

# Welcome!

Resilient Beginnings Network (RBN)

Virtual Learning Session #2

March 4, 2021

RESILIENT  
BEGINNINGS  
NETWORK

MADE POSSIBLE BY

Genentech  
A Member of the Roche Group

While we're waiting, find your team name and add the number to the front of your name (i.e. 10. Jessica Moore, PHC)

1 Alameda Health System

2 Alliance Medical Center

3 Bay Area Community Health

4 Children's Health Center  
Zuckerberg San Francisco  
General Hospital

5 Community Medical Centers

6 LifeLong Medical Care

7 Marin City Health &  
Wellness Center

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12 San Mateo County Health  
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Health

14 School Health Clinics of  
Santa Clara County

15 UCSF Benioff Children's  
Hospital Oakland

n/a If you're a guest, no need to  
rename yourself.

*If you called in, please be sure to link your video with your phone.*

# Housekeeping Reminders



## Audio

Link your audio to video if you called in via phone



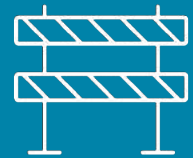
## Chat Box

Please chat in your questions



## Name

Add your team number in front of your name



## Tech Issue

Private chat Nikki Navarrete for assistance



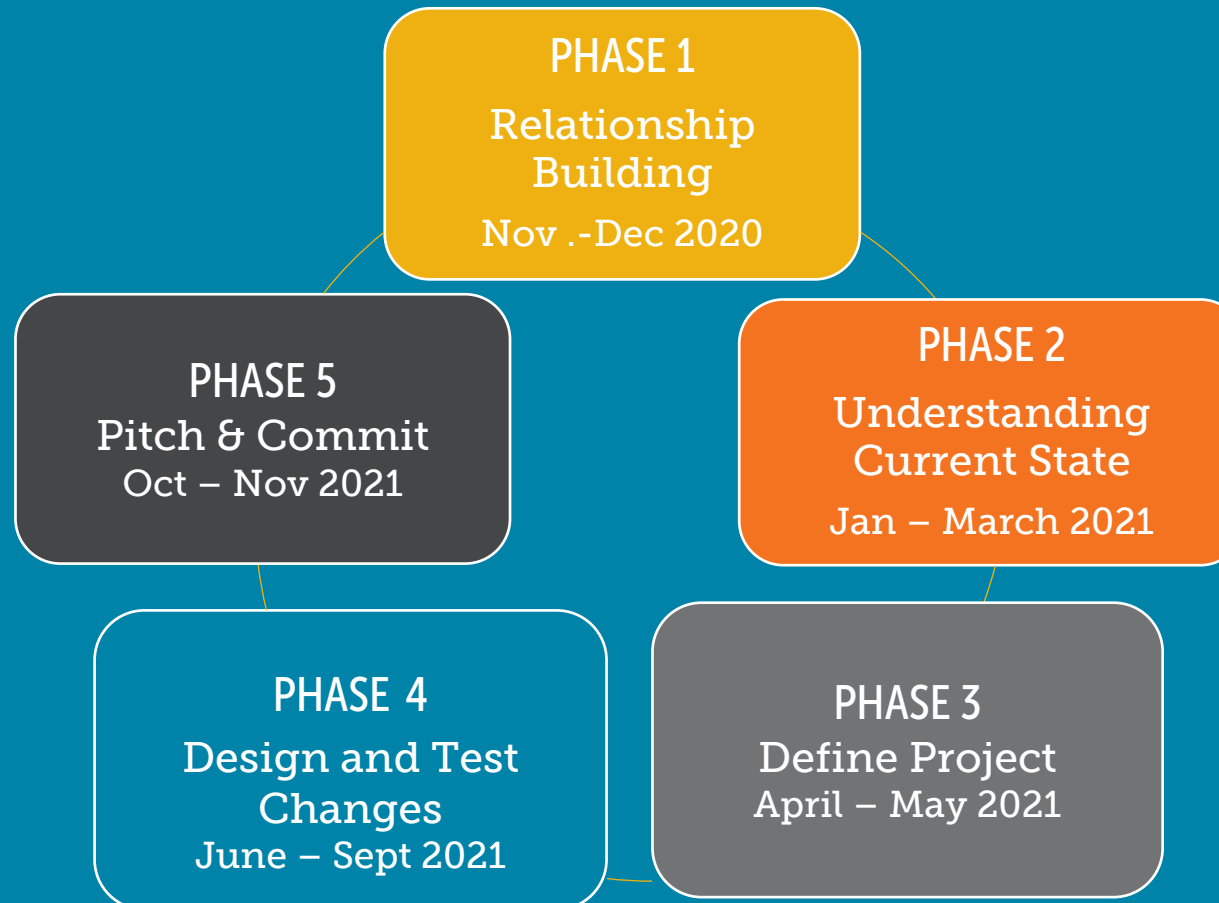
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# RBN Program Reminders & Announcements



