders and impaired behavior (Skurulsky, 2000). Cooley-Quille (1995) concluded that children exposed to higher levels of community violence demonstrated restlessness and impaired social and behavioral functioning. Martinez and Richters (1993) found that children's exposure to violence was associated with reported distress and depression.

Violence has a harmful effect on the mental health of youth because they have not developed the cognitive and coping abilities necessary to adapt to certain stressors, such as violence. This makes them more susceptible to the development of mental distress and other emotional problems. Without treatments, these mental health issues will become more severe and last through adulthood. Youth can also begin to develop maladaptive coping mechanisms which will stunt psychosocial growth and maturity (Moses, 1996). Giaconia (1995) found that 14.5% of adolescents who experience at least one traumatic event by age 18 developed PTSD. These youth also had additional psycho-social problems such as suicidal behavior and emotional problems. Those who experienced trauma but did not develop PTSD did exhibit more deficits in behavioral, emotional, and academic functioning.

Community violence has been found to be more closely related to PTSD than any other form of violence exposure (McCart, 2007). Davidson and Smith (1990) found that children who experienced trauma before age 11 were three times more likely to develop negative psychiatric symptoms and PTSD. Using the National Survey of Adolescents, McCart (2007) found that 55% of adolescents reported exposure to community violence and 6% met the diagnostic criteria for PTSD. African-American adolescents reported higher levels of community violence and PTSD symptoms. Urban boys and girls also had increased levels of PTSD, exposure to violence, and delinquent behavior.

Posttraumatic Stress Disorder (PTSD)

Posttraumatic Stress Disorder is a means by which one copes with a traumatic event (Scott, 1995). It is a type of anxiety disorder which usually occurs after a person experiences or witnesses a traumatic or violent event. This event can be a one-time experience or a continuous/chronic trauma. PTSD was the first stress related disorder to appear in the American Psychiatric

Association's (APA) *Diagnostic and Statistical Manual of Mental Disorders* (DSM) as a result of the impact of the Vietnam War (Datner, 2004). The APA defines Posttraumatic Stress Disorder as an anxiety disorder characterized by the persistent reexperience of traumatic events through distressing recollections, dreams, hallucinations, or dissociative flashbacks. Though PTSD was once thought to be an inappropriate diagnosis for children because their reactions to trauma were believed to be less severe, by 1987, the American Psychiatric Association approved PTSD as a diagnosis for children. The DSM-IV has six criteria for the diagnosis of PTSD in children: (1) exposure to a traumatic event; (2) re-experiencing the traumatic event; (3) avoidance of stimuli associated with trauma; (4) persistent symptoms of increased arousal; (5) duration of disturbance for longer than one month; and (6) clinically significant distress or impairment (Lanclos, 2001).

Community violence has been shown to have cumulative effects on children's coping mechanisms, increasing the PTSD symptoms displayed and its severity (Moses, 1996). PTSD symptoms in urban youth are complex and can be prolonged by acute responses to violence, comorbid conditions and other psycho-social issues (Datner 2004). Symptoms in children typically include: fear, agitation, exaggerated startle response, helplessness, disorganized behavior, insomnia, lack of concentration, detachment, unexplained anger, nightmares and avoidance of emotional intimacy. Children may also avoid anything associated with the traumatic event and may not want to discuss it (Moses, 1996). Children and adolescents can re-experience the trauma through cognitive cues such as nightmares, waking memories and visualized flashbacks.

Research has also shown a link between being African American and developing PTSD. African Americans are exposed to greater amounts of stress due to lower socio-economic status and lack of resources to address mental health needs. Norris (1992) found that White Americans report more occurrences of traumatic events as compared to African Americans, but the impact and nature of the trauma for African Americans is much more serious. This is primarily a result of the lack of financial and psycho-social resources to buffer the negative effects of stress, which is then compounded by additional factors such as racism and the neglect of their communities (Scott, 1998).

PTSD in Urban Youth

Researchers have recently begun to document the rate of PTSD among youth. Kilpatrick (1998) found that approximately 8.1 million adolescents between the ages of 12 and 17 had PTSD at some point. Environmental factors are one of the biggest predictors of PTSD. American cities, with high crime rates, high concentrations of poverty and the lack of proper mental health

services put inner city youth at greater risk for developing PTSD. For example, The U.S. Department of Veteran Affairs reports that 3-15% of girls and 1-6% of boys who have experienced trauma could be diagnosed with PTSD. However, in at-risk samples the rate is much higher; 37% of children exposed to a shooting and 35% of urban youth exposed to violence develop PTSD.

