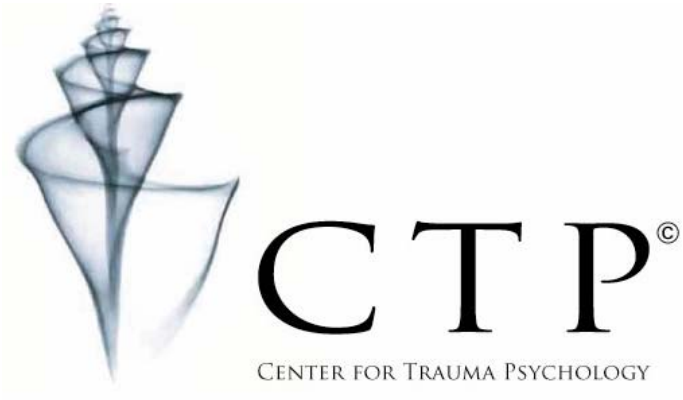


Testimony: "Addressing Gangs: What's Effective? What's Not?" Subcommittee on Crime, Terrorism, and Homeland Security

Dr. Robert D. Macy

Founding and Executive Director of the Center for Trauma Psychology
Founding and Executive Director of the Boston Children's Foundation
Founding Member and Co-Director of the
National Center for Child Traumatic Stress Network-Category III-Boston
Director of Psychosocial Initiatives-JRI-The Trauma Center-Boston
Research Associate in Psychology-Department of Psychiatry-Harvard Medical School

Center for Trauma Psychology
Boston Children's Foundation
36 Gloucester Street
Boston, MA 02115

Email: robertmacy@comcast.net
Phone: 617-699-9939

Website: http://traumacenter.org

Dear Chairman John Conyers and Members of the House of Representatives Judiciary Committee:

My name is Robert D. Macy. Thank you for your time and consideration. Since 1973, I have worked closely with impoverished children and young adults who face seemingly insurmountable challenges. The most significant of these challenges are psychological trauma and the violence that results from such trauma. Treating traumatized and thus, violent youth, is where I have focused my energies and expertise for more than 3 decades.

I am a founding member of the National Child Traumatic Stress Network (NCTSN). The NCTSN was authorized in 2000, as part of the Children's Health Act, and received its first appropriations of $10 million in 2001. Credit for this extraordinary and historical authorization to create a national center to reduce the longitudinal negative impact of psychological trauma on our nation's children must be given to Senator Ted Kennedy, Senator Tom Harkin, Senator Arlen Specter, Representative Rosa DeLauro, Representative Steny Hoyer, and others.

The NCTSN money was included in the LHHS appropriations and directed to SAMHSA. This amount quickly increased to $20 million and then $30 million in the aftermath of 9/11. The NCTSN was reauthorized in 2003 (as part of the Bioterrorism bill), and is now up for reauthorization again as part of the full SAMHSA reauthorization, which has started and is likely to be completed in 2009. Our Center's focus was and continues to be the identification, assessment and treatment of the most complexly traumatized and disadvantaged youth in America. The NCTSN intervention pathways for gang involved youth and violence exposed youth speak directly to the fundamental dynamics regarding the failure to stem the tide of youth on youth violence utilizing increased arrests and increased offense based sanctioning.

I am the Founder and Executive Director of the Center for Trauma Psychology and of the Boston Children's Foundation.

I founded The Boston Children's Foundation, a public charity, to address the rampant, ongoing psychological trauma and resulting gang violence and suicides among 56,000 children and teens enrolled in the Boston Public Schools. The Foundation is

funded in part by a federal block grant given to the state of Massachusetts and the Massachusetts Department of Mental Health. During the last 12 years, the Boston Children's Foundation has conducted over 9,500 face to face interventions with approximately 15,000 gang involved youth and violence exposed youth in 131 public schools serving the15 neighborhoods of Boston.

