"Where's the Harm?"

7/1/2021 Webinar Transcript

0:00:04.8 Natalie Williams: Hello everyone, and welcome. Thank you for joining us today for the Wellbeing a Blueprint event, "Where's the Harm? 911, Emergency Response and Community Trauma." I am Natalie Williams, Director of The Wellbeing Blueprint. We are part of a growing group of public sector and non-profit community leaders who share a commitment to using this time and moment to drive structural change that moves our country towards equity, well-being and justice, and towards the vision that everyone has a fair shot at wellbeing, I am so grateful to have you here today. I would like to begin with the beautiful tradition of acknowledging and giving respect to indigenous peoples whose land we stand on, this land historically was and is the home of indigenous people, many of whom have been forced to leave for other lands. I share now the names of the native people whose land I occupy, the Akayos, the Sanos and the Cowachican peoples. There is a link in the... There will be a link in the chat for you to find out which native peoples land you occupy in a moment. If you would like to introduce yourself in the chat, please do so by replying all with your name, pronouns and if applicable, your affiliation.

0:01:23.7 NW: So let's get to it. Here's what to expect for today. Many of you received communication prior to today about our event, but I wanted to be overt and really having this discussion with you, this event will feature frank and honest conversation about trauma, harms and violence. Our goal is to have a real conversation that speaks to the harms being concentrated in communities that already face great adversity, we will use narratives, images and conversation to speak directly to the harms, it's important that we do not sanitize this conversation, so please do what you need to do to take care of yourself during our time today together, Q&A is an important part of our event today, we will accept questions via Zoom's Q&A function throughout the event. Towards the end of our time together, our speakers will open up the floor for discussion. During this discussion, please raise your hand using the button at the bottom center of the screen, if called upon, you'll be promoted to speak and you will be visible and heard by the entire audience for the duration of your comments. If you would prefer not to be seen, please do not activate your video. As you can see, close captioning in English is available for all attendees for the duration of the event.

0:02:43.1 NW: Click the CC button at the bottom of your screen to see the captions. Caption size is adjustable using the arrow and the CC button. ASL interpretation will also be provided throughout the event. There will be a recording of the event hosted on the Wellbeing Blueprint at www.wellbeingblueprint.org tomorrow, the day after our event, if you need any technical assistance during or after the event for general inquiries, please contact Matthew Leger-Small at 413-522-4253. We will also put that information in the chat.

Our event today is an opportunity for us all to learn about systems that we may have engaged or we may have not, it will provide educationists the discussion on the history and the current day impact of the 911 system. We will have the opportunity to learn and sit with the harm and the trauma created by people and institutions that are supposed to protect and heal. We will get first-hand information through the lens of experts who study and implement emergency response to the most vulnerable communities. I wanna highlight that today's conversation is not just about the police, and leave you with that this discussion is about a systemic issue that must be examined at the root and not retooled, but instead transformed.

0:04:10.0 NW: So today, we have an amazing opportunity to talk to two leaders who will speak through their experience experienced research and direct practice on how they mobilize change through these systems. First, I'd like to start with Dr. LJ Punch, known as the saint of the streets. He is a trauma surgeon who is transforming communities through providing advocacy, care and building systems of wellbeing for all people in and out of the operating room. He's the founder of The T, a Trauma Recovery and Education Center in St. Louis Missouri, he has an extraordinary bio and quite honestly, is one of the most inspiring human beings and physicians that I've ever met. Thank you, Dr. Punch for being here. Next, I will introduce Dr. Rebecca Neusteter, Rebecca is Executive Director of the University of Chicago's Health Lab and the Director of Transform 911, a national campaign to re-shape the 911 system. Rebecca is a tireless advocate for change and wellbeing. She's committed her career to telling the truth about systems and the harms they create with the goal of creating transformation and equity for all people. Rebecca is a champion of honest and real change that is centered in community. I will now hand it over to Dr. Punch, to take us through his lens and his experience, and give us a bit about what he's experienced as a surgeon and as a community leader.

0:05:49.1 Dr. LJ Punch: Thank you so much, Natalie, and thank you to the Full Frame Initiative and the Wellbeing Blueprint for holding this space. A unique and an exciting space, a space desperately needed in our country and in this time. So yeah, I am LJ punch and I'm a trauma surgeon, trained as a trauma surgeon, and I have spent the last two decades in proximity to the experiences of people whose bodies have been physically injured by the energy transfer that is trauma and that 20 years of seeing hurt people in many different environments and in many cities including St. Louis and Baltimore has created in me, a very, very profound awareness of the ways in which trauma is really the root of so much of what we see plaguing the health and wellbeing of people that we try to serve inside healthcare. I, in that practice, have become a community health advocate, an advocate recognizing that trauma is a communal experience, it is frequently energy transfer that occurs between two people and within a community, and therefore cannot be healed without community, and that simple foundation is really going to drive a lot of what I wanna share with you all today.

0:07:26.9 DP: Again, it's already been mentioned The T, you see the logo there, standing for no more trauma, and also the symbol of a tourniquet is a building, a place, an idea, an organization in St. Louis, which is working out the ways in which trauma is the foundation of so much of what hurts our communities with a specific focus on the role of opioids, bullets, homelessness and COVID-19 since the pandemic began. And that work has really been completely transformed by this last year and a half, as our country, our world has

gone through such unprecedented times, times in which so much creative and wonderful changes occurred, some change, which I'm gonna be sharing with you later on in this presentation.