In a study of 621 urban middle school students Springer and Padgett (2000) found that 52% of the students reported severe PTSD symptoms. Fitzpatrick and Boldizar (1993) surveyed youth who were exposed to violence in their community and found that 27% met all of the diagnostic criteria for PTSD. Eighty-two percent reported symptoms such as intrusive thoughts or dreams; 54% reported physiological arousal symptoms such as irritability and hyper vigilance. Ruchkin (2007) found that youth who are chronically exposed to violence had increased levels of PTSD and higher levels of psychopathology. Ruchkin also found that boys who experienced PTSD tend to commit more violence.

PTSD can also lead to other psychiatric problems. Gianconia (1995) found that 40% of the adolescents with PTSD also had depression. Saigh (2002) found that youth with PTSD had higher levels of depression, attention deficits, aggressive and delinquent behavior, and interpersonal problems. PTSD is also linked to substance abuse. Kilpatrick (2000) found that PTSD led to an increased risk of abuse or dependency on illicit drugs. These studies document a large segment of our urban youth who are not getting their mental health needs addressed. These psychological problems can grow into permanent psychological dysfunction which may lead to additional violent and maladaptive behaviors, further impairing their development and leaving a successful or even a normal adulthood in doubt.

Treatments for PTSD

Because they are at high risk for developing maladaptive emotional and behavioral problems due to violence exposure, urban adolescents need detailed and comprehensive assessment of potential PTSD symptoms and strategic interventions (McCant, 2007). According to the National Center for PTSD, The most effective treatments for PTSD in children and adolescents are: Cognitive Behavioral Therapy (CBT), Play Therapy, Psychological First Aid, Twelve Step Approaches, Eye Movement Desensitization and Reprocessing. CBT has been regarded as the most safe and effective treatments of PTSD in children. CBT includes: the child directly discussing the traumatic event, anxiety management techniques, assertiveness training, and correction of thoughts. CBT also involves psycho-social education and parental involvement.

The RAND Corporation along with University of California Los Angeles (UCLA) and the Los Angeles Unified School District (LAUSD) collaborated to develop and implement an intervention based on CBT principles called the Cognitive Behavioral Intervention for Trauma in Schools (CBITS). Participants of the study were sixth grade students at two large middle schools in Los Angeles, who reported exposure to violence and had clinical level symptoms of PTSD. The CBT sessions were conducted by trained mental health clinicians. RAND's study of the program showed that the intervention helped participants cope with the effects of violence and the students demonstrated a significant mental health improvement. By six months in the program, the students had a significant decrease in the PTSD symptoms displayed (RAND, 2002). This was the first study to evaluate the effectiveness of an intervention for children with substantial levels of PTSD symptoms due to exposure to violent events (Stein, 2003).

Parental and social support are important aspects of PTSD prevention and treatment. Foy (1996) found that if a parent is distressed the risk of the child developing PTSD increases substantially. If a parent is able to deal with stress appropriately the outcomes for the child are improved. This is usually referred to as "resiliency" - where the child is able to buffer or recover from a traumatic event due to numerous factors including: positive parental involvement and quick and effective mental health intervention. Resiliency refers to "the ability of some children to have positive outcomes despite risk and to recover from trauma and sustain competence under stress" (Lanclos, 2001). Resilient children tend to come from families with cohesion, structure, and consistency. Children who exhibit resiliency are most likely to have support from the community and have a structured and nurturing school environment even though it may be located in a violent neighborhood.

Children who have high levels of family support exhibit less anxiety when community violence emerges (Lanclos, 2001). Richters (1993) found that the success of children in violent environments was affected by the stability and safety of the child's home. Horowitz and Weine (1994) concluded that social support, including parental support, is critical in helping children and adolescents cope with exposure to violence. Lanclos (2001) found that children with parents who used positive parenting techniques had improved social and behavioral functioning when exposed to community violence. Grossman (1992) found that a good relationship with a least one parent or an adult family member can counter the harmful effects violent experiences.

Promoting the ideals of resiliency among parents and caregivers in urban areas is one of the most cost-effective ways to combat PTSD and other psychological problems that may occur in urban youth. There is a high likelihood that the parents of these youth are experiencing the same

psychological affects of violence. Thus, any intervention addressing violence and its affects on mental health should include a strong component of parental support.