The Center for Trauma Psychology is a privately funded institute. We focus on the impact of psychological trauma and the violence that results from that trauma. The Center utilizes state of the art research methodology and what are called "psychosocial continuum interventions" for youth who have been involved with or exposed to violence. We founded this Center to address the biopsychosocial impact of trauma and the resulting violence on children and their families following exposure to extreme stressors. This includes neighborhood gang violence, civil war, ethnic cleansing and identity conflict, terrorist attacks, urban wide gang violence, man-made and natural disasters.[1]

The Center for Trauma Psychology provides all hazards mitigation initiatives with advanced training and systematic evidence based psychosocial assessment, program development, implementation, monitoring and evaluation for preparedness, stabilization and recovery strategies for clients in the United States, Europe, Middle East, Asia and Africa. The Center for Trauma Psychology utilizes psychosocial reintegration and social capital reconstitution approaches for youth populations and their adult caregivers systems that are affected by large-scale threat events, including ongoing violent gang intimidation and the violence that follows. The Center for Trauma Psychology provides training in evidence-based intervention methods to integrated trainee groups of law enforcement, judiciary, educators, social workers, parents, clergy, and youth workers. We use a multidisciplinary approach grounded in the highest quality research in neurobiology, somatocognitive psychology, and cognitive behavior approaches.

[1] Our clients include: Department of Homeland Security (DHS), Immigration and Customs Enforcement, (ICE), U.S.A.I.D., FEMA, SAMHSA/DART, U.S Department of Education, U.S. Environmental Protection Agency, HUD Housing Authorities, International American Red Cross, U.S. Peace Corps, American Airlines, National Child Traumatic Stress Network, VA's National Center for PTSD, United Nations and UNICEF, World Bank-Washington, DC, Save the Children Federation, European Commission of Humanitarian Organizations, HealthNet International, Transcultural Psychosocial Organization, PLAN International, Ministries of Education in: Turkey, Palestine, Israel, Indonesia, Sri Lanka, South Africa, Burundi & Uganda.

Since 1998, the Center for Trauma Psychology has designed, launched and currently manages child and youth trauma response and violence prevention networks in Massachusetts, New Jersey, New York, New Hampshire, Maine, South Dakota, Iowa, Nebraska, Alaska, Netherlands, Norway, Palestine, Israel, Jordan, Afghanistan, Nepal, Indonesia, Sri Lanka, Sudan, Burundi, Eritrea and South Africa. Between 1999 and 2007 over 420,000 violence exposed youth have completed our 15 session trauma and violence reduction evidence based programming.[2]

My particular areas of expertise are the design, development and implementation of field based randomized cluster controlled trials in low and middle income areas exposed to longitudinal trauma and violence, and the design, development and implementation of biopsychosocial interventions for psychological trauma and resulting violent behaviors in youth exposed to transgenerational impoverishment and slavery and other traumas.

It is clear that mental health disorders are a defining factor in violent behavior among children, teenagers and young adults. From their vantage points, we must understand that violent behaviors and gang involvement are maladaptive coping and survival strategies. Reducing violence and gang involvement, thus, cannot be achieved only through arrest and incarceration as primary treatments.

That said, we do have very good news. The evidence is in. *Mental health disorders, especially anxiety disorders and traumatic stress disorders are highly amenable to treatment-outside of jail. Kids with trauma histories who adopt violent behaviors as a maladaptive coping strategy are in fact, highly amenable to treatment.* This means that if we are willing to set in motion an evidence-based continuum of identification, assessment, and multidisciplinary treatment and psychoeducational

