Implicit Bias in the Child Welfare, Education and Mental Health Systems

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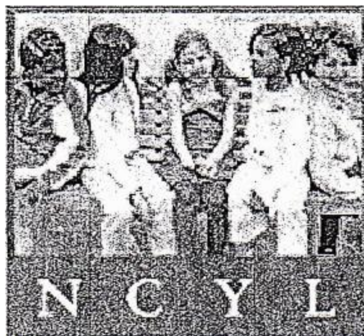

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EXECUTIVE SUMMARY

Youth of color are overrepresented at every stage of the juvenile justice process. Much of the literature that discusses this overrepresentation focuses on racial disparities in the juvenile justice process itself. However, a comprehensive understanding of this racial disproportionality is not possible without examining racial bias in the "feeder systems" that funnel our children into the juvenile justice system.

This paper investigates the impact of racial bias on three public institutions: the child welfare, education, and mental health systems. Research shows that racial disparities exist at almost every stage in these systems, and that racial bias could account for the difference in outcomes between non-White and White youth. While most of the research indicates that racial bias could be an influencing factor in the decision-making process within these three systems, this paper highlights the ambiguity in evaluation criteria determining child welfare, school disciplinary and special education, and mental health outcomes and suggests that the ambiguity leaves room for caseworkers, educators, practitioners, and juvenile judges to unconsciously rely on their preexisting stereotypes about racial groups in their decision-making. Finally, this paper will provide possible de-biasing techniques - designed to mitigate the influence of racial bias in these systems and highlight where future research can help draw the connection between implicit racial bias and the existing racial disproportionality.

CHAPTER 1: !implicit Bias and Child Protective Services -

Starting with the point of referral, various decision-makers determine the outcome of a child welfare proceeding: whether a case is referred, screened-in, investigated, and substantiated. Most decision-makers believe that their evaluation of a specific case and eventual decision are based on an objective review of the facts. Thus, many suggest that that the existing racial disproportionality is an unfortunate but nevertheless true representation of reality.

However, existing research calls into question the objectivity of the evaluation and decision-making process. Depending on a decision-maker's perspective, the idea of "abuse and neglect" can encompass a range of experiences from severe forms of physical and sexual abuse to neglect that stems from poverty. Given research finding that families of color are no more likely to mistreat their children than White families, the racial disparities in the child welfare system reflect a distortion of reality and suggest that the decision-makers malleably apply the definition of maltreatment.

The following research will illustrate the stages of the child welfare system, highlight racial disproportionality in a number of key decision-making points, and suggest the role racial bias plays in case outcomes. As this research shows, there are various points where decision-makers might unconsciously rely on racial biases about families and children of color when reviewing the facts of a case, and consequently, case review and evaluation may not be objective.

Overview

A child's initial contact with the child welfare system begins when he or she is referred to child protective services for suspected abuse or neglect. After a child is referred, the case will either be screened-in or screened-out depending on whether the situation meets the state's definition of maltreatment. If a report is screened-in, child protective services will conduct an investigation to ascertain safety concerns and determine the level of risk (Child Welfare Information Gateway, 2013).[1] If evidence of abuse br n e glebt i§loUnd:the Od§e i dc5nsidefed "substantiated," upon which a court may either remove the child from the home and place him or her into out-of-home care, or provide additional services to the child and family to improve in-home care.

Racial Disparities at the Referral & Investigation Stages

[1] An increasing pUmber of jyrisgglignps etpJoy diffwenVRjs,esp,9ns 9,1n screened-in,fan?ijies .may_ receive a traditional investigation may receive an alterhat iv e resPorise. Determining wh'ether a case will be referred to traditional investigation or receive an alternative response also requires the application of criteria, which may allow racial bias to interfere with objectivity. Although this decision-making point is increasingly important within the child welfare system, this paper is not able to discuss the possible disparities at that point.

Some scholars view poverty as the primary factor accounting for high levels of racial disproportionality in cases of child maltreatment reporting and investigation (Drake et al., 2009), while others suggest non-racial factors such as parental drug use and family circumstances (Howell, 2009; Font et al., 2012). In citing such socioeconomic factors, scholars highlight the intersectionality between race and socioeconomic status, simultaneously illustrating the non:significance of race/ethnicity and accounting fOr the racial-disproportionality in case assessment_and.outcomes.. According:_to thjs-theory„racial disparitieSin case,putcomes-merely reflectJhe correlation between socioeconomic status and race.

However, many scholars show that similarly-situated Black families are most severely overrepresented—about three times the rate of White families—at acceptance for investigation or assessment, despite no evidence to suggest that Black children were abused more severely than White children (Bowman et al., 2009; Fluke et al., 2003; Hill, 2004; Rolock &Testa, 2005). This research suggests that socioeconomic status may not be the determining factor in child welfare case outcomes, but that race may play a significant role in determining those outcomes.

Racial Disproportionality in Substantiated Cases and Causes for Removal

Studies also reveal higher rates of substantiation for Blacks than Whites (Baird, Ereth & Wagner, 1999; Eckenrode 'et al., 1988). Additionally, Latino children are disparately affected, since Latino families are more likely to have a substantiated case than White counterparts. Cases involving Latino children were also brought into the system more quickly, with less time devoted to assessment from the time of referral to the time of substantiation (Church, Gross & Baldwin, 2005).

While scholars might explain the disparate treatment as a result of either a correlation between socioeconomic factors and race, or as a reflection of reality, other scholars show that non-racial factors alone do not account for the overrepresentation of Black children in the child welfare system. For instance, either the presence of abuse or neglect could cause substantiation and subsequent removal.. However, the kind of abuse which results in a child's removal from the home is not consistent across races. Black children are more likely to be removed from their homes for neglect, which can often be related to poverty, than for physical or sexual abuse (Hill, 2004; Katz et al., 1986; Lindsey, 1991). Hill elaborates on this phenomenon by saying:

> "In other words, families (which are disparately White) that have been substantiated as physically or sexually abusing their children are more likely to keep their children and receive services,in thehome. On the other hand, families (Whieh-are'disparately Black) that'haVe been-fo-und to -neglect theirthildr6n:are more likely to have their children taken from them" (Hill, 2004, 25).

While it appears that racial bias does affect case outcomes, it is still unclear as to how exactly it affects child welfare decision-making. Thinking about the decisions made by child welfare workers alone, for instance, are they more inclined to substantiate cases for Black families, and therefore view facts as meeting criteria for neglect? Or do racial biases have a greater impact-at the point of removal, when the caseworker needs to: decide whether he or she believes the family can take care of the child?·

Racial Disproportionality in Foster Care -

Though some studies suggest that the professional background of the decision-maker affects out-of-home placement decisions (Britner & Mossier, 2002.), others show that the ethnicity of the family is the best predictor of length in time in an out-of-home placement. Jenkins and Diamond tested the visibility hypothesis to determine its effects on foster-care placement in counties where Black children comprised 5-10% of the population. The visibility hypothesis stipulates that the rates of out-of-home placement of children of color will be higher in locations in which the proportion of individuals of color is relatively small (Jenkins & Diamond, 1985, 272). Their study found that Black children were twice as likely to be placed in foster care in counties where Black children comprised a small proportion of the total population when compared to counties where Black children comprised the plurality or majority (Jenkins & Diamond, 1985; Garland et al., 1998; Barth et al., 2001). Other studies substantiate race as a factor in influencing placement decisions. Latino children were found to be placed into and spend longer periods of time in out-of-home placements than White children (Church, Gross & Baldwin, 2005). Black children are also more often placed out-of-home, less likely to be reunited with family of origin, and more likely to be placed in foster care than children in comparable White families (Bowman et al., 2009; Lu et al., 2004; Hill, 2004). Race not only seems to affect out-of-placement decisions but also the quality of resources given to Black caregivers: Once in foster care, Black caregivers are less likely than White caregivers to receive equitable economic and special services resources (Hill, 2004):

Racial DisprOortionality in Treatmblit SeniiCes

Racial biases can also affect the services provided to youth in the child welfare system who have mental health diagnoses. Garland and Besinger found that Black foster youth are the least likely to receive court[2] orders for mental health treatment and were less likely to receive mental health services, even though the rate of diagnosis and presence of a mental health disorder was comparable to that of White youth. In care, more White children consistently use mental health services at higher rates pre-and post-removal than Latino and Black children, with the most notable racial difference in the use of counseling and psychotherapy (Garland & Besinger, 1997).

[2] "Court" here refers to a juvenile dependency court, See, e.g.,- - •
https://www.childwelfare.gov/pubs/factsheets/cpswork.pdf

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However, the study does not suggest that youth of color have less need of these services. Rather, the study suggested that cultural barriers may exist: for example, Latino children and families may be less likely to use mental health services because of the presence of a language barrier. By breaking down cultural barriers, judges, practitioners, and caseworkers can get a better understanding of a child's need and recommend services appropriately.