Interventions and Programs Addressing Youth Violence and Mental Health

In the Healthy People 2010 report, the federal government acknowledged there has been a slow response to youth violence due to a lack of data sources, standardized definitions, resources to establish a tracking system and funding for prevention programs. Youth violence has tremendous societal costs on local governments. The resources needed to provide medical care for violence related injuries (including mental illness) and funding for law enforcement and the detention of young people are great (Datner, 2004). Therefore, it is in the best interest of federal, state and local governments to develop programs aimed at improving the well being of its youth through violence prevention.

School Based Health Centers (SBHCs)

In recent years, many researchers have shed light on the need for effective mental health interventions in a community setting that can reach a large number of children and adolescents. Schools are a prime setting for such interventions. However, these interventions are rare and there is an even scarcer amount of research evaluating the existing programs. Schools have the ability to bring health services to students who would not otherwise have access to them (Stein, 2003). Schools are a prime location for mental health services because they transcend the barriers to mental health care which may include a lack of transportation to mental health facilities and limited financial resources (Brenner, 2007).

Currently, there is no one agency or systematic approach set up to deal with children with mental and emotional problems. According to the President's Freedom Commission on Mental Health (2003), numerous agencies work independently to treat children's mental health needs. School health programs, social service agencies, primary care providers, the juvenile justice system, and special education programs all have the ability to put children in touch with mental health providers. Therefore, the Commission recommends the nation develop a multi-dimensional approach to the mental health needs of children. The Commission's report calls for a collaboration between parents, mental health providers and educators, but identifies schools as the entity that should take the lead on children's mental health since children are in school for most of the day and mental health is such a key component to educational success. According to the

Commission, more than 52 million students attend over 114,000 schools in the United States; that amounts to 97% of 5 – 17 year olds in the country.

Funding for school based mental health comes from multiple sources. It is partly funded through the Individuals with Disabilities Education Act (IDEA), which also requires schools to screen, assess, and plan treatment for students with emotional and behavioral disabilities. The Safe and Drug Free Schools and Communities Act also provides states with funding to implement plans for drug abuse and violence prevention. In addition, many states rely on Medicaid funding to provide mental health services to students. Addressing mental health services in America’s public schools is also a requirement within No Child Left Behind (NCLB). NCLB calls for schools to “remove the emotional, behavioral, and academic barriers that interfere with student success in school” (Brener, 2007). Currently 42% of students with emotional problems graduate from high school compared to 57% with other types of disabilities. With an obvious need for improvement, schools need to collaborate with other stakeholders to assist children with mental health challenges (Brener, 2007).

School health centers, including school counselors, psychologists and social workers have historically provided mental health services to children (Stein, 2003). The School Health Policies and Programs Study (SHIPP), a survey of a nationally representative sample of school districts conducted every six years, found in 2006 that approximately 77% of schools had at least a part time counselor who provided mental health services. Forty-five percent of schools had a contract with another entity to provide mental health or social services to students at a site not located on school property. Less than two-thirds of schools had a full time psychologist and less than half had a full-time social worker (Brener, 2007). Having a SBHC however does not guarantee mental health services are provided at the school. According to the SHIPP study, while 29.9% of school districts had at least one SBHC on school property, only 13.6% of schools with a SBHC offered mental health services to students.

The school districts and state’s department of education can also provide mental health services to students if the school does not. Eighty percent of states and 75.2% of school districts offer counseling for emotional or behavioral disorders (Brener, 2007). Furthermore, the SHIPP study found that 83.3% of states and 69.2% of districts offer funding for crises intervention for personal problems; 93.9% of states and 79.3% of districts offer funding for violence prevention; and 76.1% of states and 62.3% of districts offer funding for case management for students with emotional or behavioral problems (Brener, 2007).

Funding directly targeted for mental health services is crucial to their existence, but the SHIPP study also showed that policy guidance is needed on the district and state level to insure

that provision of mental health services remains a priority for schools. Over 35% of states and 62.2% of districts have a policy which requires mental health and social services via professionals who work at the school, linked health centers, or with a clinician who has a contract with the school. In 2006, 8.9% of states adopted a policy that each school will have someone in charge or coordinating mental health and social services. This represents more than a fifty percent decrease in the percentage of states adopting this policy (18.8%) since the 2000 study. However, the percentage of states with a school mental health or social service coordinator increased from 52% in 2000 to 79.2% in 2006 (Brener, 2007).