[2] See, http://www.savethechildren.org/publications/CBI_Impact_Evaluation.pdf http://www.unicef.org/turkey/lf/ep1i.htmlUNICEF Turkey / Resources / Less Fearful, More Active / Classroom ...);Robert D. Macy, et. al., Community-Based, Acute Posttraumatic Stress Management: A Description and Evaluation of a Psychosocial-Intervention Continuum; Harvard Review of Psychiatry, Issue # 12.4, Taylor & Francis, September 2004;Robert D. Macy, Issue Editor, Youth Facing Threat and Terror: Supporting Preparedness and Resilience; New Directions In Youth Development, No. 98, Jossey-Bass, June 2003;Solomon, R, and Macy, R. (2003) La gestione dello stress da Eventi Critici. In Gainnantonio, A. (ed.)Psicotraumatologia E Psicologia Dell'Emergenza. Salerno, Italy, pp. 155-165 Ecomind Srl

programs for youth, youth offenders and their caregivers, we can absolutely reduce their attachment to violence as a survival strategy.

And in so doing we are actually targeting the reduction of identification and deep allegiance to authority structures organized around the principles of violence. Children and youth in our country today who are proximal to organized gang violence are faced with a critical life changing choice: do they give their permission to be told what to do and how to become-how to develop- to the authority of the violent gangs or do they give that precious permission to those community members representing democratic justice including law enforcement, court officials and educational and civil authorities

It is best if we accomplish this *prior* to any incarceration. Once incarcerated, effective treatment is far more difficult, if not impossible, to achieve. Once incarcerated, it is almost impossible to support the traumatized child or teen to commit their allegiance to democratic justice. This is especially true for younger teens as evidenced by multiple domains of investigation, most notably public health, Department of Justice and mental health research.

One striking example of incarceration actually increasing gang recruitment and gang commitment is the arrest and incarceration, for minor offenses, of young "wanna be-gang member" kids, who are not yet gang involved,. In order to survive in jail-literally to protect their life-they join a gang on the "inside", trading their sworn allgience for protection. Obviously this is a major problem. Incarceration actually forces young teens to choose a violent gang to protect themselves. Additionally, inappropriate incarceration forces young minds and hearts to choose gang authority over government authority. Developing youth seek permission to belong and to become. If they are forced to give their respect and allegiance to violent authority, we, the elected officials and law enforcement, we-the system of justice put in place not only to protect public safety but to continually evolve the standards of justice in a democratic society, are rejected by these young minds . Honestly, it is a loose –loose situation

Choosing effective, tested intervention over incarceration not only preserves precious social capital (our youth-our future workers and leaders). The current economic literature on utilization of incarceration as a violence prevention method indicates extreme expenditures on the "bricks and mortar" of jail systems and appears not to be

effective, especially on a longitudinal basis. In fact, statistics indicating the upward trend of aggravated assaults and resulting arrests and incarcerations appear to be actually increasing the demand for more prison beds and longer sentencing. We can save taxpayers billions of dollars over the next 30 years if we adopt an evidence-based continuum of identification, assessment, a multidisciplinary treatment and psycho educational approach.

The House Judiciary Committee's decision to conduct hearings to examine the causes and cures for violent gang activity in United States marks a crucial turning point in the history of violent gang intervention and the treatment of traumatized youth who use violence, especially gang related violence, as a means to survive and establish attachment to authority structures that provide protection and status.

U.S. scientists and clinicians have contributed to an expanding body of knowledge, more or less reaffirming and quantifying the enormous role that traumatic stress plays in mental illness in the millions of Americans. Through an understanding of trauma, we can better understand violence and thus how to intervene and stop such violence.

Most notably, Vincent J. Felitti, M.D., in a series of robust, pathbreaking studies, in collaboration with Robert Anda, M.D., of the Centers for Disease Control and Prevention (CDC), demonstrate that in a sample of more than 17,000 a statistically significant, graded relationship between adverse childhood experiences(ACE), and psychiatric illness, substance abuse, suicide, and medical illnesses underlying the major causes of death in the United States.[3] Also, the so-called ACE studies demonstrate a strong relationship between adverse childhood experiences and obesity, earlier pregnancy, smoking, and sexually transmitted diseases.