Conclusion

The existing body of research shows that racial disproportionality exists throughout the child welfare decision-making process and manifests in the following ways:

(1) *Referral & Investigation:* Black families are overreported for suspected maltreatment;

(2) *Substantiation:* Caseworkers are more likely to substantiate abuse and remove a child in cases involving neglect (disproportionately involve Black families) than those of physical and/or sexual violence (disproportionately involve White families);

(3) *Removal & Out-of-Home Placement:* Black and Latino children are more likely than White children to be removed and placed into out-of-home care and less likely to receive treatment services.

- a. *Foster Care Placement:* Black children are more likely to be placed into foster care, while Black caregivers receive less than equitable economic and social resources to help support the child;
- b. *Treatment Services:* White foster youth are more often referred to seek mental health treatment. Upon referral, they are also more likely to be diagnosed and treated for a mental health disorder.

While the existing research highlights racial disproportionality among similarly situated families, it does not claim that implicit racial bias plays a direct causal role. It does, however, confirm that racial bias plays some role in the decision-making process and suggests the possible points at which racial bias can take effect. It also opens the door for future research that might investigate the various ways caseworkers, juvenile court judges, medical practitioners, and other professionals involved in the child welfare system unconsciously rely on racial and cultural biases when determining case outcomes. Given the large number of individuals who have discretion throughout the child welfare process—the judge, State's Attorney, child welfare worker, treatment providers, and referral source—further research is needed to determine how to avoid racial bias impacting those discretionary decisions.

CHAPTER 2: Implicit Bias and Education

Contrary to popular belief, research has found that exclusionary discipline policies are largely ineffective. In 2006, the American Psychological Association reviewed ten years of research relating to hyper-punitive school policies and concluded that zero tolerance policies can actually increase undesirable behavior without creating a safer learning environment (American Psychological Association Zero Tolerance Task Force, 2008). In addition to their inefficacy, teachers are more likely to refer Black students for detention, suspension or expulsion for the same infractions of school regulations as their White counterparts (Hill, 2004; Smith & Chunn, 1989). Black and Latino students are also over-referred for behavioral problems and recommended for special education. The disproportionate disciplinary and special education outcomes for students of color create a two-track system: the "disciplinary track" and the "special education track." After the initial point of teacher referral, students of color are either (1) placed along the "disciplinary track," where they are subject to harsher disciplinary sanctions, or (2) the "special education track," where they are placed into restrictive special-education classrooms.

For students of color, neither the "disciplinary track" or "special education track" result in meeting their educational needs. Consequently, both tracks make it more likely that students of color will be displaced out of school and into the juvenile justice system (Cobb, 2009). The following research outlines the decision-making points along both tracks and shows that the key decision-making point is the teacher's initial perception of student behavior. It also demonstrates that recommendations for harsher disciplinary outcomes and placement into special education for students of color are largely based on loose, subjective criteria, leaving ample room for teacher and administrator biases to affect decision-making. This overview suggests that implicit racial biases account for the overrepresentation of students of color in exclusionary discipline and restrictive special education placements.

Overview

The "school-to-prison" pipeline begins with the teacher's initial perception of student behavior. The teacher can choose to address the behavioral problems in the classroom, or seek administrative help by either referring a student for harsher disciplinary sanctions or recommending special education placement. The administration can then choose to disregard or uphold the teacher's recommendation; however, the administrator is often making this decision in heavy reliance on the teacher's reported perception.

Disciplinary Track & Rational Disproportionality

Behavior Perception

Most of the research shows that the greatest predictor of whether or not a student will be placed onto the "disciplinary track" begins with the initial assessment of student behavior. Downey and Pribesh found that White teachers typically rate Black students as poorer classroom citizens than White students, exhibiting more externalizing problem behaviors, and demonstrating fewer approaches to learning skills. The negative evaluation of Black students, however, is restricted to Black student-White teacher relationships. In fact, when Black teachers were asked to evaluate student behaviors, they rated Black students as exhibiting fewer problems than White students (Downey & Pribesh, 2004).

Another study showed that teachers' racial identity mattered only because White teachers are more likely to harbor pro-White racial tendencies. In this study, only White teachers with less sophisticated racial identity statues (either more-racist or more prone to idealizing White values) perceived more externalizing behaviors and were less successful at contextualizing behaviors; teachers with more sophisticated racial preferences were less likely to misconstrue these behaviors as "rude, disrespectful, threatening, or troublesome" (Chen, 2013, 104).

Racial bias can affect teacher perception even before teachers enter the classroom. Research literature shows that the prevailing perception of Black males as threatening and troublesome lead educators to enter a classroom with the mindset of controlling student behavior. This in turn leads to unnecessarily severe disciplinary sanctions, such as the implementation of zero tolerance policies (Monroe, 2005). In some cases, school discipline policies were used to preemptively label primarily Black and Latino students as potentially dangerous, who were then removed and placed into alternative schools (Casella, 2003).

The preexisting assumptions associated with students of color points to a belief that students of color lack "cultural capital," a term referring to an individual's awareness of certain cultural tastes, skills, preferences, and knowledge (Morris, 2005, 26). According to this theory, schools must preemptively tailor their disciplinary policies accordingly or exercise discipline policies incongruently to elevate some students' understanding of acceptable social practices. The "cultural deficiency" bias also extends to schools' administration of bodily disciplinary policies, specifically designed to teach culturally appropriate dress and punish culturally incongruent behavior. One study found that educators viewed the behavior of Black female students as "unlady like" and attempted to discipline them into more gender appropriate dress and manner. The ubiquitous use of the phrase "tuck in that shirt," "act like a lady," and statements reprimanding "hoochie-mamma" clothing illustrate the educators' emphasis on bodily discipline and an adherence to socially appropriate dress and mannerisms (Morris, 2005, 32). Concern over dress and behavior also extended to Latino boys, who were viewed as especially threatening and often received strict, punitive disciplinary sanctions as a result. Notably, such statements were rarely addressed to White and Asian American students, whom officials assumed required little to no guidance in

behavior or dress (Morris, 2005). Race and gender were also significant predictors of when corporal punishment was used, rather than frequency and severity of rule violations (Shaw & Braden, 1990). Black males were by far the most frequent recipients of corporal punishment (Gregory, 1995). Though corporal punishment was rarely used, when used, school officials send the message that a student's behavior is culturally incongruous to the point that that his or her body requires physical punishment. The research shows how racial biases influence bodily discipline policies, and suggests that the same racial biases influencing bodily discipline policies also influence the application of exclusionary discipline policies.

Office Referral

Educators who may unconsciously perceive Black students to be more belligerent than White students are more likely to refer Blacks for detention, suspension or expulsion (Hill, 2004). Disproportionate representation in office referrals is present in both elementary and middle school (Skiba et al., 2011). In elementary schools, Black students were more than two times as likely to receive at least one disciplinary referral compared with students of other races and are more likely to receive more disciplinary reports in total (Skiba et al., 2011; Roque & Paternoster, 2011). In middle school, Black students are almost four times as likely to be referred to the office for behavioral problems (Skiba et al., 2011):

Some suggest that knowledge of student's past behavior, as opposed to race, was the strongest predictor of punishment-(McCarthy-& Hoge;•1987; Okonofua & • Eberhardt, 2015). This seems to indicate that racial bias is located most strongly at the teacher's perception of externalizing behavior. However, this does not account for why, even after holding disruptive behavior as a constant, Black students were still more likely than Whites to receive a disciplinary report by teachers (Roque & Paternoster, 2011). The research suggests that racial bias does seem to influence both teacher referral rates, teacher recommendations to administrators and administrative decisions.

Removal

Race/ethnicity similarly affects administrative decisions. Both Black and Latino students are more likely than White students to receive expulsion or out of school suspensions as consequences for the same or similar behavioral problem as Whites (Skiba et al., 2011). Moreover, the rate at which Black students received suspensions increased significantly (by ten) from elementary to middle school (Mendez & Knoff, 2003). In addition, Black male students are overrepresented in suspensions in almost all infraction types, except for suspensions involving substance and weapons possession (Mendez & Knoff, 2003).

Race not only seems to account for the increased likelihood that students of color will receive harsher disciplinary sentences and be removed from school, but also accounts for the disproportionate application of referral and removal criteria. While Black male students are at the greatest risk for suspension, the reasons for suspension are unclear (Mendez & Knoff, 2003). Contrary to popular belief, disproportionality in suspension does not reflect higher rates of disruptive behavior among Black students (Skiba, Michael & Nardo, 2000). Perhaps the lack of explicit criteria that prescribes when exclusionary discipline policies should be enforced exacerbates the racial biases undergirding teacher perception, and ultimately fuels the "school-to-prison" pipeline by funneling referred students out of the classroom. One study found that a teacher expelled a Latina student from the classroom for being disruptive, despite the fact that she was asking the teacher a question on behalf of the class (Vavrus & Cole, 2002). Students from this study commonly cited: "They [teachers] get frustrated at the class and whoever is the last person to talk, oh there you go, bye bye... You know you not going to say the last word. You're going to get sent out!" (Vavrus & Cole, 2002, 104). Here, the study found that a teacher's decision to remove a student from the classroom is a highly contextualized decision vulnerable to racial prejudices and inadequately constrained by school discipline policies.