School Health Councils can also be beneficial for structuring the policy guidance for mental health services. Jones (2007) found that 39.5% of schools had a school health council which offered guidance on various health topics. Eighty-six percent had a state level health council and 72.9% had a district level health council. According to the Institute of Medicine, a school health council or team can assess the health status, issues, and concerns of children and families district wide and obtain input from the community to help direct health programs and make policy recommendations to the school board.

Finally, the 2006 SHIPP study revealed that there is no “best practice” model for school based mental health programs since schools typically offer programs and services based on student need and resources available. While less than 14% of SBHCs offered mental health services, research indicates there are measurable benefits to providing mental health services on school grounds. Slade (2002) found that when mental health services are available at school, students were more likely to see a counselor even after controlling for other factors, such as mental health status and health insurance status. These students also had improved academic outcomes. Roness and Hoagwood (2000) reported that school based mental health programs had an impact on a range of emotional and behavioral problems (Brener 2007).

Federally Funded Activities Addressing the Affects of Violence on Mental Health

The federal government has recognized that violence in Americans cities has created a public health crisis. Currently, the federal government funds numerous programs and targeted interventions toward youth violence. However, there are fewer programs that target violence as well as its direct influence on mental health. Listed below are some federally funded programs and interventions that take this multidimensional approach.

National Institute of Justice (NIJ) – Adolescent Violence in Schools and Communities

This is a project in collaboration with the Vera Institute of Justice which evaluates how violence affects adolescent development. Adolescents are being studied at three New York City Junior High Schools. Four areas are addressed: (1) what adolescents actually do in order to stay safe; (2) what kinds of social supports adolescents draw in order to avoid violence and to cope psychologically with exposure to violence; (3) the relationship between the fear of being victimized and the propensity to victimize others; and (4) an understanding of the meaning of violence for adolescents.

National Institute of Mental Health (NIMH) /Center for Mental Health Services (CMHS) – Efficacy and Effectiveness Studies of Youth Violence Intervention

NIMH is funding 17 efficacy studies on: approaches to youth violence prevention, treatment of externalizing behavior problems and maintenance; successful intervention to treat and prevent adolescent depression; cognitive therapy techniques in after school programs; and social problem solving techniques. Also, a white paper will be done analyzing the current status of literature regarding resilient adaptation in African Americans. The paper will identify the risk and protective factors; identify the evidence-based programs that foster resilient adaptation for African Americans; and provide recommendations regarding what programs and interventions need to be ready for national dissemination. The paper will include federal recommendations to promote resilient adaptation among African Americans.

National Institute of Mental Health (NIMH) /Center for Mental Health Services (CMHS)– Real Life Heroes

This mental health treatment and intervention is geared toward children and adolescents from ages 6 – 17. Real Life Heroes (RLH) is a cognitive behavioral therapy for treating PTSD in school-aged youth. The program is designed for use in child and family agencies to treat attachment, loss and trauma resulting from violence, neglect, disasters and abuse. RLH focuses on rebuilding attachments, building the skills needed to reintegrate painful memories, fostering healing and restoring hope. RLH was first implemented in 1998 and has been used in more than 200 sites on 3,000 children in the U.S. and Taiwan. Nonverbal creative arts, narrative interventions, and gradual exposure are used to help children process traumatic memories and develop coping strategies. The intervention consists of 6 to 10 months of weekly therapy sessions, depending on the child's circumstances. In one study, children and caregivers that participated in RLH after four months reported a reduction in self reported trauma symptoms. A

second study found that after four months of using RLH, caregivers reported fewer problem behaviors.

National Institute of Mental Health (NIMH) – Child Exposure to Violence and Post Traumatic Stress Across Urban Settings

This project is located at Harvard University within the Project on Human Development in Chicago Neighborhoods and will assess 6,000 males and females beginning at age 1, then at ages 4, 7, 10, 13, and 16. The study aims to determine the prevalence and correlates of exposure to violence and PTSD in large urban environments that vary in social class and ethnic group composition. It also aims to examine the causal links between exposure to violence and cognitive, social, and academic functioning of children. The goal is to advance the current understanding of the causes and prevention of psychopathology in children and improve the planning and efficacy of health promotion and violence prevention activities on the local level.