In August 2005, Steven S. Sharfstein, M.D., President of the American Psychiatric Association (APA), charged Paul J. Fink, M.D., and Richard J. Loewenstein, M.D., to organize a task force to report to him on the biopsychosocial consequences of early childhood violence. Their report stated: "During the last several decades, the

[3] Heart disease, cancer, stroke, pulmonary disease, and liver disease).

American public increasingly has been made aware of the impact of traumatic stress on human functioning. Events like the wars in Vietnam and Iraq, the 9/11 terrorist attacks, genocides in Cambodia, Rwanda, and Darfur, the Catholic Church priest sexual abuse scandal, and natural disasters like (most recently) the Asian tsunami, the Pakistan earthquakes, and Hurricanes Rita and Katrina have been widely reported in the media. In addition, the public has gained awareness of the sizable prevalence of domestic violence, childhood physical and sexual abuse, and child neglect, and their adverse impact on children and families."

As the APA noted in its 2005 report, the World Health Organization, three years prior, in 2002, had (WHO) issued its own report. In this report, it terms violence "a leading worldwide public health problem." The WHO report notes as well that violence exacts huge financial, morbidity and mortality costs. (World Health Organization, 2002).

Another study, cited by the APA report, this one from the "Prevent Child Abuse America" and funded by the Edna McConnell Clark Foundation, estimated that the costs, both indirect and direct of child maltreatment United States exceeded $90 billion. (Fromm, 2001). The U.S. Government recognizes this relationship already. Indeed, in 2005, the Office of the Surgeon General convened the Surgeon General's Workshop, "Making Prevention of Child Maltreatment a National Priority: Implementing Innovations of a Public Health Approach."[4]

The scientific community is rapidly increasing its knowledge of the way in which adverse experience and environments create trauma and then engender violence. More specifically, new recent research in neurobiology provides explanations for how life experiences alter the brain development especially among the young. This rapidly expanding body of research discourages the old reductionistic nurture vs. nature paradigm. It encourages us to adopt a more complex, exacting understanding of the way in which the environment, experience, the brain and the body and the social context interact and affect each other. These understandings, in turn, allow us to develop even more effective interventions to mediate the effects of trauma and thus, prevent violence

[4] (The workshop was a live Webcast and is archived at http://videocast.nih.gov under Past Events.)

among young people. Poverty and deprivation correlates with traumatic experiences and this is a reality that cannot be ignored. Violence is far more prevalent in communities of concentrated disadvantage. It is no accident that rates of gang involvement are higher there as well.

However, we do know what works.

Clearly the methodologies for identifying, assessing, treating and sanctioning youth involved in violent gang activity must address integrated intervention and prevention protocols at multiple levels We must use these multidisciplinary approaches and coordinate and intervene in family systems, with medical providers, the judiciary, the educators in public schools, public housing authorities and others. If we are to be effective, we must continue to elucidate the vast disparities in health care services and quality and mental health services between more affluent communities and communities of concentrated disadvantage, which are almost always communities of color. We must use use thehigh fidelity biopsychosocial research in combination with advanced law enforcement techniques that go far beyond the use of incarceration.

Prevalence of Mental Health and Psychosocial Disorders
Among children and adolescents in traumatic stress situations

Much of today's armed violence is born of intense animosity among identity groups based on ethnicity, language, culture, race, religion, regional roots, or other fundamentally differentiating factors. These hostilities can be labeled as "identity conflicts." Extreme brutality, widespread citizen involvement, and societal implosion such as the depletion, destruction, degradation of social capital, characterize identity conflicts. The number of people affected is considerable, largely as a function of the random and indiscriminate nature of these conflicts. Although identity conflict has appeared in the past, its emergence in the 1990s as the prevalent form of violence has produced such notable troubled spots as Rwanda, Burundi, Somalia, Sierra Leone, Bosnia and Herzegovina, the Caucasus, Chechnya, and Kosovo.