Special Education Track & Rational Disproportionality

While much of the discussion on racism focuses on the role negative out-group bias against Blacks plays in creating racial disproportionality, some studies show that that racial biases are internalized by people of color and exhibited against members of their own race. For instance, Black teachers are also found to exhibit aversively racist "double standards" in the differential treatment of Black and White students in special education placement (Hill, 2004, 22). Black students are more likely than White youth to be labeled as "mentally or educationally" retarded and assigned to special education. They are almost three times more likely to be identified as mildly mentally retarded and almost two times more likely to be identified as seriously emotionally disturbed (Oswald et al., 1999). This internalization of racial biases shows that discrimination can occur on such a deep, Subdonscious level that one can harbor aversive racist feelings towards someone of the same race.

Nevertheless, most research focuses on out-group bias, where teachers exhibit a tendency to refer students of different racial/ethnic groups for special education rather than their own (Maynard, 2012). A common explanation as to why teachers will typically refer students who are not of the same race to special education is that teachers exhibit in-group bias to students from their own racial/ethnic group or have a better understanding of student behavior when the student is of their own racial/ethnic group (Tobias et al., 1982).

The principle that a teacher can better understand the behavior of a student with the same racial/ethnic background could answer why Black male students are

overrepresented in special education. Specifically, teachers who are unable to reduce the difference quotient between themselves and their Black students are less likely to understand Black cultural codes, and subsequently rely on racial stereotypes to understand behavior. One study found that teachers perceived students with Black culture-related movement styles as_ lower in achievement, higher in education, and more likely to need special education services (Neal et al., 2003). Teachers who were unaware of ritualistic cultural codes could over-identify Black students as needing special education. Sherwin elaborates on this by stating:

> "Because people co-create and maintain ethnic culture as a function of identity, verbally aggressive greetings and ritualistic mock-battle greeting aggressiveness among males will be seen as discrete cultural communication codes among the African American participants. The data from this study clearly show that the goals and motivations for aggressive greetings and mock-battle greeting operations have manifest communicative intent and do not carry intention to harm. However, the operation can easily be misunderstood by others" (Sherwin & Schmidt, 2003, 50).

Teachers with a limited cultural vocabulary are forced to borrow from another lexicon that prescribes appropriate responses when faced with cultural codes and behaviors they do not understand. It is possible that teachers bridge the cultural knowledge gap by tapping into their own unconscious and act according to their preexisting assumptions about another racial group. Thus, a teacher can be cultural-sensitive yet still allow racial biases to affect his or her decision-making because that decision-making is contingent on his or her breadth and depth of cultural competency.

Conclusion

The research defines the racial biases against students of color and how this manifestS in the application of various school policies. Specifically, it shows that the lack of explicit criteria determining what behaviors are subject to harsher discipline and how context should inform disciplinary decisions creates a gap where teachers might rely on preexisting assumptions about specific racial groups to understand student behavior, sometimes even before a student steps into the classroom. They respond to the cultural dissonance created by a lack of cultural competency by falling back on implicit assumptions about their students, resulting in students of color receiving harsher disciplinary sanctions and being placed in restrictive special education.

CHAPTER 3: Implicit Bias and Mental Health Treatment

In exploring the possible factors role of racial bias in mental health treatment, research points to a two-track system that results in worse mental health treatment for youth of color. Despite similar symptoms and primary diagnoses between White youth and youth of color, youth of color are more likely to be diagnosed for behavioral disorders and prescribed psychiatric medication. At the same time they are less likely to receive counseling and psychotherapy, and spend less time in care. The following research studies will identify the presence of a "dual-track system" and demonstrate that race plays a role in creating disparate outcomes for children of color.

Overview

Racial bias within mental health treatment is seen along two tracks: a "non-diagnosis" and "diagnosis" track. The two-track system results in inadequate treatment for youth of color by either 1) leaving symptoms undiagnosed and untreated, which increases the likeliness that the child will end up in the juvenile justice system; or, 2) creating a "revolving door" phenomenon where children who are diagnosed receive more and more restrictive placements, eventually often including incarceration.

Many youth of color, and particularly those involved in the juvenile justice system, are placed along the "non-diagnosis" track. Their symptoms are either left undiagnosed or mischaracterized as delinquency as opposed to a mental health disorder. When diagnosed, children of color are more often diagnosed with behavioral and psychotic disorders, which are typically treated with medication rather than therapy. Children of color also receive different levels and types of care when compared to their White counterparts. They are more likely to receive inpatient versus outpatient care, stay in care for shorter periods of time, and be placed in correctional facilities instead of mental health hospitals.

"Non-Diagnosis" Track & Rational Disproportionality

The disparity in mental health disorder diagnoses and treatment can be explained in a number of ways. First, the fact that clinicians make fewer judgments of mental health disorders for Black patients could be a result of the fact that they simply judge Black patients to'exhibit fewer severe symptoms (Gushue,'2004). However, what appears to be-a favorable evaluaficin for the client of color could be a reflection of racial stereotypes that hold people of color to lower standards. Thus, the meaning of the evaluation is synonymous with "healthy for a Black person" (Gushue, 2004, 403). Secondly, the disparity in judgment of mental disorder could result from clinician's differing interpretations of similar behavior depending on race. Pottick found that clinicians depended on contextual information in determining mental illness, where an overwhelming number judged mental disorder if the behavior appeared to be a result of internal dysfunction but not if it was a'resUlt of harsh environmental conditions. Thus,

he hypothesizes that clinicians' implicit biases'about Black individuals causes him to assess similar behavior differently, consequently judging White youths as having a mental disorder (and recommending treatment) but characterizing youth of color as delinquents (directing them to the juvenile justice system) (Pottick, 2007).

In the juvenile justice system, a significantly higher proportion for White youth were diagnosed with mental health disorder, while only a very small proportion of Black youth received referrals for mental health services (Janku & Yan, 2009). Instead, Black adolescents were overwhelmingly sent to the local correctional facility, while White adolescents who exhibited the same level of psychopathology and violent behavior were referred to the area's mental health hospital (Lewis, Shanok & Pincus, 1982; Lewis et al., 1980). Research shows that demographic variables, as opposed to psychological/psychosocial measures, were most predictive in determining whether youths would enter the juvenile justice or mental health system, with ethnicity being the most indicative factor (Westendorp et al., 1986).

"Diagnosis" Track & Rational Disproportionality

When youth of color are on the "diagnosis track," they nevertheless receive disparate diagnosis, treatment, and care outcomes. While scholars disagree on how specifically race influences mental health diagnoses and services, many agree that racial biases create racial disproportionality in the mental health service system.

Even after controlling for socio-demographic factors, race influences mental health diagnoses. Black and Latino children are more likely than White children to be diagnosed with disruptive behavioral disorders and conduct related problems (Nguyen et al., 2007; Cameron, 2002). However, the sensitivity and specificity of the conduct disorder diagnosis with respect to youths' externalizing behaviors was found to be "poor, close to random, or not uncommonly, negative" (Cameron, 2002, 91). In other words, the diagnosis had no rational relationship to the exhibited externalizing behaviors. Black children are also more likely to be diagnosed with schizophrenia or other psychotic disorders, despite exhibiting the same level of psychopathology and violent behavior. Whaley hypothesizes that psychotic disorder diagnoses are • predicated on the stereotype that Black individuals are violent and therefore require more severe diagnoses and restrictive interventions. Because clinicians make assessments based on their interpretation of the patient's behavior, their diagnoses could be a series of subjective reports undergirded by their own implicit prejudices against Blacks. Racial biases also influence clinicians' treatment recommendations. When psychiatrists were presented with identical patient data except for race, the Black patient was deemed less able to benefit from psychotherapy because he was "less articulate; competent,.introspect; self-critical, sophisticated about mental health centers, and psychologically minded" (Geller, 1988, 124).

Racial disparity in mental health diagnoses is especially troublesome because an individual's diagnosis affects treatment recommendations, access to therapy, and levels of care. Patients diagnosed with psychotic disorders (disproportionately Black) are more likely to be treated with medication rather than therapy and are less likely to receive outpatient treatment. Instead, these patients receive inpatient treatment and Black patients are underrepresented in private mental facilities and overrepresented in public mental health institutions. Racially informed diagnoses create a "revolving door" problem because Black patients are simultaneously turned away from the care they need and, when offered treatment, are only offered medication and institutionalization.

Socioeconomic Factors and Racial Bias

Some research indicates that socioeconomic status is a more accurate indicator of mental health treatment and care. One study used sources of funding for youth's mental health services—private insurance or state insurance—to conclude that the disparity in mental health outcomes of youth is due to socioeconomic factors. Researchers found that privately-insured youth who are hospitalized in private facilities are predominantly White. In constrast, publicly-insured youth are less frequently hospitalized in private facilities and general hospitals, but overrepresented in state or county facilities. Privately-insured youth also stay a significantly longer time in care (Mason & Gibbs, 1992). Surprisingly, while the primary diagnosis of the majority of both publicly- and privately-insured youths was affective disorder (mood disorder), publicly-insured youths were significantly more likely to be subsequently diagnosed as having a behavior disorder while privately-insured youth were more likely to be diagnosed and treated for substance abuse (Mason). Patients diagnosed with behavior disorders received shorter-term hospital stays.