# RBN Year 1

Understand the current state, strengthen capacity, and engage with stakeholders to determine focus



← **We are here**

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BEGINNINGS  
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## Understanding the Current State Assignments



**Complete the RBN Capacity Assessment**



**Uncover insights and understand experiences**



**Current State Storyboard**



# New Opportunity!



**2021 VIRTUAL NATIONAL FORUM**  
WORKING TOGETHER TOWARDS RACIAL EQUITY  
FOR CHILDREN, FAMILIES, AND COMMUNITIES

**APRIL 6-8, 2021**



<https://www.brazeltontouchpoints.org/2021-national-forum/>

CCI will fund up to 2 people from each RBN team to attend all or part of the forum.

Questions? Contact [nikki@careinnovations.org](mailto:nikki@careinnovations.org)

# Important Dates & Timelines

**Brazelton  
Forum Form  
due**

**March 26**

**Current State  
Storyboard  
Due**

**March 31**

**Share &  
Learn  
Webinar**

**April 8**

**Progress  
Report #1**

**April 15**

# The RBN Club

*Log in (or create an account) to the CCI Academy and Join the RBN Club*

We want your feedback!

[Academy Dashboard](#)[Courses](#)[Forums](#)[Program Clubs](#)

[Home](#) > [Clubs](#) > [Resilient Beginnings Network \(RBN\)](#)

[📖 Unread Content](#)[✔ Mark site read](#)

## Resilient Beginnings Network (RBN)

Open Club · 70 members

[Announcements](#)[Calendar](#)[Resource Library](#)[Assignments](#)[Network Collaboration](#)[Community](#)[Members](#)[Overview](#)[Leave Club](#)



# Virtual Learning Sessions Roadmap

*\*RBN Cross Cutting Themes Focus*

Year 1 - 2021

Date	Topic
January 14	Where are we now with trauma- and resilience-informed care?
March 4	Centering Dignity in Trauma and Resilience Informed Pediatric Care
May 13	Science of Resilience and Strengths-Based Approaches
July 15	Power and Patient and Family Engagement
September 9	Putting it all together
November 4	RBN Year 1 Showcase <i>*Team Leadership Sponsor Invited</i>

← We are here

**Find your team name and add the number to the front of your name (i.e. 10. Jessica Moore, PHC) for the 2<sup>nd</sup> break out room.**

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# Centering Dignity in Trauma and Resilience Informed Pediatric Care