0:08:18.1 DP: I'm gonna need though, to open us up to start talking about trauma and what happens when bodies experience trauma, when bodies physically experienced trauma, they break and they bleed, and so we're going to have some things in here that are going to depict blood and the physical experience of trauma, and I know there's no way in a group this large that there aren't people who haven't personally experienced significant trauma, so I just wanna let you know that we are going to do that and we're also going to have some music that we're getting ready to play right now, that will probably come through the speakers a little bit louder than my voice is coming, and it's a little bit intense, but it's straight up, and I think it really, really is incredible that words that were written in 1990 are as relevant as they are today. So without any further ado, let's go ahead and get into the slides.

[music]

0:10:10.3 DP: 911. What does it mean to you? When I share these words from Public Enemy, I show you a picture of an ambulance and blood on the ground, what feelings, what emotions, what thoughts? Do they evoke thoughts of safety and protection or fear and past memories of pain? Do they intrigue you and make you curious about what might be happening at the scene, or do they cause you to be overwhelmed with worry? Right now, what I wanna do is take a little bit of time, and this is important because if we don't know how we feel, it's impossible to take new information and ideas in, right? So I want us to spend a little bit of time in the chat, if you could just throw up a sentence, throw up some words, give us some imagery and let us know what this image and what 911 means to you, we're gonna take about 90 seconds to let people throw some stuff up into the chat.

[pause]

0:12:40.0 DP: The chat is filling up with an incredible array of reflections that range from the absolute terror of losing control and being hurt, to the financial reality of what it is to dial 911, to the way in which something seems like it can be helpful and oftentimes is helpful in ways, but maybe for others a scene in which there is no help to be gotten. Concern and a loss of control, and many, many words that express fear and terror. Let's go on to the next slide.

0:13:32.4 DP: I wanna share a little bit what it means to me, and I appreciate everyone's candid remarks in the chat of what I'm seeing, and certainly what I have seen initially, was the way all of this presented to me in the beginning of my training as a trauma surgeon. Which was the unfettered and uncontrolled response of my own sympathetic nervous system telling me there is threats in the area, and I am not safe. That single message that we get when someone is hurt, when someone is bleeding, when there has been conflict, when something has happened, where someone has taken something from someone else or hurt someone else's body, invokes in us an ancient deep, well, well, well rehearsed set and cascade of events in which we go into a response, which is programmed to keep us alive when our brains can't really figure out what's going on. The fight, flight, freeze and

fawn response. The way in which we automatically respond to that terror is something so deeply programmed in us, we cannot bring it to consciousness in the moment unless we deeply practice and train ourselves to not be controlled by that response.

0:14:53.9 DP: Those fight or flight responses really drive so much of what I see around the experience of what it is to call 911. There might be a scene where someone has been hurt, or again, something has occurred which has caused someone pain or suffering. And the thought is, we cannot in this place handle what has happened. That the primary feeling out of that fight or flight is right now in this moment, there is not enough resource here to manage what's going on in the scene, and so we need help. The primary feeling, therefore, that flows out of that fight or flight response, as soon as the brain comes back online is, where is the help? When people are brought into the emergency room after calling 911, for instance after being shot, a thing that I have seen so often as a trauma surgeon. The thing is, where is the help? The look and the need intensifies, because now someone has gone from a scene where trauma or pain have occurred, and they're in an environment of strangers looking to see who is there to help. And unfortunately, what I have seen over and over and over again that at each step of the way, each inch they move away from the scene where the event occurred, they are driven further and further into obscurity and removed from their identity in a way that literally drives the bullets that entered their bodies deeper.

0:16:36.9 DP: What I see when I think about an emergency response system and the way it exists in this country is a beautiful array and a deep intent, for the healthcare system to make sure that people get to hospitals so that they can stop bleeding and have lives saved. And I see that help totally enmeshed inside a system, which is there to enforce law and assess criminality. The juxtaposition of those two things burdens patients and burdens families with an unbelievable amount of additional trauma, and it's this part that I really wanna spend some time unpacking today. Next slide.

0:17:25.2 DP: When someone has been hurt and they are bleeding, there is literally only moments before their life will end. We know that time is life when someone has been injured. In fact, the entire body of care that we give inside the US healthcare system and trauma system, once someone has been brought by emergency responders that were triggered by 911, is based on the experience of an orthopedic surgeon who lost family members after crashing a plane in the late 70s. He was able to provide more care to his family members then the local hospital where he was taken. The extreme grief of losing his wife and one child and to care for the trauma in the bodies of the children while he himself was still hurt, caused him to create a system, which is a systematic way of approaching people who have been injured. ATLS, adult trauma life support.

0:18:32.4 DP: And while that system is so very good at assessing and stopping and making sure that people's body survived, it falls so sort of acknowledging the bodies in which those people live, being part of a whole human being. It includes from the time people are assessed at the scene by the paramedics, getting stripped of their clothes. It includes being searched rigorously for injuries. It includes being prodded with needles and given medicine that can cause disorientation. It includes painful assessments of body parts and all of that occurs without necessarily making the connection at any point in time, that there's at least one person there who's there just for you, and wants you to know that

you're safe now. Next slide.

0:19:30.8 DP: As I have grappled with that harsh reality, there's another depth and another level that many, many, many urban centers deal with, which is the truth that even when 911 comes to the scene, there is often not a fast enough response to save a life. This picture are the 20 children and six administrators whose lives were lost in Sandy Hook Elementary in Newtown, Connecticut, in December of 2012. The loss of these children, these precious children, ignited a nationwide discourse amongst the trauma responder community asking what could be done so that less people die in mass shootings. And from that, came the outpouring of the national Stop the Bleeding campaign, which was designed around the idea of making community members first responders, understanding that in a mass casualty like this, there's simply not enough emergency response and not enough time to save the lives that could be saved, and while that campaign is riveting and important and has been brought widely to schools, and businesses, and public spaces around the country, why is it that it was this event that caused us to recognize that people should be trained and equipped and ready to respond to life-threatening injuries? Because when someone is bleeding, time is life, and 911 responses cannot get there fast enough to ensure that every life will be saved.