Implicit racial bias may not be the sole cause of disparity between privately-insured and publicly-insured youth, but it may still be a significant factor insofar as race is predictive of sources of funding. Research showed that Black adolescent (50%) Black patients are significantly more likely to be publicly-insured than their White counterparts (22.4%) (Mason & Gibbs, 1992). The result is a "two-tier system" in which "uninsured low-income and minority adolescents with serious psychological or behavioral problems tend to be 'handled' by the juvenile justice system, while middle-class and White adolescents tend to be 'treated' in the mental health system" (Mason & Gibbs, 1992, 447).

Conclusion

The existing body of research shows that racial bias operates on two tracks in the mental health system. At the onset, many children of color are less likely to be diagnosed and treated for mental health disorders (Mason & Gibbs, 1992; Pottick et al., 2007). Even when presenting similar symptoms and receiving preliminary diagnoses, children of color are nevertheless subject to disparate treatment. Ethnicity has found to

be a significant predictor of behavioral disorder diagnoses, prescription treatment, decreased odds of receiving therapy, reduced length of stay in care, and outpatient care. It is also the only variable that predicted site placement, with Black youth more likely to be in a correctional placement and White youths in a psychiatric hospital (Cohen et al., 1990).

However, further research is necessary to determine what causes a two-track system in the first place. Specifically, researchers should aim to identify the presence of and the extent to which racial bias. plays at two key decision points:1) whether or not a child should receive mental health_treatment; 2) what kind of diagnosis and treatment should be prescribed:-Furthermore, future'research-should study the factors that influence differing diagnosis and treatment for patients of color who nevertheless face similar symptoms to White patients.

CHAPTER 4: De-biasing

Research shows that the racial disproportionality in public systems may be a byproduct of the lack of cultural understanding between key decision-makers and youth or families of color. Addressing this disproportionality requires increased cultural understanding and targeted, appropriate services for youth of color.

Most research prescribes data collection and analysis to better assess the needs of at-risk youth. For example, implementing a Mullticultural Assessment-Intervention Process model can be used at various points in the assessment-intervention process to emphasize the relevance of assessment instruments, increase the reliability and accuracy of clinical diagnoses, and foster the use of more credible and beneficial intervention services (Dana, 2002).

In schools, early intervention programs can ensure that students of color can receive appropriate educational services without special education placement. One study researched the efficacy of a two-pronged intervention program that teaches youth social-cognitive skills based on the principles of cognitive behavioral therapy (CBT) and provides intensive individualized academic remediation. Participation alone reduced course failures by approximately 66% in both math and non-math classes, increased preparedness for graduation by nearly one-half, and showed large gains in math test scores (Cook et al., 2014). Prevention and intervention programs can help by identifying at-risk children, addressing their academic and emotional needs, and eventually putting them back on the path to educational success (Skiba & Rausch, 2006). They can also minimize·the negative effects of edubators' biases by serving as an intermediary step between referral and removal (Proctor, Graves & Esch, 2012).

Most research suggests that bridging the cultural gap is the next crucial step to addressing the racial disproportionality in public systems. Patients exhibited a moderately strong preference for a therapist of one's own race/ethnicity. While the racial/ethnic matching of client and therapist was found to be more relevant to the cognitive heuristics of preferences for and perceptions of therapists than to average effectiveness of therapy (Cabral & SMith, 2011).'However, some do find that quality of care increases, where patients served by ethnically-matched therapists stay in outpatient treatment longer and use less day treatment service, a more intensive level of care (Jerrell, 1998). In the child welfare system, reflective decision-making' training (an implicit and institutional bias training intervention), coupled with the benchcard tool', was associated with less home removal and fewer non-relative foster care placements (Russell & Summers, 2013). The use of cultural competency staff training

[3] "A process to collect information relevant to a decision-making problem, to think deliberately and carefully about possible solutions, then to examine other alternative solutions, and finally to reflect upon both the process and the outcome in terms of what went right and what went wrong" (Paternoster & Pogarsky, 2009).

° "A practical tool to guide hearing practice; provide ready reference to relevant laws and accepted practices to ensure the judge is conducting a thorough hearing, providing effective due process, providing opportunities for engagement in the hearing, and issuing and enforcing appropriate and comprehensive court order" (Russell & Summers, 2013).

and cultural consultants can form closer ties with local communities and improve child welfare services for all children (Bowman et al., 2009).

In schools, culturally-responsive discipline policy that values, rather than attempts to reform, marginalized forms of behavior and appearance can avoid pushing away students and reproducing the very inequalities that educators aim to break (Morris, 2005). The most commonly identified factor that accounts for negative perception of students of color is teacher inexperience. Inexperienced teachers often misunderstand student behavior to be disruptive or disrespectful. By recognizing the cultural factors that affect student behavior, teachers can better understand the difference between when a student is acting out or acting outside the realm of the teacher's norm.

Schools can aid teachers in their quest in categorizing student behavior by questioning school policies related to behavioral expectations. For instance, when students sit improperly, teachers may perceive this as a sign disrespect or disengagement, despite the fact that the student in question might be intensely involved in the given academic task (Townsend, 2000). Teachers can adopt culturally-relevant classroom management and instruction techniques that create positive environments and promote physical movement (Lewis et al., 2010; Townsend, 2000). Teachers can also create deeper interpersonal relationship with students by becoming a "cultural" broker who teaches- language as a setting-specific skill and facilitates code switching and elevating their own expectations of their students' learning outcomes (Townsend, 2000). Providing professional development and creating a discipline team representative of the community can create responsive, cultural competence training that will help teachers better teach and understand their students (Fenning & Rose, 2007; Monroe, 2005). Combined, teachers and administrators can work together to break the systemic and sociocultural factors that perpetuate societal disproportionality for students of color.

CHAPTER 5: Conclusion .

The research shows that racialdisproportionality exists at almost every stage within the child welfare, education and mental health systems. In the child welfare system, cases involving children of color are more likely to be screened-in, investigated, substantiated, and recommended for out-of-home placement. In schools, students of color are more likely to be referred for disciplinary sanctions and receive harsher discipline sentences, even when exhibiting similar behavior as their White counterparts. They are also more likely to be placed in restrictive special education. Youth of color are less likely to be diagnosed with and treated for a mental health disorder. When diagnosed, their symptoms are more likely to be diagnosed as behavioral or psychiatric disorders, and consequently treated with prescription medication as opposed to therapy.

The research questions the objectivity of the criteria used for evaluation in these systems. In the child welfare system, caseworkers must rely on their judgments when assessing for "maltreatment." In school discipline policies, teachers can interpret externalizing behavior in a variety of ways, which for students of color typically involves greater office referrals and expulsion/suspension sentences. In the mental health system, even when practitioners are faced with similar symptoms, they nevertheless provide different diagnoses depending on the race/ethnicity of their patient. Practitioners and juvenile judges who believe that children of color and their families are less likely to use or benefit from therapy will prescribe different treatment recommendations for non-White patients.

Because these decision-making criteria are not as objective as they appear, caseworkers, teachers, and clinicians must necessarily rely on something other than those criteria when making an assessment Or·redommendation. However, more research must be done before researchers can directly cite racial bias, let alone implicit bias, as a causal factor of all racial disparities in these systems. Future research should focus on the role of implicit bias in these decision-making points. Specifically, research studies should assess whether or not decision-makers unconsciously rely on their preexisting assumptions about youth of color and their families in the evaluation process. In all three of these systems, special attention should be given to how key decision-makers assess youth behavior. While key decision-makers could explicitly hold negative stereotypes aboutyolitl'i"of coldr' and their families; the more likely case is that decision-makers will self-report high levels of egalitarian beliefs but still judge the behavior of youth of color to a different standard than that of White youth. Future research could help expose how preexisting assumptions about families of color accounts for differing recommendations for youth of color whose behavior is similar to White children. In turn, this might account for the overrepresentation and poor outcomes of children of color in all three systems and the resulting overrepresentation of youth of color in the juvenile justice system.

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My Grandmother's Hands: Racialized Trauma and the Pathway to Mending Our Hearts and Bodies

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Unarmed and Dismembered

Your Body and Blood

Our bodies have a form of knowledge that is different from our cognitive brains. This knowledge is typically experienced as a felt sense of constriction or expansion, pain or ease, energy or numbness. Often this knowledge is stored in our bodies as wordless stories about what is safe and what is dangerous. The body is where we fear, hope, and react; where we constrict and release; and where we reflexively fight, flee, or freeze. If we are to upend the status quo of white-body supremacy, we must begin with our bodies. New advances in psychobiology reveal that our deepest emotions—love, fear, anger, dread, grief, sorrow, disgust, and hope—involve the activation of our bodily structures. These structures—a complex system of nerves—connect the brainstem, pharynx, heart, lungs, stomach, gut, and spine. Neuroscientists call this system the wandering nerve or our vagus nerve; a more apt name might be our soul nerve.