The violent animosity inherent in identity conflict means that the purpose of humanitarian intervention is no longer only about meeting physical and material needs. In prolonged identity conflicts and their resultant complex emergencies, humanitarian intervention must also respond to a wider range of factors causing physical and non-

physical human suffering. Stabilizing the physical condition of human beings does not necessarily ameliorate their overall degraded situation nor does it eliminate the potential for greater pain and increased suffering. Rather such amelioration is something akin to the Band-Aid approach on a much larger wound. Separation from family, the destruction of community solidarity, the interruption or cessation of basic education, an inability to create an adequate livelihood, continual fear of abuse and concomitant retaliatory violence, deep resentment against former friends, physical torture, personal remorse and guilt, the sudden, violent death of parents or siblings, or homelessness are defining characteristics of identity conflicts. We must consider gang-related violence among American youth in the same manner.

Humanitarian response to this "new face" of war entails conducting all activities in a foreign environment based on extensive awareness of current local conditions. It requires an in-depth understanding of cultural, social and economic patterns, comprehensive knowledge of the conflict, a thorough grasp of international and humanitarian law, and a consideration of the entire situation in light of its political, human rights, social, development, and military implications. This same understanding applies to children and teenagers living in resource-starved, opportunity poor environments that are segregated from the rest of the United States. In-depth analysis must also assess local capabilities – the strengths in these environments – and tap into the innate capacities of the community. The process of utilizing and increasing the local population's abilities to provide for itself, manage operations, make decisions, solve problems, and locate resources is a central aspect of community healing and recovery in the aftermath of communal violence engendered by on identity conflict. Building the ability of local communities to provide for themselves can decrease dependency and create alternative leadership to fighting factions by building chains of responsibility in, and receiving input from, other, non-combatant lines of authority. Relying on and building local resources affect nearly all aspects of psychosocial recovery. The renewed interdependence between groups, for example, enhances safety, while inter-group cooperation can promote communization across identity boundaries. Trust gradually builds through enhanced reliance on other community members. Personal and social

morality, similarly, increases as a consequence of greater community and authority accountability.

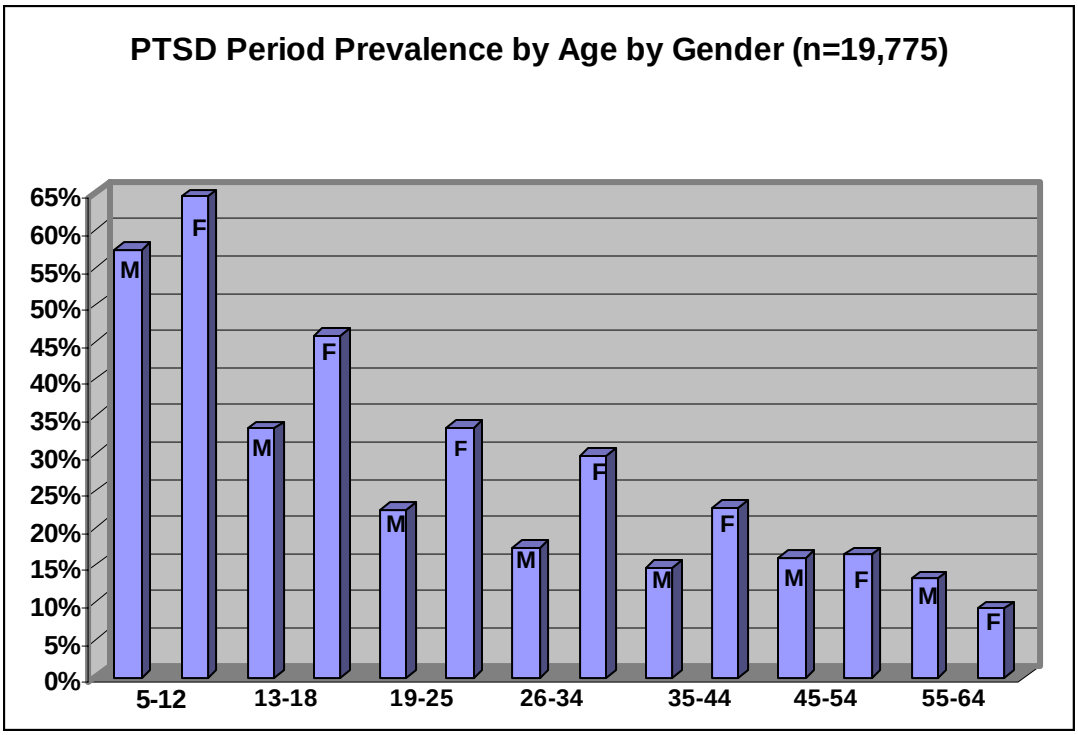
Programmatically, helping to stabilize and eventually heal those psychologically hurt by exposure to extreme violence is critical. As new data sets are being analyzed we may see perhaps that the most cost effective interventions, post conflict, will include a structured, evidence-based, community managed psychosocial component. Current research indicates that the most costly and longest term negative impacts of identity conflicts, and unfortunately the most difficult to address, are the longitudinal psychosocial disruption and attendant psychological impairment, both of which can significantly undermine the rebuilding and stabilization of social capital and the reintegration of the community.