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# VitalVillage

**BELONG • LEARN • ENGAGE • TRANSFORM**

**at BOSTON MEDICAL CENTER**

Renee Boynton-Jarrett, MD, ScD  
Founding Director, Vital Village Networks

Ronda Alexander, MA  
Director of Operations, NOW



# Agenda

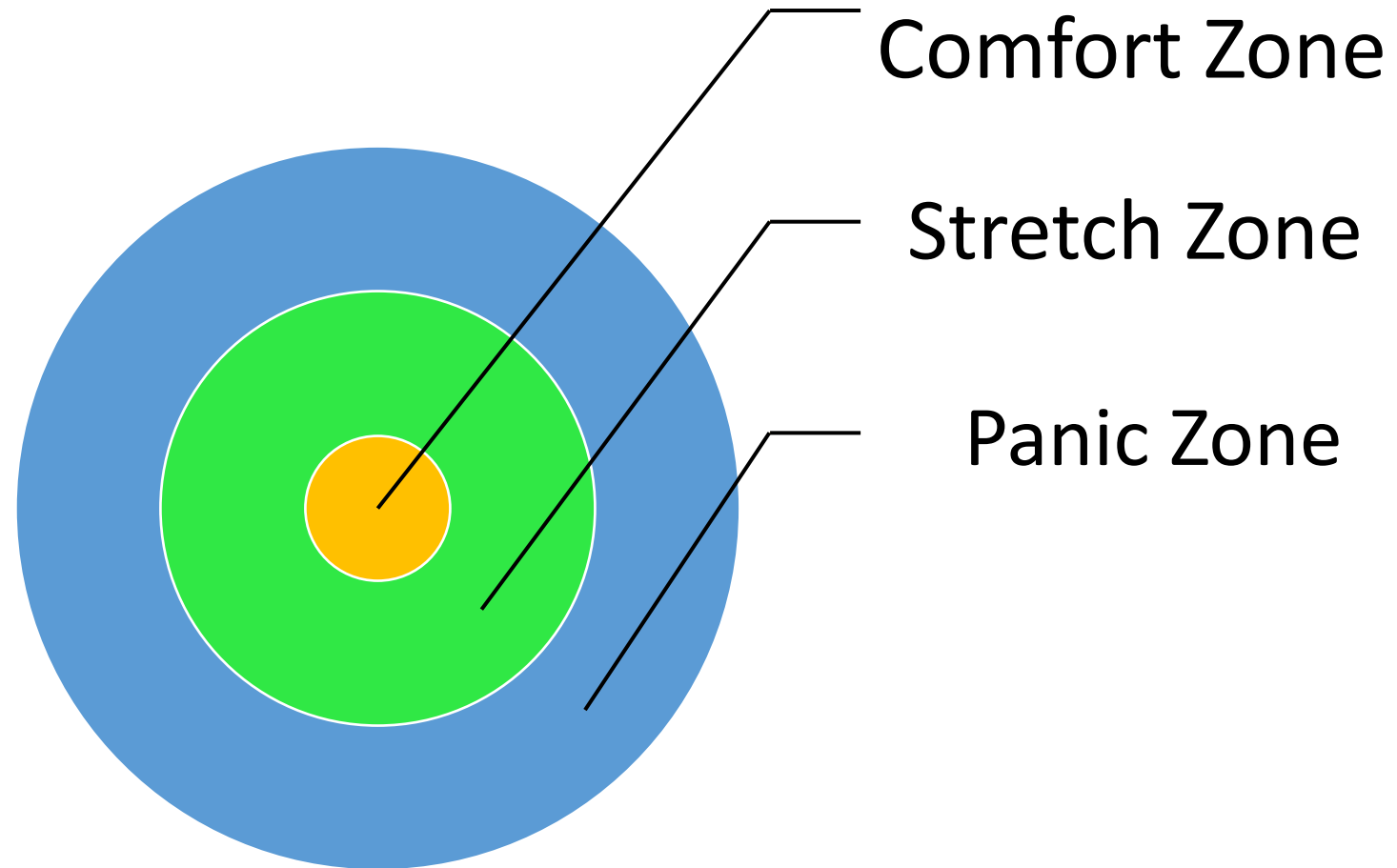
- Reframing Dignity
- Connection between Dignity and Equity
- Root Causes: Childhood Adversity and Structural Racism
- Break
- Identifying Structural Racism in Practice
- Fishbowl: Finding Solutions Together
- Closing Conversations



“Caste is insidious and therefore powerful because it is not hatred, it is not necessarily personal. It is the worn grooves of comforting routines and unthinking expectations, patterns of a social order that have been in place for so long that it looks like the natural order of things.”