National Institute on Early Childhood Development and Education (NEICDE) – Role of Family and School in Promoting Positive Developmental Outcomes for Young Children in Violent Neighborhoods

This study is being done at the University of Maryland to examine the effects of neighborhood violence on the preschooler; the role of family and schools in reducing the impact of violence; and the effectiveness of early childhood antiviolence interventions. The sample is 104 African American families with children in Head Start centers in the Washington, DC metropolitan area.

Maternal and Child Health Bureau (MCHB) – Health, Mental Health and Safety in Schools Guidelines

MCHB is funding the development of a compendium of health, mental health and safety guidelines for schools. The compendium will include policies, guidelines, procedures and standards for schools, school districts, school boards and other organizations that address health, mental health and safety issues for students and school staff. Non-governmental partners in this effort include the American Academy of Pediatrics, the National Association of School Nurses and a steering committee of health, education, mental health and safety organizations.

Local/Community Activities Addressing the Affects of Violence on Mental Health

Local governments and community organizations are the best entities to address violence in their communities. Schools, law enforcement, and the healthcare providers are all under their jurisdiction. Local programs and intervention have had the best success in dealing with violence and its wide ranging influence on behavior and mental health. Listed below are programs which have documented successful results among troubled youth in urban areas.

SURVIVE Community Project

This project is a family based intervention to treat the effects of exposure to family and community violence. Supporting Urban Residents to be Violence Free in a Violent Environment (SURVIVE) is a 12 week family group intervention implemented through a collaboration of community leaders, mental health professionals, teachers, parents and a team of university based researchers in the Bronx, New York. SURVIVE helps parents do the following to strengthen the parent/child relationship: (1) identify adaptive strategies for care of their children in violent environments; (2) obtain and increase awareness of the impact that being exposed to violence has for their children; (3) provide structure for their children; and (4) enhance communication with their children. The Survive Project is an initial and promising attempt to address the affects of violence exposure on inner city families (DeVoe, 2005).

Dallas School-based Youth and Family Centers

This program has been identified by the President's New Freedom Commission on Mental Health as a model program. It aims to provide the physical and mental health care needs of 3,000 low-income children and their families. The mental health component features partnerships with parents and families, treatment and follow-up with teachers. The staff train school nurses, counselors, and principals to identify problems and create solutions tailored to meet each child's needs. This program has lead to improvements in attendance, discipline referrals, teacher evaluation of child performance, and children's standardized test scores. The program's funding comes from the school district and a local hospital.

Wraparound Milwaukee

Also identified as a model program by the President's New Freedom Commission on Mental Health, this program is a managed care program operated by Milwaukee County Behavioral Health Division to provide care to children with complex mental health and emotional needs. In 2005, the program provided services to 1,029 families with 71% of the enrollees being African American. Wraparound Milwaukee has three major components: the Mobile Urgent Treatment Team, Family Advocacy, and the Youth Council. The program provides various services for clients and their families including: transportation, residential treatment, parental support services, outpatient mental health services, mentorship, in-home therapy, care coordination, and psychological assessments. Clients enrolled in the program have shown: a reduction in legal offenses, improved school performance and caregivers report an improvement in behavior. Wraparound Milwaukee is funded totally through public funds which include various Medicaid sources and the local court system.

Urban League Affiliate Programs

The National Urban League's *Opportunity Compact* has set out a platform of principles and policies that address the economic and social ideals necessary for our citizens to become full participants in America's success. There are four cornerstones to the Opportunity Compact: (1) Opportunity to Thrive; (2) Opportunity to Earn; (3) Opportunity to Own; and (4) Opportunity to Prosper. In accordance with the Opportunity to Thrive, the Urban League affiliates listed below have created programs which address the deficiencies in many urban environments where scores of our young people live and help them recognize the many opportunities available.

Urban League of the Upstate Inc. -Right Step Juvenile Diversion

The Right Step Juvenile Diversion (RSJD) is a juvenile diversion program developed through a collaborative effort between the Urban League of the Upstate Inc., South Carolina Department of Juvenile Justice (DJJ), the local solicitor's office, local law enforcement, family court, and the Greenville County School District. The goal of RSJD is to prevent youth that are in the early stages of criminal involvement from becoming further involved in the juvenile justice system.

Right Step began operations in April 2004 with enrollment of 44 youth offenders. To date, RSJD has serviced over 341 youth between the ages of 8-17. The overall successful completion rate is 86.8%.