0:21:13.5 DP: I was ignited by this campaign and decided to bring it to the streets of St. Louis, after I joined the community in 2016, I was out doing community engagement around the issue of so-named gun violence, when a community member came face-to-face with me and made it clear that while I had a shiny white coat and worked in a big fancy building, one of the best hospitals in Missouri and one of the best trauma centers in the country, they had no sense of my presence in their neighborhoods and in their community. They didn't have that one person assigned to ensure that they matter as people, and that they were safe. So, I decided to take the national Stop the Bleeding campaign, before 911 arrives, and twist it, and morph it, and change it. Not just to be something that was for schools, that was recognizing how important that is, but bringing it to the lives of people who day-to-day were dealing with the impact of trauma and violence. Next slide.

0:22:23.3 DP: Through that work that began in 2018, I began morphing and changing the national Stop the Bleeding message, because so much of it is based on this idea that the first thing you do is call 911. But the truth is, studies from the trauma world have shown us that your likelihood of surviving is less if you wait for an ambulance, if you've experienced penetrating trauma, being shot or stabbed. Trauma that's likely to cause a body to lose its life from bleeding. In fact, a study done in Baltimore that had been previously done in LA, looking at 100,000 people who were injured and then went to trauma centers, found that their chance of dying was 11% if they went in an ambulance and only 2% if they went in a car. We had to change what Stop the Bleeding was telling our community members, so we didn't put inside them the false idea that they were powerless to get themselves to the hospital and that it was better to wait.

0:23:27.5 DP: The truth is, 911 can sometimes be a joke. Because the words that Flavor Flav was playing down in 1990 are true today. If the ambulance can't get there fast enough and take you fast enough, the five, 10 and 15 minute delay, can be the difference between life and death. This is one of the first ways in which my work as a trauma surgeon really

started to dig into what 911 is all about. Next slide. It's interesting, 'cause as we started teaching this in the St. Louis region as part of the T, there was a lot of criticism that no one's gonna respond to that, no one's gonna actually help somebody, no one's actually gonna be at the scene and do something but we found that by teaching the class the way we taught it and making sure everyone had a trauma first aid kit, and over 50% of the people were confident in their ability, confident in their ability to save a life and stop the bleeding. And many, if not all, improved their confidence level in their ability to intervene. Next slide.

0:24:32.7 DP: It's not just what happens before the ambulance arrives, it's what happens inside the ambulance. This was a study that my group did through the leadership of Erin Andrade, who's now a fourth-year surgery resident at Washington University. She noticed, along with her resident colleagues that there seemed to be a difference in which people were being brought to our hospital system and center, based on race when they were adolescents. We have a trauma center that's on a very large street, and if you're coming south, the first building you hit is the Children's Hospital with a trauma center. If you're coming north, the first hospital you hit is an adult hospital with a trauma center. They're right beside each other, and the only reason why you end up in one versus the other is if the ambulance decides to drive another block.

0:25:28.4 DP: This study looked at the way in which African-American adolescents were more likely to be triaged to the adult trauma center, rather than the pediatric trauma center for the same age and same severity of injury. That created a whole cascade of decreased support in social work, increased likelihood of being discharged from the ER with an opioid, rather than actually having a plan for pain control outside of opioids, and an increased likelihood of returning to the emergency room with a problem in the next 30 days. This is a real example in which harm is being done at every level, simply because black children are being assessed to be more adult than they actually are. Another way in which 911, an emergency response, taking people out doesn't have that one single voice saying, "I see you as you are and you're safe now." Next slide.

0:26:26.7 DP: What I'm getting at is this tension between 911 being a mechanism for getting healthcare, a magnificent healthcare system, at times detached of a presence to people by literally ripping them out of their environments as they're getting access to emergency care, all within a structure whose sole purpose is law enforcement. There are so many opportunities for acts of commission and omission to bleed into these interactions which can cause the kind of suffering and pain I've already alluded to. Enforcement rather than care. Arrest, rather than freedom. Assaults. Literally being further traumatized physically and emotionally by being called a criminal rather than a patient. And then the delays, the detaining, the deception as if help was on the way, when I have heard stories from patients who I take care of, that they have not just only called 1-1 and had to wait, but they've literally been hung up on when they're in the middle of a tragedy. And the fact that this system is the default system that everyone believes is the only way to get help, is in and of itself, one of the worst acts of omission I've seen and one that I actively try to teach differently. Again, we teach people how to stop the bleeding. Next slide. How did we get here? How did this happen? How did a system for care get enmeshed in a system for enforcement? I'm not gonna tackle that, I'm gonna let Rebecca tackle that in her slides coming up next.

0:28:27.1 Rebecca Neusteter: Thank you, Dr. Punch. For the work that you've done today and the work that you're doing every day, we're all incredibly grateful for the perspective that you bring, and the creativity and the experience and perception. I really appreciate what you've shared, is very heavy. I'm feeling it. I know that all of you are as well. I also wanna thank Natalie, for moderating this panel and the Full Frame Initiative for having us all today, as well as the Well-being Blueprint, which has been incredibly influential to us as we're thinking about our Transform 911 initiative. But I just wanna give a little bit of context about 911 nationally. How it came to be and how it operates. Dr. Punch has talked about what happens after people call 911, I think it's important to also understand how 911 itself operates. And many of us as children, maybe children that we spend time with are familiar with this game of telephone, in which one child whispers a word or a phrase into another child's ear and it gets passed along from person to person until inevitably at the end of that chain, the words and the phrase have changed, sometimes very significantly. And so we see in this example, that the word goes from peas, to bees, to knees, to cheese, to fleas. And this isn't so unlike the 911 system itself, because it's not as though you pick up the phone and you speak to just one person.