The soul nerve is connected directly to a part of our brain that doesn't use cognition or reasoning as its primary tool for navigating the world. Our soul nerve also helps mediate between our bodies' activating energy and resting energy. This part of our brain is similar to the brains of lizards, birds, and lower mammals. Our lizard brain only understands survival and protection. At any given moment, it can issue one of a handful of survival commands: rest, fight, flee, or freeze. 3 These are the only commands it knows and the only choices it is able to make.

White-body supremacy is always functioning in our bodies. It operates in our thinking brains, in our assumptions, expectations, and mental shortcuts. It operates in our muscles and nervous systems, where it routinely creates constriction. But it operates most powerfully in our lizard brains. Our lizard brain cannot think. It is reflexively protective, and it is strong. It loves whatever it feels will keep us safe, and it fears and hates whatever it feels will do us

harm. All our sensory input has to pass through the reptilian part of our brain before it even reaches the cortex, where we think and reason. Our lizard brain scans all of this input and responds, in a fraction of a second, by either letting something enter into the cortex or rejecting it and inciting a fight, flee, or freeze response. This mechanism allows our lizard brain to override our thinking brain whenever it senses real or imagined danger. It blocks any information from reaching our thinking brain until after it has sent a message to fight, flee, or freeze.

The body is where we live. It's where we fear, hope, and react. It's where we constrict and relax. And what the body most cares about are safety and survival. When something happens to the body that is too much, too fast, or too soon, it overwhelms the body and can create trauma. Contrary to what many people believe, trauma is not primarily an emotional response. Trauma always happens in the body. It is a spontaneous protective mechanism used by the body to stop or thwart further (or future) potential damage. Trauma is not a flaw or a weakness. It is a highly effective tool of safety and survival.

Trauma is also not an event. Trauma is the body's protective response to an event—or a series of events—that it perceives as potentially dangerous. This perception may be accurate, inaccurate, or entirely imaginary. In the aftermath of highly stressful or traumatic situations, our soul nerve and lizard brain may embed a reflexive trauma response in our bodies. This happens at lightning speed. An embedded trauma response can manifest as fight, flee, or freeze—or as some combination of constriction, pain, fear, dread, anxiety, unpleasant (and/ or sometimes pleasant) thoughts, reactive behaviors, or other sensations and experiences. This trauma then gets stuck in the body—and stays stuck there until it is addressed. We can have a trauma response to anything we perceive as a threat, not only to our physical safety, but to what we do, say, think, care about, believe in, or yearn for. This is why people get murdered for disrespecting other folks' relatives or their favorite sports teams. It's also why people get murdered when other folks imagine a relative or favorite team was disrespected.

From the body's viewpoint, safety and danger are neither situational nor based on cognitive feelings. Rather, they are physical, visceral sensations. The body either has a sense of safety or it doesn't. If it doesn't, it will do almost anything to establish or recover that sense of safety. Trauma responses are unique to each person. Each such response is influenced by a person's particular physical, mental, emotional, and social makeup—and, of course, by the precipitating experiences themselves. However, trauma is

never a personal failing, and it is never something a person can choose. It is always something that happens to someone.

A traumatic response usually sets in quickly—too quickly to involve the rational brain. Indeed, a traumatic response temporarily overrides the rational brain. It's like when a computer senses a virus and responds by shutting down some or all of its functions. (This is also why, when mending trauma, we need to proceed slowly, so that we can uncover the body's functions without triggering yet another trauma response.) As mentioned earlier, trauma is also a wordless story our body tells itself about what is safe and what is a threat. Our rational brain can't stop it from occurring, and it can't talk our body out of it.

Trauma can cause us to react to present events in ways that seem wildly inappropriate, overly charged, or otherwise out of proportion. Whenever someone freaks out suddenly or reacts to a small problem as if it were a catastrophe, it's often a trauma response. Something in the here and now is rekindling old pain or discomfort, and the body tries to address it with the reflexive energy that's still stuck inside the nervous system. This is what leads to over-the-top reactions. Such overreactions are the body's attempt to complete a protective action that got thwarted or overridden during a traumatic situation. The body wanted to fight or flee, but wasn't able to do either, so it got stuck in freeze mode. In many cases, it then develops strategies around this "stuckness," including extreme reactions, compulsions, strange likes and dislikes, seemingly irrational fears, and unusual avoidance strategies. Over time, these can become embedded in the body as standard ways of surviving and protecting itself. When these strategies are repeated and passed on over generations, they can become the standard responses in families, communities, and cultures.

One common (and often overlooked) trauma response is what I called trauma ghosting. This is the body's recurrent or pervasive sense that danger is just around the corner, or something terrible is going to happen any moment. These responses tend to make little cognitive sense, and the person's own cognitive brain is often unaware of them. But for the body they make perfect sense: it is protecting itself from repeating the experience that caused or preceded the trauma.

In other cases, people do the exact opposite: they reenact (or precipitate) situations similar to the ones that caused their trauma. This may seem crazy or neurotic to the cognitive mind, but there is bodily wisdom behind it. By

recreating such a situation, the person also creates an opportunity to complete whatever action got thwarted or overridden. This might help the person mend the trauma, create more room for growth in his or her body, and settle his or her nervous system.

However, the attempt to reenact the event often simply repeats, re-inflicts, and deepens the trauma. When this happens repeatedly over time, the trauma response can look like part of the person's personality. As years and decades pass, reflexive traumatic responses can lose context. A person may forget that something happened to him or her—and then internalize the trauma responses. These responses are typically viewed by others, and often by the person, as a personality defect. When this same strategy gets internalized and passed down over generations within a particular group, it can start to look like culture. Therapists call this a traumatic retention.

White-body supremacy doesn't live just in our thinking brains. It lives and breathes in our bodies.

• As a result, we will never outgrow white-body supremacy just through discussion, training, or anything else that's mostly cognitive. Instead, we need to look to the body—and to the embodied experience of trauma.
• Our deepest emotions involve the activation of a single bodily structure: our soul nerve (or vagus nerve). This nerve is connected to our lizard brain, which is concerned solely with survival and protection. Our lizard brain only has four basic commands: rest, fight, flee, or freeze.
• In the aftermath of a highly stressful event, our lizard brain may embed a reflexive trauma response—a wordless story of danger—in our body. This trauma can cause us to react to present events in ways that seem out of proportion or wildly inappropriate to what's actually going on.
• Trauma is routinely passed on from person to person—and generation to generation—through genetics, culture, family structures, and the biochemistry of the egg, sperm, and womb. Trauma is literally in our blood.
• Most African Americans know trauma intimately. But different kinds of racialized trauma also live and breathe in the bodies of most white Americans, as well as most law enforcement professionals.
• All of us need to metabolize the trauma, work through it, and grow up out of it with our bodies, not just our thinking brains. Only in this way will we heal at last, both individually and collectively.
• Trauma is not destiny. It can be healed.
• Talk therapy can help with this process, but the body is the central focus for healing trauma.

• Trauma is all about speed and reflexivity. This is why people need to work through trauma slowly, over time, and why they need to understand their own bodies' processes of connecting and settling.
• Sometimes trauma is a collective experience, in which case the healing must be collective and communal as well.
Trauma can be the body's response to anything unfamiliar or anything it doesn't understand.
• Trauma responses are unpredictable. Two bodies may respond very differently to the same stressful or painful event.
• Healing involves discomfort, but so does refusing to heal. And, over time, refusing to heal is always more painful.
• There are two kinds of pain. Clean pain is pain that mends and can build your capacity for growth. It's the pain you feel when you know what to say or do; when you really, really don't want to say or do it; and when you do it anyway, responding from the best parts of yourself. Dirty pain is the pain of avoidance, blame, or denial—when you respond from your most wounded parts.

Trauma can spread from one body to another, like a contagious disease—through families and from generation to generation.

When someone with unhealed trauma chooses dirty pain over clean pain, he or she may try to push his or her trauma through another human being, by using violence, rage, coercion, betrayal, or emotional abuse. This only increases the dirty pain, while often creating trauma in the other person as well.
• When one settled body encounters another, there can be a deeper settling of both bodies. But when one unsettled body encounters another, the unsettledness tends to compound in both bodies. In families and large groups, this effect can multiply exponentially.
• Over months or years, unhealed trauma can become part of someone's personality. As it is passed on and compounded through other bodies, it often becomes the family norm. If it gets transmitted and compounded through multiple families and generations, it can turn into culture.
• Trauma can damage the genes in our cells. That damage can be passed on from parent to child, and from the child to his or her own child.
• One of the best things each of us can do for ourselves, and for our descendants, is metabolize our pain and heal our trauma. When we heal, we may spread our emotional health and healthy genes to later generations.