Urban League of Greater Pittsburg -Duquesne Community Mobilization Project

The Duquesne Community Mobilization Project (DCMP) is a collaborative effort with the Duquesne Delinquency Prevention Team in an effort to prevent youth violence and other problem behaviors. The project promotes the development of positive social skills for youth and young adults ages six to twenty-one years that reside in the City of Duquesne. Using a variety of approaches and the nationally recognized “best practices” Communities That Care® Model, developed by Dr. J. David Hawkins and R.F. Catalano, the program seeks to identify the community’s prioritized risk factors and outline strategies which will address these factors to eliminate problem behaviors affecting community youth. The goals of the program are: (1) to build the capacity of residents and others in the City of Duquesne to address youth problem behaviors which include violence, crime, teen pregnancy, school dropout, and substance abuse; (2) to create a safe, nurturing environment for residents of all ages; and (3) to foster youth development and youth leadership by formally connecting youth to the community building process. The services provided include: leadership training, career and vocational development, academic enrichment, conflict resolution, crime and violence prevention, youth employment, social skills development, mentoring (Urban PRIDE Youth and School Coalition), and Community Service.

Metropolitan Orlando Urban League -Black-on-Black Crime Prevention Program and Youth Crime Prevention and Intervention Program (YCPIP)

The Black on Black Crime Prevention Program focuses on strengthening families within the Metro Orland community. It encourages youth through: workshops, youth conferences and other community activities in churches and schools. The program is a collaboration between local law enforcement, community leaders and families. The Youth Crime Prevention and Intervention Program serves youth 10-18 years old who are living in an at-risk environment. The programs services include: anger management, tutoring, workshops, and career counseling for youth ages 16-18 that are not enrolled in school.

Minneapolis Urban League -Youth Achievement Cluster - Juvenile Advocacy

This program serves youth who are at-risk for criminal activity. By entering into a “Contract for Change,” at-risk youth agree to change their problem behaviors, increase school attendance and performance and avoid committing crimes. The program also educates young people about the positive ways to participate in their community. In 2006, the program served 114 youth. At the end of the program, they demonstrated improvement in: conflict resolution, anger management,

problem solving, and/or personal responsibility. The program is funded by the state of Minnesota, Hennepin County, United Way and other general contributors.

Summary and Recommendations

Provided are three main recommendations to address PTSD and overall mental health in urban youth due to witnessing or experiencing violence: **(A) Improve and Expand School Mental Health Programs; (B) Incorporate Evaluations of Mental Health in Primary Care Settings for Children and Adolescents; and (C) Increase Collaboration Between Community Leaders, Families, Schools, and Mental Health Providers.**

Research shows that students with mental health problems and other emotional disturbances do not finish school at the same rate as students without these issues. Even when they do finish, they may not finish at an academic level that is sufficient to go on to secondary education or function adequately in society. School mental health programs can improve by increasing the number of licensed psychologists and social workers at schools and having a School Health Coordinator and/ or a School Health Council.

Primary care physicians are in a direct position to identify mental health problems in children and adolescents. They can provide referrals for mental health screenings and treatments and prescribe psychotropic drugs for children and adolescents experiencing psychological disturbances. Primary care physicians are extremely critical for at-risk populations such as low income children and minorities in urban areas who are unlikely to have adequate access to mental health providers. The federal government can take the lead by providing additional mental health resources for publicly funded community health centers. In addition, the government can identify those primary care physicians that provide services under Medicaid and Medicare and urge them to provide collaborative care for their patients within the mental health community (President's Freedom Commission on Mental Health, 2003).

Improved mental health and the prevention of mental health maladies such as PTSD must begin at home. However, assistance from the community is essential to provide the support for parents that lack the resources to escape the violence within their communities. For instance, social service providers, hospitals and schools can devise plans to intervene at school and provide home visits for such families. Community based coalitions consisting of law enforcement; religious leaders, school personnel; mental health clinicians; and youth themselves are necessary to address the mental health needs of children and youth and can drastically improve mental health outcomes.

Poor and minority youth are at the highest risk for exposure to violence and are the least likely to get adequate care from the mental health system (Stein, 2003). Government resources directed at the outcomes of poor mental health including; crime, poverty, and unemployment are great. Research has shown significant savings – both financially and in terms of lives -- when funds are directed toward early prevention. Early detection, intervention and treatment of PTSD is also necessary and vital to preventing long-term psychological problems and improving the mental health of urban youth.

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