0:29:55.0 RN: A caller who calls 911 speaks to sometimes two people, an operator, a call handler or a call taker. That person then enters information into a 911 system, that system is then taken by a 911 dispatcher. The 911 dispatcher then deploys whatever they've deemed as the appropriate response for that particular call. There's sometimes as many as four different people that are interacting with the same call and that's if the call is only coming in once. If the person repeats the call or multiple people are calling about the same thing, then this entire cycle is again replicated over and over again. It can be very confusing, and it is in fact the real life game of telephone. It's also a completely blind-sided, one-sided operation. When we talk about blind spots, 911 is by definition a blind spot. You're listening to one person's side of the story and you're intuiting it as though it's truth. There are major problems with that, which has resulted in harm in many communities across the country, as we see biased calls and other kinds of calls that result in harm because of basic omission.

0:31:08.0 RN: Next slide, please. One particularly pronounced example of the game of telephone having real life and death consequences in the 911 system is the case of Tamir Rice. If you listen to this 911 call, which is available on the internet, it's been [0:31:26.4] ____. I encourage you to listen to it if you haven't ever listened to it before. The caller expresses extreme amounts of skepticism at multiple points, at least four times, during a very short call with a 911 call taker. The caller expresses that this might be a child playing with a gun, emphasizing multiple times that this might be a child and that it might be a toy gun. The call taker does not enter any of that skepticism into the call taking record, into what we call the computer-aided dispatch system or the CAD. Instead, what was entered, it was a gun call at a park. No reference to it being a child, no reference to being a toy gun.

0:32:05.9 RN: So these officers were primed for the worst possible scenario, a person with a gun at a playground, and they entered that situation recognizing that there might be people in danger. They didn't have any of the skepticism that they needed in order to understand that there might be something else going on there, just a child playing with a gun. We'll never know if those officers would have acted differently had they have had that

information but I'd like to think that they would have and that this omission, as Dr. Punch has acknowledged, causes serious harm in the system that we see play out each and every day. But it's not just the omission that happens on the day-to-day from 911 call taking that we need to pay attention to, it's the omission of the lack of knowledge and history of how this system was set up in the first place and the fact that it's actually set up in a way and is acting just as it was designed. Next slide please.

0:33:05.5 RN: The first 911 call was made on this red phone in Haleyville, Alabama in February of 1968. And this is important because there were a lot of things happening in 1968 but Haleyville, Alabama recognizes this as their claim to fame. They have a museum set up around being the first to have made 911 happen in their communities, they have an annual fair every single year that honors and celebrates 911, but very rarely do you actually hear the exact details of what happened. So I'm gonna share a little bit about that today and hopefully, it will become clear that some of what we see today as these omissions and harms of 911 are product of the system and how they were designed. Next slide, please.

0:33:55.9 RN: So this is that red phone in action. You see US Representative Tom Bevill holding that red phone in his hand, answering that first 911 call. Who's next to him in the center of this picture is Bull Connor. Many of us know Bull Connor. He's an infamous white supremacist. That's not a controversial statement. If you look at the National Park website, they described Bull Connor, even under the Trump administration, as being a white supremacist. Bull Connor was responsible for violence against children who were protesting segregation and the children's crusades. He was responsible for the monitoring and the terrorism of civil rights protesters all across the state of Alabama and Birmingham, specifically throughout the 1960s. And when he stopped being in charge of public safety and policing in Birmingham and Alabama, he went on to be the public service commissioner and in his role as the director of that commission, he was responsible for bringing 911 into Alabama and setting the stage for what 911 looked like across the country. Next slide, please.

0:35:06.0 RN: So 911 was implemented but it was implemented for the wrong reasons and it was the technical infrastructure that was developed, which I'll talk about in just a moment, that set the stage for what Bull Connor began in Alabama and what now is the architecture and the foundation of 911 that we live with today. 911 was developed for the wrong reasons. It was aimed at suppressing protests by black communities against segregation and police brutality, otherwise described as civil disorder. This was not the first time that 911 had been attempted but it was the first time that had the political will and the commercial capital to make sure that it actually happened. Next slide, please.

0:35:54.4 RN: So the Kerner Commission was a commission that Lyndon B. Johnson put in place and after, there were almost 160 protests in the summer of 1967, there were protests against racial violence and segregation, much of this violence being perpetrated by the police against people of color. This was a summer that was not so dissimilar from the summer of 2020 but it was even more violent. And the Kerner Commission was was comprised in order to understand what caused these protests and to try to present a series of recommendations and proposals to try to put an end to protests like them in the future. It condemned white America's racism as the cause of protest and it demanded investments

in black communities and against discrimination. The proposals were far and sweeping, went from employment to education, to reducing the police apparatuses control in communities and really everything in between.

0:37:00.5 RN: But at this time, President Johnson was facing a very contested election against, who then ended up winning, President Nixon, our law and order candidate, and under political pressure, he suppressed the early findings that had concluded that the protests were a response and a logical effective response to political pressures and white supremacy. There was internal agreement about how to handle this, and so essentially, all of the staffers, over 100 of them, that had worked on the Kerner report were fired. There were, however, other pieces of the Kerner Report that got less play, less attention, but ended up actually being much more important to our story today. Next slide, please.