• Trauma and other adverse childhood events are associated with a wide range of illnesses, disabilities, social problems, and early death. All of these can also get passed down through the generations.
• Secondary trauma or vicarious trauma involves watching someone else be traumatized (and, sometimes, giving aid to them). An especially poisonous form of secondary trauma can occur when a person not only witnesses another person being harmed, but also inflicts that harm.
• Resilience is built into the cells of our bodies. Like trauma, resilience can ripple outward, changing the lives of people, families, neighborhoods, and communities in positive ways. Also like trauma, resilience can be passed down from generation to generation.
• The human brain always retains the capacity to learn, change, and grow. While trauma can inhibit or block this capacity, once the trauma has been addressed, growth and positive change become possible again.

White Cultural Impressions of the Black Body
Some of the most pervasive images, sensations, and impressions of the Black body include:

- The Black body is dangerous and threatening.
- The Black body is impervious to pain.
- The Black body is incredibly strong and resilient—almost invulnerable.
- The Black body is hypersexual.
- The Black body is dirty.
- The Black body is unattractive, especially in comparison with the white body.

Therefore, the Black body needs to be managed and controlled—by any means necessary. •

When these images, sensations, and impressions are embedded in a white body, that body feels unsafe and uncomfortable in the presence of a Black body, especially an unfamiliar one. As a result, when many white American bodies encounter Black bodies, the white bodies automatically constrict, and their lizard brains go on high alert.

When two or more unfamiliar bodies first encounter one another, each body goes on alert while its lizard brain discerns, ASAP, whether the other body is safe or dangerous. One shortcut the lizard brain uses to make this determination is by asking, How closely does this body match mine? The lizard brain then tells the body to either relax in recognition or constrict in self-protection. Both white and Black bodies often do this.

The Soul Nerve

As I briefly noted earlier, most human behavior involves a part of the body that many people don't know about—the soul nerve. The soul nerve is the unifying organ of the entire nervous system. Health and mental health professionals call it the vagus nerve or wandering nerve, but I call it the soul nerve—a much stickier and more descriptive term.

The soul nerve is not a nerve in the way we typically think of one. It is a highly complex and extraordinarily sensitive organ that communicates through vibes and sensations. This communication occurs not only between different parts of the body, but also from one person to another. Your soul nerve reaches into most of your body, including your throat, lungs, heart, stomach, liver, spleen, pancreas, kidney, and gut (both your large and small intestine). It is the largest organ in your body's autonomic nervous system, which regulates all of your body's basic functions. The largest part of your soul nerve goes through your gut, which has about 100 million neurons, more than your spinal cord. This is why we sense so many things in our belly—and why some biologists call the gut our "second brain." This second brain is where our body senses flow, coherence, and the rightness or wrongness of things.

One of the organs your soul nerve does not connect to, however, is your thinking brain. It connects directly to your brainstem—your lizard brain. We are only now beginning to understand how the soul nerve works. The organ itself was not identified until 1921, and much of what we know today was discovered only in the past two decades.

There are a great many things about it we still don't understand. We do know that the soul nerve is where we experience a felt sense of love, compassion, fear, grief, dread, sadness, loneliness, hope, empathy, anxiety, caring, disgust, despair, and many other things that make us human. When your body has an emotional response, such as when your stomach clenches, your voice catches, your pulse races, your shoulders tighten, your breathing quickens, your body braces for impact, or you have a sense that danger is lurking, that's your soul nerve at work. When you feel your heart opening or closing down; when you feel anxious in the pit of your stomach; when you sense that something wonderful or terrible is about to happen; when something feels right or wrong in your gut; when your heart sinks; when your spirit soars; or when your stomach turns in nausea—all of these involve your soul nerve. When your body feels relaxed, open, settled, and in sync with other bodies,

that’s your soul nerve functioning. When it feels energized, vibrant, and full of life, that’s also your soul nerve. When it feels tight, constricted, and self-protective, that’s your soul nerve, too. And whenever you have a fight, flee, or freeze response, that involves your soul nerve as well. In fact, one of the main purposes of your soul nerve is to receive fight, flee, or freeze messages from your lizard brain and spread them to the rest of your body. Another purpose is precisely the opposite: to receive and spread the message of it’s okay; you’re safe right now; you can relax.

Your soul nerve is vital to your health and well-being. It regulates your breathing, heart rate, and blood pressure. It helps prevent inflammation. And it can reduce pain, improve your mood, and help you manage fear. We also know that your soul nerve is intimately involved with how your body interacts with other bodies, and with how your body makes memories. Without your soul nerve, you literally would not be human. But your soul nerve, like your lizard brain, has zero capacity to think. Your soul nerve tells most of the muscles in your body when to constrict, when to release, when to move, and when to relax and settle. Much of this is outside of your deliberate, conscious control. However, as you will discover, with some attention and patience, you can learn to work with your soul nerve. With practice, you can begin to consciously and deliberately relax your muscles, settle your body, and soothe yourself during difficult or high-stress situations. This will help you avoid reflexively sliding into a fight, flee, or freeze response in situations where such a response is unnecessary.

The soul nerve is not just where we experience our emotions. It’s also where we feel a sense of belonging. This is why we can think of it as both a bodily organ and a communal one. More than almost anything else, each of us yearns to belong. Within each human body is this deep, raw, aching desire.

Here is what makes white-body supremacy so pervasive and so intractable: Beneath all the exclusion and constriction and trauma, white-body supremacy offers the white body a sense of belonging. It provides a false sense of brotherhood and sisterhood, of being a part of something intrinsically valuable. A variety of organizations, from the Ku Klux Klan to the NRA, have capitalized on this, offering quasi-community, a manufactured history, respected elders, cohesive symbolism, rules of admonishment, an internally coherent (though toxic) worldview, and so on. White-body supremacy partly soothes white bodies in this way. But white-body supremacy also reflexively triggers the historical trauma embedded in those bodies.

African American bodies also feel a sense of belonging, of course. Ours, however, has its roots in necessity and an actual shared history. American police have their own sense of belonging, too, sometimes called the Blue Brotherhood. But there are many other ways to belong, and many other people and groups we can belong to. We can belong as family, as friends, as intimate partners, as neighbors, as countrymen, and as fellow human beings. We will not end white-body supremacy—or any form of human evil—by trying to tear it to pieces. Instead, we can offer people better ways to belong, and better things to belong to. Instead of belonging to a race, we can belong to a culture. Each of us can also build our own capacity for genuine belonging.

The soul nerve is the unifying organ of your entire nervous system, reaching into your throat, lungs, heart, stomach, liver, spleen, pancreas, kidney, and gut.

- Your soul nerve is where you experience a felt sense of love, compassion, fear, grief, dread, sadness, loneliness, hope, empathy, anxiety, caring, disgust, despair, and many other things that make us human.
- One of the main purposes of your soul nerve is to receive fight, flee, or freeze messages from your lizard brain and spread them to the rest of your body.
- Another purpose is to receive and spread the opposite message of it's okay; you're safe right now; you can relax.
- Your soul nerve is intimately involved with how your body interacts with other bodies.
- Your soul nerve tells most of the muscles in your body when to constrict, when to release, when to move, and when to relax and settle.
- With some attention and patience, you can learn to work with your soul nerve—consciously and deliberately relaxing your muscles, settling your body, and soothing yourself during difficult or high-stress situations.
- Over time, with further practice, you can also learn to use your soul nerve to activate and mobilize your body on demand.
- Your soul nerve is also where you feel a sense of belonging. More than almost anything else, each of us yearns to belong.
- Beneath all the exclusion, constriction, and trauma, white-body supremacy offers the white body a sense of belonging, a false sense of brotherhood and sisterhood.
- We will not end white-body supremacy—or any form of human evil—by trying to tear it to pieces. Instead, we can offer people better ways to belong and better things to belong to. Each of us can also build our own capacity for genuine belonging.

TRAUMATIC STRESS
INSTITUTE

Overview of Services

The Traumatic Stress Institute (TSI) of Klingberg Family Centers is an internationally-recognized leader in the rapidly growing field of trauma-informed care (TIC). TSI envisions a world where organizations and service systems fully embrace and embed TIC so that all trauma survivors who enter their doors heal and thrive.

Whole-System Change Model Produces Measurable Outcomes

Through our Whole-System Change Model, TSI supports organizations that serve people with histories of trauma and other adverse childhood experiences (ACEs) to transform their organizational culture and services to TIC. Over 12-18 months, TSI works intensively with client organizations to deliver:

- Leadership consultation
- Foundational trauma training
- Train-the-Trainer to credential internal trainers
- Coaching for a TIC Task Force around implementation
- Program evaluation using an online dashboard tailored to the organization
- Ongoing professional enrichment via webinars and in-person training events

MISSION:
To foster the transformation of organizations and service systems to trauma-informed care through the delivery of whole-system consultation, professional training, coaching, and research.

TSI helps organizations develop a stable and well-trained workforce and increase clinical expertise. It has assisted organizations worldwide reduce restraints and seclusions, decrease staff turnover, sustain referrals within a competitive marketplace, and achieve lasting results with even the most difficult clients and families.