Highly traumatized individuals can continue to harbor resentment and anger towards former adversaries and unfortunately these individuals will engage in coping strategies, such as substance abuse, prostitution, and domestic violence that undermine their ability to become securely engaged in education, employment or successful parenting. Culturally sensitive, highly structured, evidence based programs addressing the fundamental components of psychosocial disruptions and the underlying psychological trauma can, therefore, benefit the individuals as well as the community as a whole. In fact, the support and development of such psychosocial intervention structures may significantly reduce the mid to long-term costs of recovery post conflict and contribute to the absolute reduction of incarceration as a means to "control" or "treat" violent behavior, most significantly because incarceration cannot address the underlying trauma and resultant maladaptive survival strategies.

We acknowledge that there are no blanket prescriptions for healing wounds and rebuilding communities and that community cohesion is an internal process, not one that can be imposed from the outside. Each step must be taken when the time is right and the participants ready. Nonetheless, we have learned that outsiders can play an important role in preparing, supporting and otherwise encouraging community healing, primarily by working carefully with local partners to build knowledge infrastructure that affords those most impacted by the violence to play a central role in the stabilization and recovery of their own community.

Macy and colleagues, working with Domestic and International donors over the last 7 years have launched evidence based, highly structured psychosocial intervention programs, such as **CBI®** services, for children and youth exposed to armed conflict, gang violence, terrorist recruitment, child soldiering and mass casualty natural disasters. It is important to note that our efforts and our resources are aimed at what appear to be the most at risk populations impacted by community violence: children and youth. In an epidemiological study by Macy (2008, *In Press*) Medicaid youth living at the poverty level in H.U.D. housing developments exhibited some of the highest rates of severe mental health disturbances yet reported: 609.5 per 1,000 (CI: 601.0-618.0) for the 5 year to 12 year old age group. These youth were not exposed to a discreet threat event but rather have suffered continuous chronic exposure to community violence-traumatogenic lifestyles, an environment not dissimilar to communities impacted by armed identity conflict. See the chart below.

Period Prevalence Rates of PTSD for H.U.D. Housing Development Youth Sample



We are concerned that when high rates of psychosocial disturbances and resultant mental health disorders arise among youth in armed identity conflict areas, and go

unchecked, the economic and societal consequences for that community may be overwhelming and too costly to rectify in a timely manner. Our method has been and will continue to be the application of state of the art psychosocial assessment and intervention programs targeting the impacted youth in states and countries requesting psychosocial stabilization and traumatic stress reduction programs.

Thank you for this opportunity to testify on this most important matter and thank you for the time and consideration you are giving to perhaps one of the most pressing public health/public safety issues facing our country today.

Respectfully Submitted,
Dr. Robert D. Macy