0:37:49.1 RN: The supplement on control of disorder which was led by Arnold Sagalyn is a very infrequently published and referenced piece of the Kerner Report. It's hard to find it. We were able to find it through our archival research. My collaborator on this project is Katrina Feldkamp, who's a very talented legal scholar, and was able to access many of these archives, and what we found in the supplement on control of disorder is that it focused on expanding the police capacity to actually suppress these protests. It created the structure that we have in place today for riot control training and equipment to be provided to police, what we see in operations and communities all across the country. Certainly, we saw this happen much in last summer and still today, and all of this was with the intention of trying to infiltrate black communities and movement spaces, sending spies into movement campaigns in order to try to end disorder. This report was omitted, as I mentioned, or this supplement, rather, was omitted as I mentioned but it's incredibly important and it really did set the pathway for 911 as we know it today. Next slide, please.

0:39:16.0 RN: The supplement and the proposal around 911 though had been given early warnings of concern in February of 1968 as the report was being released and 911 was being fully operationalized. LBJ said that 911 would decrease response times for police and fire, and paramedics but he also said that it would increase arrest and provide a more immediate solution to civic and civil unrest. He recognized that the police deployment would often be related to non-emergency calls, and his advisors advised him of this but he ignored those concerns. And in fact, shortly after, Haleyville, Alabama implemented 911. Several other jurisdictions did as well. The biggest city of which in July of 1968 was New York City. They made the choice to only implement initially 911 for police and we saw immediately the way that 911 acts today. Half of the calls that were made almost immediately to 911 were for non-emergencies and this resulted in over... Excuse me, almost 10% increase in police deployments, even though most of these calls were non-emergency.

0:40:37.0 RN: So returning now to the central question that Dr. Punch asked, and which we will discuss further now, next slide, Why did we couple care and enforcement? Why did we make this decision in order for 911 to default to police? We know that people experience crises and emergencies, we know that people need care in their communities, and we know that the police and often, fire and paramedics are not the best equipped to actually respond to these problems but we've made a decision to default to police and to require that 911 involved the police. So even when people are asking for non-police

responses... And when you hear 911 callers, they will often say, "Please don't send the police." We do not listen to them. We do not hear their cries for care. Instead, we continue to couple care with enforcement. Dr. Punch, I'll pass it back to you now.

0:41:44.0 DP: Wow, thank you for taking us to school, and that is the history that I did not know before I started working with this event, and it's astonishing to me. You would think, as a trauma provider, I would have known it and it really, really, really... It's so important and here's one of the reason why I'm realizing it's really, really important. It could be misconstrued at this point, with what we're sharing, that we're somehow insinuating that all people who are part of the emergency law enforcement and medical response are in some ways biased and intend harm to the people that they've been employed to serve. And I would adamantly deny and reject the idea that that is at all what is happening. The people who make it their life to ride on ambulances, to go into the middle of conflict, to show up when someone's life is on the line are not the problem. In fact, they are desperately trying to be part of the answer. And in fact, the burden of trauma that they carry in their bodies as a result of being exposed to so much pain and suffering is unreal and burdens their lives with very, very high rates of depression, PTSD, and suicide.

0:43:27.8 DP: So I just wanna take a moment to recognize and honor the people, not only like myself, who are inside this system, but it's actually liberating. So the point is it's liberating to recognize that it is not us as individuals who are making these choices but it is the design of the system. And if we don't know our past, how can we have control over our future? I wanna share a story with you that really embodies how much harm the system can create and where the actual harm might come from as we think about a path forward. So I was in training at the University of Maryland in Baltimore where I had the privilege of spending 11 years as a trainee and on staff at the Shock Trauma Center. And as a center in Baltimore, it was a referral center for a lot of other hospital systems, and so we often got patients sent to us who are really, really, really sick. And one of the patients that I remember receiving as a young trauma surgeon was a young man, a beautiful young man, who had lost parts of three out of four of his extremities, a part of both legs and one arm had been removed all as a result of having been shot 14 times. And I also knew that he had had operations on his abdomen and chest and when he got to our trauma center, it had been about two or three weeks of care that he had been through and he needed a lot of help.

0:45:17.4 DP: I ended up operating on, literally, his entire being at some point in time. Multiple trips back and back to the operating room to try to get his abdomen secure, make it so that he could digest, make it so his limbs were in some kind of recovery mode, make it so he wasn't literally covered in open wounds. And one of the days after the operation that we had done that day, I had an opportunity to sit with his mother. And as a patient that had transferred from another hospital, I didn't know his story from the beginning and I didn't know how he had ended up shot 14 times with injuries over his entire body, losing part of three extremities. And she sat with me and told me what had happened.

0:46:10.3 DP: See, he was burdened with struggling at times with symptoms of schizophrenia and he would sometimes act in a way that, remember, like I mentioned, was not in control and required help and his mother had gotten into the pattern of reaching out through 911 to a response that was specifically catered and focused on people who were

having mental health crises. They were officers who would respond who knew him, that came always the same ones, they were crisis trained and they were able to de-escalate his moments and get him and his family safely through a number of times when his symptoms were really severe. Well, one time, his mom made the call but the system did not align and instead of activating a group of CIT, crisis intervention trained officers, officers who knew him, a standard group, a standard team was sent to his house unable to recognize what was happening in the moment, responding to his physical threat, assessing him, to me, represent a threat to everyone, which he did not. The officers took action and it was actually police who shot this man 14 times.