Evidence-Based Staff Trauma Training Models

The workforce development pillars of the Whole-System Change Model are: Risking Connection®, an industry-leading foundational trauma training model; Risking Connection for Foster Parents; and Restorative Approach®, a trauma-informed alternative to “point and level” systems for group care settings. TSI uses a Train-the-Trainer model of dissemination so that organizations can embed and sustain the training indefinitely in their system. Both Risking Connection® and the Restorative Approach® are listed on the California Evidence-Based Clearinghouse for Child Welfare (CEBC).

TIC Research

TSI staff are thought leaders in TIC research as well. With Tulane University, we created the Attitudes Related to Trauma Informed Care (ARTIC) Scale, one of the first psychometrically valid measures of TIC to exist in the field that is being used worldwide. Client organizations of TSI benefit from the use of this and other state-of-the-art measurement tools.

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TRAUMATIC STRESS INSTITUTE

WHAT IS TRAUMA-INFORMED CARE (TIC)?

A model for offering services that is responsive to the needs of people who have endured adverse childhood events (ACEs) and trauma. It maximizes healing and reduces the chance of re-traumatization.

WHY BECOME A TRAUMA-INFORMED ORGANIZATION?

Two-thirds of the general population has suffered ACEs such as abuse, witnessing violence, or living with an alcoholic parent. The percentage is higher for at-risk populations. TIC is best practice for organizations serving people with this history. TIC enhances client outcomes, reduces costly staff turnover, and elevates an organization's reputation in the eyes of funders.

HOW DO WE BECOME A TRAUMA-INFORMED ORGANIZATION?

Becoming a trauma-informed organization requires a system-wide change in culture. Time-limited trainings, training clinicians in an evidence-based practice, or restraint reduction will NOT, by themselves, make an organization trauma-informed. Becoming trauma-informed usually requires a multi-year initiative involving broad administrative buy-in, mandated staff training, policy changes, and persistent reinforcement by TIC champions in the organization.

HOW DOES THE TRAUMATIC STRESS INSTITUTE HELP CLIENTS BECOME TRAUMA-INFORMED ORGANIZATIONS?

WHOLE-SYSTEM CHANGE MODEL. TSI works for 12-18 months with organizations to transform their organizational culture and practices. It begins with leadership education and involves coaching throughout.

PROVEN, TESTED TRAUMA TRAINING MODELS. TSI is national provider of the *Risking Connection (RC)* Trauma Training Model and the *Restorative Approach (RA)*, a model for implementing TIC in congregate care settings. TSI helps you embed these models in your organization through a train-the-trainer dissemination model.

INFORMED BY EVIDENCE AND THEORY. TSI has been conducting empirical research on our model for implementing TIC for 10 years. RC and RA are listed on the California Evidence-Based Clearinghouse for Child Welfare.

SUSTAINABLE. TSI training and consultation is not "flavor of the month." Embedding trauma training, awareness, and practice enables organizations to sustain TIC and prevent backslide.

DATA AND OUTCOME-DRIVEN USING STATE-OF-THE-ART TOOLS. TSI is a leader in development of TIC measurement tools such as the ARTIC Scale. We move beyond vague TIC principles to tangible outcomes.

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TRAUMATIC STRESS INSTITUTE

Trauma-Informed Care (TIC)

Whole-System Change Model

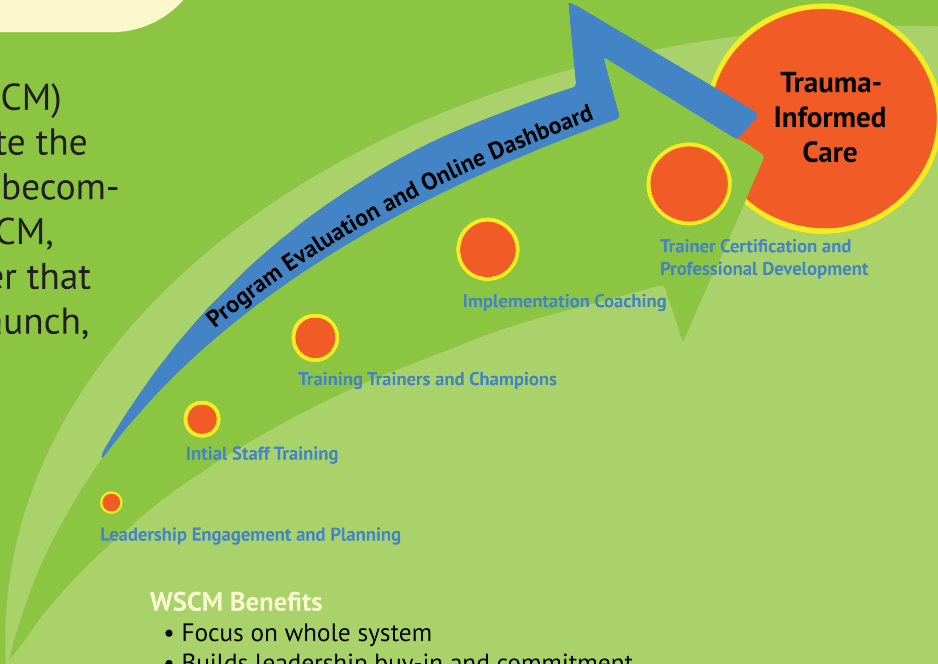
Transform your system, Transform your care

Request Your Free

- Consult call
- Guide for Evaluating TIC Training and Consulting Services
- And more

www.traumaticstressinstitute.org/whole-system-change-model

Our Whole-System Change Model (WSCM) supports organizations as they navigate the challenging and rewarding process of becoming trauma-informed. Through the WSCM, we serve as a steady, long-term partner that supports systems as they prepare to launch, implement, and sustain TIC culture and practices.



WSCM Features

- 12-18 Month Training and Coaching Process
- Leadership Engagement and Planning
- Risking Connection® (RC) Trauma Training
- Restorative Approach® (RA) Training
- Risking Connection® Foster Care Training
- RC, RA and Foster Care Training of Trainers and Champions
- Program Evaluation and Online Dashboard Results
- Trainer Certification and Ongoing Professional Development

WSCM Benefits

- Focus on whole system
- Builds leadership buy-in and commitment
- Uses a training of trainers model for sustainability
- Rooted in principles of implementation science
- Join a community of agencies committed to TIC culture change
- State-of-the-art program evaluation
- Data for stakeholders demonstrating TIC change

"Hillsides has been transitioning into a trauma-informed organization for several years and TSI's Whole- System Change Model was the magic solution. We needed to help our employees understand what TIC looks like when working with children, youth, and families. TSI mentored and trained us on the model and it was extremely helpful. It was a game changer for us and we are thankful."

– Stacey R. Roth, LCSW, Executive Vice President and Chief Operating Officer
Hillsides, Los Angeles, CA

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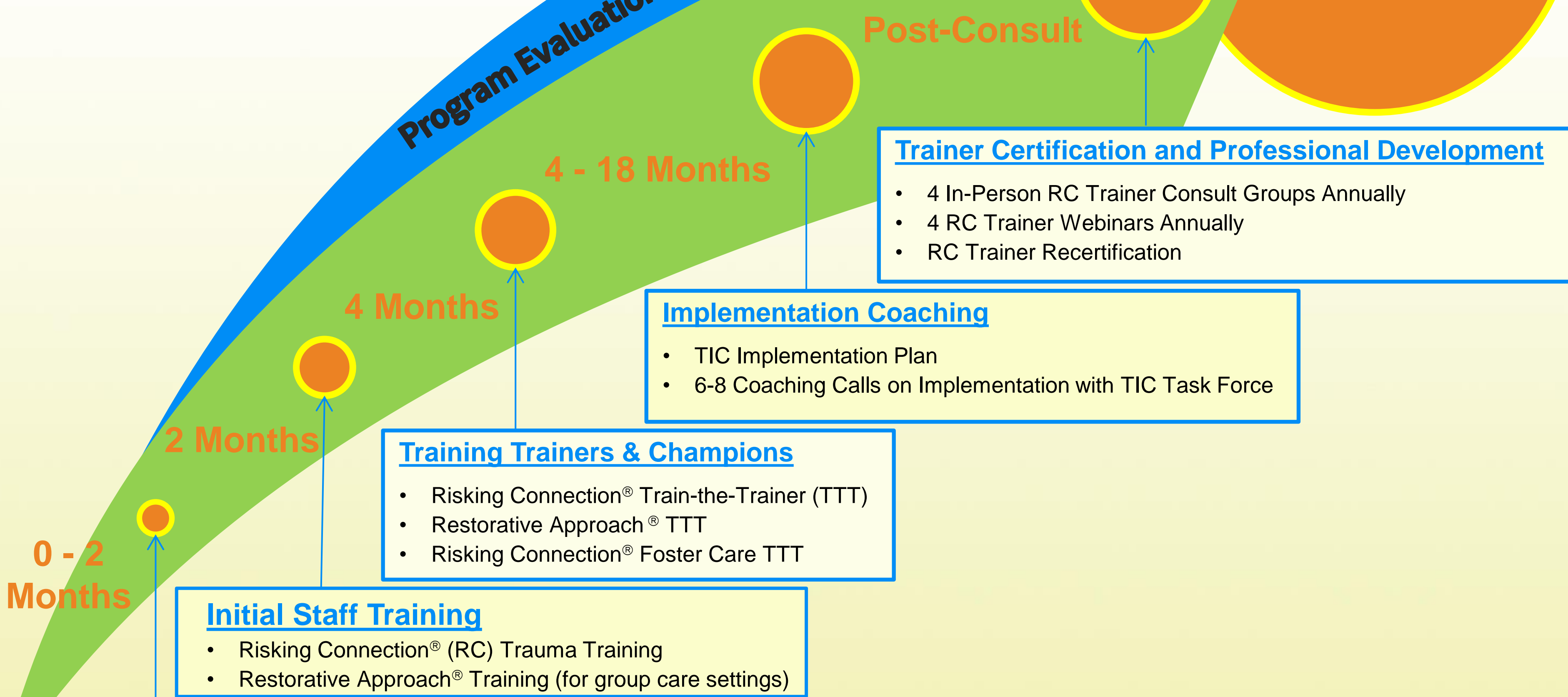
TRAUMATIC STRESS INSTITUTE