0:47:41.3 DP: As I sat with his mother and tried to grapple myself being inside a system that was supposed to be the answer and instead had become very, very much the question. I said to her, "How? And surely, there must be some way that you can recover from this. Surely, the officers, the department, you can get someone to attend to this, you can get some relief," because she had been, now many weeks, caring for him at his bedside, unable to work, and the whole family was reeling from the impact of this devastation. And she told me that she could not even get a lawyer to sit with her and hear the case. They were so dismissive. It had just become so normalized that there was no faults of anyone but her son. And it was in that moment when I really, really, really came to this crisis and understanding, "Wow, how could something that's supposed to be so right act so wrong?" And I think what we've just heard, makes it make sense. It makes sense that something that is composed of well-meaning, hard-working, sacrificing individuals creates outcomes which are unimaginable and quite honestly, untenable. Next slide.

0:49:12.0 DP: One of the ways in which I see this manifest in a smaller way is the way in which down the role of the healthcare system continues to dismiss and not respond to the ways in which people are presenting with their pain, asking for help, and instead, getting told that it's not anyone's responsibility to deal with the burden of that pain except for themselves. The same word that that mother had been receiving. This is a body of work done, again, by Dr. Andrade, as well as Jane Hayes, who's a medical student working with this body of work, and we looked at the experience of people who had retained bullets versus people who did it.

0:49:57.3 DP: Now, you might be like, "What does this have to do with 911?" But here's the deal, this is an example of a system which has normalized harm at every step of the way. See, you've seen it in every Western movie or even some sci-fi movies that are futuristic. If someone's been shot, what's gotta happen? The bullets gotta come out. I don't care if it's the veterinary student is the only person who can help, they're gonna get that bullet out and someone's gonna take a shot of whiskey, and they're gonna heat up something, a metal, and they're gonna bite and scream, and then the bullet's gonna come out, and that would be it. Everything will be fine. The reality is that simply taking out a bullet physically doesn't always solve all the problems of what's happening, and the practice in surgery is to leave bullets behind. The thought process being that going in and digging out a bullet is not worth the harm of the surgery and the trauma that that would create.

0:51:00.0 DP: The thing about it is for patients psychologically, emotionally, metaphysically, I don't know what it is, but for them it is like the movies. The moment that

bullet comes out, there is such a peace and a calm. There is a sense that what was intended for their harm has been removed. And we looked at the experiences of people who had retained bullets versus not, and found that people with retained bullets stayed in the hospital longer, were more likely to come back to the ER for care in the next 30 days, and were much more likely to experience a bullet injury in the future. This is the one example that drove me to create a body of work, which I think is the antithesis of some of what we've talked about with what's so wrong at 911.

0:51:53.2 DP: Next slide. I have found that the way in which the healthcare and the emergency system burdens people with more trauma drives bullets deeper to be so egregious, that I with the cooperation of a whole lot of really invested and caring people in the St. Louis region, have created something called the Bullet-related injury clinic. And it is a system of care, which is the opposite of so much of what we just talked about. It's a system of care that's focused on people who are leaving the emergency room after having been shot, who are then going back to their environments where they came from and having to deal with having a hole in their body, having suffered the intention for death, energetically moving through their flesh.

0:52:44.5 DP: That body of work starts with a radical generosity. We give people a gift before they leave the emergency room, that includes wound care supplies, pain control techniques, and our number. And even my face. Like that person saying, "Hey, we're here. We see you. We care. And you're not alone. You're safe now." We bring people into a clinic that is in the community That's one door you walk in, you don't have to dial one if it's raining or two of it's snowing, it's just open. We have a phone number where we can text and call, and we make it as accessible as possible. We don't ask them to sign things and give us information on their insurance because it's free. Because the financial trauma of experiencing emergency care is real. We saw that come up in the chat.

0:53:34.4 DP: We focus on pain relief, sleep aid, stress management and GI support, because people's sympathetic nervous system has totally dysregulated. So they can't sleep, they can't eat, they're in pain, and they are really stressed out. We focus on relationship building, because we know that the primary injury of going through this kind of trauma is an injury to trust. People have a very hard time believing that the world is a good place and that their bodies are safe after they have been shot. And then we add and connect them to other social resources so that they can get the care they need. And sometimes, we're even able to provide immediate financial relief or at least a free ride, a meal and some TLC.

0:54:20.8 DP: This bullet-related injury clinic is the pinnacle of my work as a trauma surgeon, and it's the idea that I shared with you earlier. That while trauma is not experienced in an individual, it can't be healed in an individual. And having this community of health surrounding this injury has led to a system of care, which by design is anti-trauma. A system of care very, very different from 911. Next slide. The brick is a big, beautiful building where folks can play basketball and they sit on a table and get their wounds cared for by loving, concerned people. And it's a community that says explicitly, especially to Black men, "You're safe here, your pain matters, and we're gonna get you through this." Next slide. You can learn more about this body of work at our website. Here it is, thetstl.com And I wanna share that framework to kinda set up this next set of ideas.

That if it's possible to do this for trauma recovery, isn't it possible to transform 911 itself? Back to you, Rebecca.

0:55:43.9 RN: Thanks Dr. Punch. And not only is it possible, it's necessary. It's a social and moral imperative to transform 911. People rely on 911 for care. They should be able to rely on it for care, it should not default to enforcement. That's why we need to transform 911. Next slide, please. The work that we're doing at the Health Lab with a large number of partners, including the Full Frame Initiative, is seeking to transform 911 in order to innovate crisis response for public health, safety and justice. Next side. To support healthy communities. Next slide. And to improve equity and crisis response. Over the next year, we'll be bringing together our stakeholders across the country who are interested in getting involved in developing inspired ideas. There are no wrong ideas, there should be no wrong door to seeking care. And care should not involve enforcement. I wanna reiterate what Dr. Punch said, this is a broken system that breaks people. The people who enter this system often are incredibly well-intentioned and work really hard and have to work much harder because they're working within a broken system. And so, we hope that you'll all join us to make really need a transformative change in this system.

0:57:13.1 RN: Next slide. And my contact information is on the slide. I would be more than happy to hear from you and work with you, and are very grateful to have people engaged in the conversation, see what is the ask. The ask is to join in the conversation and to start to come up with ideas that really help to engage in all of us. Feel free to reach out to me directly if you're interested, and we will share more information as we have it in the coming weeks and months, but I will pass it to Natalie now for the next piece of the conversation, and thank you all for being with us today to think about how we can change these broken systems.

0:57:58.4 NW: Thank you, Dr. Punch and Rebecca for an amazing education. So grateful for you today. Now is our time to open it up to our attendees for Q&A. So again, please raise your hands, type your questions into the Q&A chat at the bottom of your screen, we'd love to hear from you and we love to take advantage of this time that we have from our experts sitting here.

[pause]

0:58:33.1 NW: So I think Katia put in a question in the chat. I think more on innovations you've seen including beyond St. Louis, while people are putting... What other innovations have you all seen beyond St. Louis? And maybe that's directly for Dr. Punch and Rebecca.

0:59:08.0 RN: I'd love to encourage Dr. Punch to talk about some of the re-use of ambulances that you all have put in place there that I think is a really creative model, if you'd be willing to share what people are generating other questions.

0:59:22.6 DP: Yeah. I was thinking perhaps you could speak about Cahoots as well, but just a simple thing, when we do mobile outreach or we're at events, we do a significant amount of harm reduction work for folks who are using opioids, and we do community events that are engaging youth and otherwise. We use an ambulance that we have repurposed and actually, we have a mural that a local artist, Cbabi, made for us. He's a

nationally known artist, and it depicts our community of health and this idea that we are not well unless we are all well. And the idea is turning around the idea that the ambulance goes to your neighborhood and pulls you out and takes you to this big foreign place, but in fact that the ambulance brings resource and love out to you where you are, because you deserve to have it where you are. And it's repurposing something that was intended to see deficit, to see deficit in community, and instead is simply adding to the richness of community because that's where real healing occurs.

1:00:45.3 DP: But, I also will comment that Forward Through Ferguson, an incredible body of work that is the non-profit that was created after the Ferguson Commission, which was created by the Governor after Michael Brown's murder in Ferguson, that that group has been working locally on re-imagining 911, and has been looking at some other national models. That's what I was referencing, Cahoots, as a way of thinking about having a separate, not law enforcement contained response to emergency calls, which could focus on getting people the care they need when it does not in any way, need to be connected to law enforcement.

1:01:30.9 NW: As the questions are... Oh, sorry, go ahead Rebecca.

1:01:34.4 RN: I was just gonna add a couple of points. Dr. Punch mentioned Cahoots, and I know that there are some questions about 988. I think that if it's okay, Natalie that I can address some of those together. Cahoots is a model program, it has yet to be evaluated but it's been in place for over 30 years. It's based in Eugene, Oregon, it's being replicated all across the country. Basically it aligns medics along with outreach workers, and they proactively engage with people on the street, and they also respond to some 911 calls. They're primarily responding to behavioral health calls and people who are experiencing homelessness, and there are other programs in Denver and Albuquerque, as well as a number of other cities that are cropping up that are similar to this. It's a really inspired area, it definitely needs a lot more attention and investment. I would argue that a lot of what we need also though, doesn't deal with behavioral health as specifically and that as Dr. Punch has mentioned, bringing care to people is essential in answering these questions. And that we need to start to answer some of the really tough questions. Some of these models that are cropping up are cropping up because they're dealing with calls that feel safe.

1:02:53.8 RN: Calls that don't involve violence. And what we need to see is we also need to see creativity when it comes to domestic violence, when it comes to neighborhood disputes, when it comes to people who are having crises because they don't know how to communicate and problem solve with each other. Because these are some of the times in which police are most often called, but yet they have very few tools to effectively deal with these problems, and instead leave communities broken by making arrests and taking people out of communities and destroying social capital. In terms of 988, I think it's important to highlight 988 at this moment in time. About one year ago, Congress enacted legislation to ensure that 988 would be available in all communities across the country, similarly to when Congress made 911 available in 1968, but it took until 1999 until Congress actually mandated that 911 be available in communities all across the country. In 2000, 988 was introduced as a line that people are supposed to be able to call if they're experiencing behavioral health crises. Aand these lines are going to have to be put in

place by the middle of July of 2022, so one year from now. This is progress, but we also have to recognize that no investment was really made in order to make sure that people are gonna be receiving the services and the care that they need.

1:04:24.7 RN: It's just another number to call, and we fear that some of the challenges that are being experienced with 911 will not only be replicated, but will be compounded by the fact that people will be confused about which number to call for whom, and that resources will be even more diffuse than they are now.

1:04:46.0 NW: Thank you, and thank you for that. And I'd like to call Jeanne Milstein to the screen. Is she still there? Okay, Jeanne, go ahead.

1:04:54.2 Jeanne Milstein: Can you hear me?

1:05:01.9 NW: Yes.

1:05:03.3 JM: Okay, thank you. First of all, thank you for organizing this. It's extraordinary. Thanks to both speakers. I'm the Director of Human Services in the city of New London, Connecticut. We are a city of 27,000, and we are the number three most distressed municipality in Connecticut. And we implemented a model four years ago to deal with the opioid crisis in our community, it's a peer navigator model, and to Dr. Punch's point, it's based on harm reduction, it's based on the work with HIV/AIDS married with our housing coordinated access network. And our navigators are individuals with lived experience, and they do outreach, they meet people where they are. During the pandemic, if somebody needed PPE, etcetera, etcetera.