Whole-System Change Model to Trauma-Informed Care



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KLINGBERG FAMILY CENTERS

TRAUMATIC STRESS INSTITUTE

Risking Connection® Trauma Training Model

When a child depends on a caretaker for nurturance and love, they should not be taking a risk. If hurt and betrayed in those relationships, making future connections as a teenager or adult require risking disappointment at minimum, if not shame, loss, and further trauma. Many people in the human service system have been hurt and betrayed many times — by parents, by other caretakers, by the system itself.

To heal, a traumatized person must risk connecting with caring helpers who are different from those of their past. Yet, there are many reasons why people would not take that chance. Over time, however, through the experience of RICH® relationships — those that demonstrate Respect, Information, Connection, and Hope — people can learn to put their trust in helpers and move beyond the wounds of the past.

Risking Connection® (RC) is an evidence-informed foundational trauma training model rooted in relational and attachment theory. Listed in the California Clearinghouse of Evidence-Based Clearinghouse for Child Welfare (CEBC), it provides a framework for understanding and healing the wide array of symptoms and behaviors that land traumatized people in a wide range of human service settings.

MISSION:
To foster the transformation of organizations and service systems to trauma-informed care through the delivery of whole-system consultation, professional training, coaching, and research.

The Risking Connection Training Model is unique in that:

- It is a staff training model that organizations can adopt as a critical step toward TIC system change.
- It uses a Train-the-Trainer model so organizations can sustain RC staff training indefinitely by having internal RC Trainers and Champions.
- RC Trainers and Champions benefit from certification and professional enrichment through annual consult groups and webinars.
- Our clients join an international community of organizations using RC to implement TIC.

Risking Connection training is unique in that:

- It is a philosophy for providing services rather than a treatment technique.
- It is aimed at organizational staff from all disciplines, roles, and levels of training.
- It creates a common language among staff.
- It asserts that relationships are the primary agent of change.
- It stresses that treating traumatized people also poses risks to helpers – the risk of vicarious trauma. Therefore, respect for and care of *both* consumer and treater are viewed as vital.

KLINGBERG FAMILY CENTERS

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TRAUMATIC STRESS INSTITUTE

The Restorative Approach®

The Restorative Approach® (RA) is a trauma-informed alternative to traditional "point and level" systems for child congregate care settings. Based on the book *Trauma-Informed Care: The Restorative Approach* by Patricia Wilcox, it answers the question: "Now that I understand how trauma affects children, what should I actually do on Monday?"

RA, rooted in attachment theory and the principles of restorative justice, translates what we know about trauma, the brain, and how children heal into specific strategies that all treatment providers can use. When children display behaviors that hurt others and the community, rather than "doing time" or dropping levels, staff assign learning and restorative tasks to help children learn skills and make amends. Therefore, after children lose control, they learn that all is not lost; they can handle emotions differently and take effective action to mend relationships.

The RA Basic Training in a 6.5 hour training that organizations can adopt as a standard staff training via the RA Train-the-Trainer. An organization's Risking Connection Associate Trainers learn to teach the RA Basic Training so they can embed this training model in their organization in addition to Risking Connection.

MISSION:
To foster the transformation of organizations and service systems to trauma-informed care through the delivery of whole-system consultation, professional training, coaching, and research.

"The Restorative Approach® has given us a concrete method to respond to the behaviors of our girls. Staff now have the tools they need to provide trauma- informed care."
-Jean Alberghini
Director of Residential Services, Noank Group Homes and Support Services, Inc., Noank, CT

The Restorative Approach® Basic Training includes practical strategies for:

· Using state-of-the-art brain science to understand negative behavior.

· Responding to behaviors with concrete learning and restorative tasks.

· Designing unit structure and programming to promote healing relationships.

· Using a "working theory" about each client to guide daily life and respond to negative behavior.

· Teaching children that effective action is possible and that problems within relationships can be solved.

· Structuring and strengthening self-aware teams consisting of staff who care for themselves and each other.

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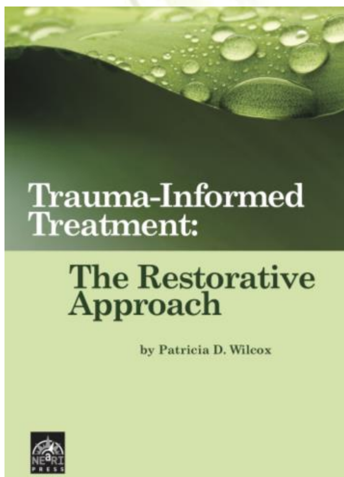
Trauma-Informed Treatment: The Restorative Approach

Patricia D. Wilcox, LCSW
NEARI Press 2011



Author Patricia Wilcox has written the essential guide to trauma-informed care with at-risk youth. Wilcox provides a foundational understanding of trauma's impact on the developing brain and then details its implications for treatment, the promotion of pro-social behaviors, and improving the culture among clients and staff. Incorporating the key concepts of compassionate understanding, validation, skill-teaching, and the primacy of trustworthy relationships for healing trauma and rebuilding connections in the child's brain, Wilcox tackles some of the most difficult challenges in treatment settings with practical approaches grounded in theory and research. This book is an invaluable resource for parents, social workers, childcare staff, therapists, agency administrators, and anyone who cares about how kids are treated when they need skillful, trauma-informed care.

A must-read for trainees and workers new to this field and a wonderful resource for administrators, families, policy makers, and staff at all levels of experience. Anyone who works with this population or who is treating or raising kids can benefit from reading this fine volume."

-Laurie Anne Pearlman, Ph.D. Co-author, Risking Connection: A Training Curriculum for Working with Survivors of Childhood Abuse

Pat Wilcox has written a book full of compassion and common sense. She integrates the restorative approach with a trauma-informed one, enriching both in the process. Her vast experience with children, youth, and their families is fully apparent here, as is her creative way of thinking about and working with them. Pat tells important stories about young people and their traumas, about their responses to being traumatized, and about how a particular kind of setting with a particular set of staff behaviors might be most helpful. Her bulleted lists of ideas are priceless and the volume's valuable appendices are an additional highlight. Pat's deep caring for children and youth, their families, and the staff who serve them is evident throughout this important, new work.

-Roger D. Fallot, Ph.D. Director of Research and Evaluation; Community Connections; Washington, DC

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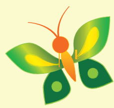

TRAUMATIC STRESS INSTITUTE

NEW
- Online and fully automated!
- Fast, easy and secure set-up, survey and results

ARTIC Scale

Attitudes Related to Trauma-Informed Care Scale

Measure what matters, measure trauma-informed care

Request your FREE sample at articscale.org

Is your organization or service system striving to become trauma-informed? Are you looking for a cost-effective, validated tool to measure and demonstrate progress toward trauma-informed care (TIC)? The ARTIC Scale is one of the first and most widely used tools available to measure TIC. It has been administered globally to more than 20,000 professionals by school systems, human service agencies, state agencies, and researchers.

With the new online ARTIC Scale, you can boost your TIC success with the click of a button

Administer ARTIC Scale to staff → Generate organizational and individual reports → Discuss report findings → Access resources → Take action

Online ARTIC Features
- Psychometrically valid, with overall and 7 subscale scores
- Administration at multiple time points
- Fully automated data collection, analysis and reporting
- Comprehensive dashboard reports for organizations
- Confidential dashboard reports for individual staff
- Implementation recommendations and resources

Online ARTIC Benefits
- Cost-effective
- TIC measurement made easy for data novices and experts alike
- Promotes data-driven decision-making across staff roles and sites
- Targets training and resources where most needed
- Accelerates and fine-tunes implementation

"ARTIC Scale is a user friendly, cost-effective tool that helped us track staff attitudes and culture change over time."

—Mashana Smith, Ph.D., Chicago Public Schools

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