1:05:50.5 JM: And model has worked very effectively 'cause there's trusting relationships. And we are now taking that model in New London and we are replicating it into a public safety mental health initiative. With the police, while we do have mobile crisis and we have crisis intervention training, there's really no follow-up. We see the same people all too frequently, so I'm excited about the model because again, if there will be relationship building, harm reduction, support, meeting people where they are. I would love feedback and love to know if anyone else is doing anything innovative that we can learn from here.

1:06:35.2 DP: You got me speechless over here. You are talking my language. We did a very similar effort that was fueled by Covid first, the need for trusted messengers and then the ways in which peers are not only better communicators, but they're just smarter and do it better. And so, I cannot say enough about how powerful what you're saying is because it brings everyone's trauma response and sympathetic nervous system tone down, when you're helping in community rather than from outside a community. I think one of the things that I think is really, really powerful is to move that response all the way into the emergency room and to have people, not just once someone's transported or has an interaction, but to have people... And I even had one of our prosecutors ask to have a presence in their office. There's so much opportunity, I think, to keep that peer support going because sometimes we do this really great job of meeting people where they are and then they go into the system and then they still have to go through the same stuff. But you know what? I'm gonna send you my email because I wanna know more about what you're doing in New London. It sounds amazing.

1:08:02.7 JM: Well, I was actually... Since I'm old school, I was gonna ask you if I could give you my phone number in the chat so we can have a real conversation. Thank you.

1:08:12.2 DP: Love to.

1:08:18.0 NW: One of the questions that came up is, What can people do to really advance this discussion to create change and transformation no matter their position, no matter where they work, or who they are in what community? So I'll kick that to each one of you for a down and dirty, quick response. [chuckle]

1:08:44.0 DP: My biggest thing is when I stopped allowing myself to be agnostic to pain and suffering, I just refused to think it's okay. And no matter what the system was telling me was acceptable, I was still able to see people as whole real people that needed to have their pain and suffering acknowledged. I think simply standing up for that and starting right there, is it something that everyone can do. There's always discourse and conversation and small and big decisions that are being made, that dismiss that kind of experience. And I think that's with the foundation. When I started being intolerant of ignoring pain and suffering, I really started having a voice in conversations, which was really different. I also think grappling with system level dynamics rather than getting dragged into individual human resource people, sensitivity training type conversations, by insisting that the conversation happened at the right level, I think you can really, really elevate everyone's discourse around it. That's philosophically where you can start as an individual.

1:09:57.6 RN: Yeah. I second everything that Dr. Punch said. I think also what's really important here is that we need to understand how 911 operates. There's a universal number, there's no universal application or way really that it's being applied in your community. There's over 6,000 911 centers in this country. They're known as PSAPs, or public safety answering points. I encourage you to understand what the PSAPs look like in your community. Sometimes there are multiple. Los Angeles County, for example, has almost 80 different 911 centers. And so, we need to think about how resources are being spent, but also how care is being delivered when it's so fragmented. I think really trying to educate yourselves and try to ask these questions.

1:10:46.1 RN: There are increasing amounts of resources in how to be involved in bystander training, if you hear someone say that they're gonna call 911, I strongly encourage you to ask them why and whether or not there might be another solution. 911 may very well be the right answer, but as we've learned through our work in very different applications, whether it's trauma and surgery or police enforcement, 911 often isn't the best answer, isn't often the quickest solution. And I want to highlight another point here is that 911 is very unlikely able to solve underlying problems. What we can do best, if we are at our best, is that we can stabilize in the moment. What we need to do, and I wanna give credit to my co-faculty director, Harold Pollack, for coming up with this idea of second response. We need to use 911 calls as a flag for a problem and be very deliberate in following up afterwards to make sure that people have the resources and the care that they need to prevent the next crisis.

1:11:53.9 NW: That's amazing. And I know that we are close to time, and so there are so many questions that people have and need to be answered. What I've heard from Dr. Punch and Rebecca is that, please reach out to them. Please reach out to us at the Well-being Blueprint, if you have additional questions we can work to get those answered. Overall, please get involved and we have many ways for you to do that. I will end today as I began thanking Dr. Punch and Rebecca, for your... As new language and terminology. Thank you to Dr. Punch, radical generosity. Because you didn't have to give us this time and space but you did, and we appreciate you for that and love you for that. And I wanna thank our attendees for your time and participation. I will add that this is a time for all of us to mobilize, and I will add to that my request for you to get involved. We need each of you out there. I think we have over 130 participants. We need each of your voices to move the needle on this and to create transformation for our communities and for our world.

1:13:12.0 NW: As with Dr. Punch and Rebecca, we all get ignited some place. Let this be the place that ignites you. Where's the harm in 911 emergency response and community trauma? This event gave us the history of current issues with our emergency response system. And this is a system, it's not a one siloed program, that needs to be really looked at and reconstructed in a way that it serves community through a trauma informed lens and creates space and time for well-being for all people. The other place is the Well-being Blueprint. As a community of signers, we are radical in our conversation about social change, and we create a space where you can use your passion to drive structural change along with others who believe like you do. Our goal is that everyone in our world has a fair shot at well being. I know each of you has a gift to share with our amazing community and change makers, and we'd love to have you join us if you're not already a part of this conversation and of this movement. Please look us up on the Wellbeingblueprint.org website. Or, you can contact me directly at Natalie@fullframedinitiative.org.

1:14:25.5 NW: Thank you to all of the full frame initiative staff that worked on this, and thank you to our presenters, Rebecca Neusteter and Dr. Punch for your passion, your time. And thank you to our ASL interpreters who basically took your presentation and did it through a different way of speaking today, you all are amazing. Thank you to everybody, and I hope you have a great rest of the day.