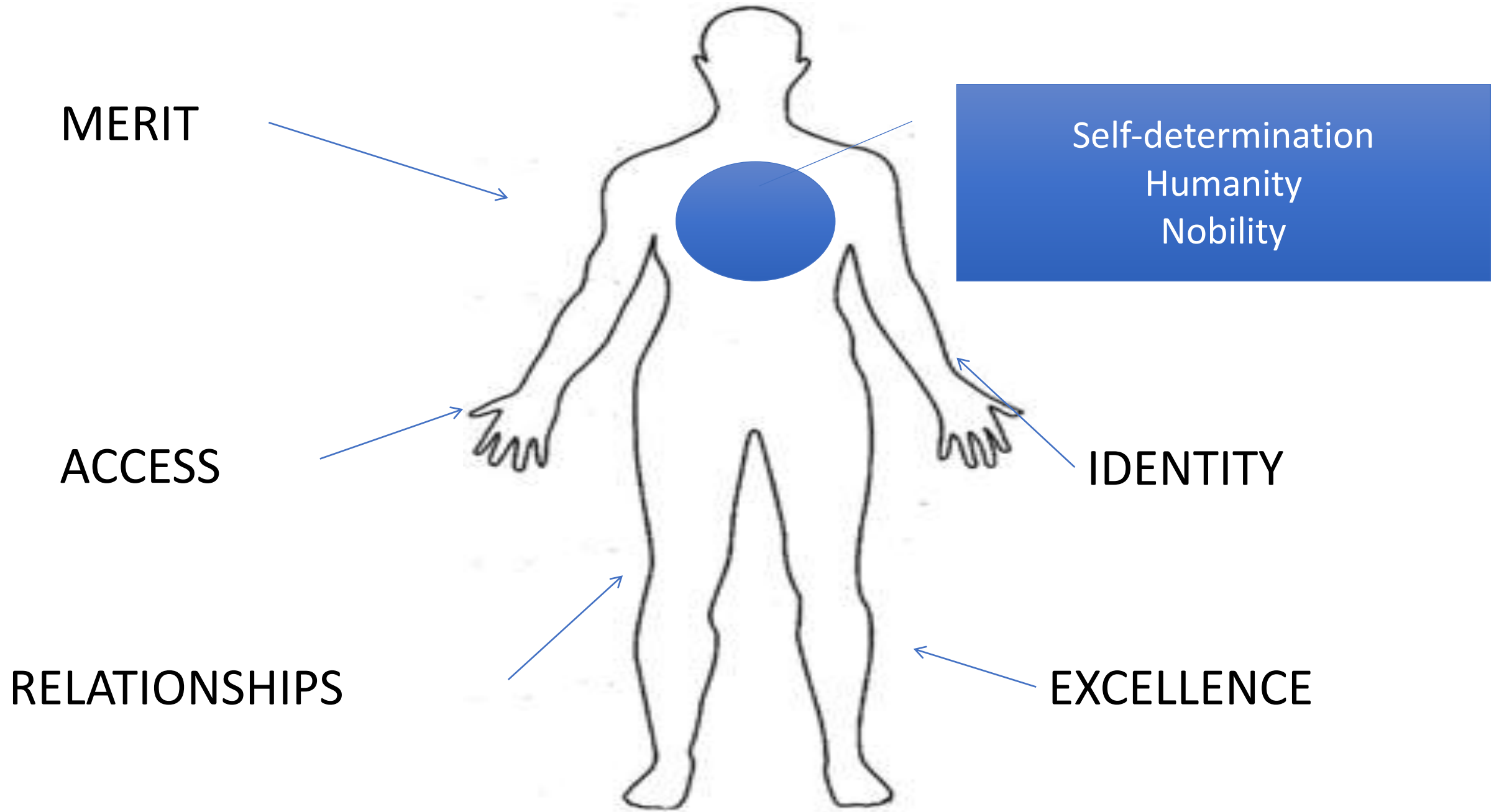
—*Isabel Wilkerson, Caste*

# In the Zone



# Dignity

*The state or quality of being worthy of honor*



# Dignity

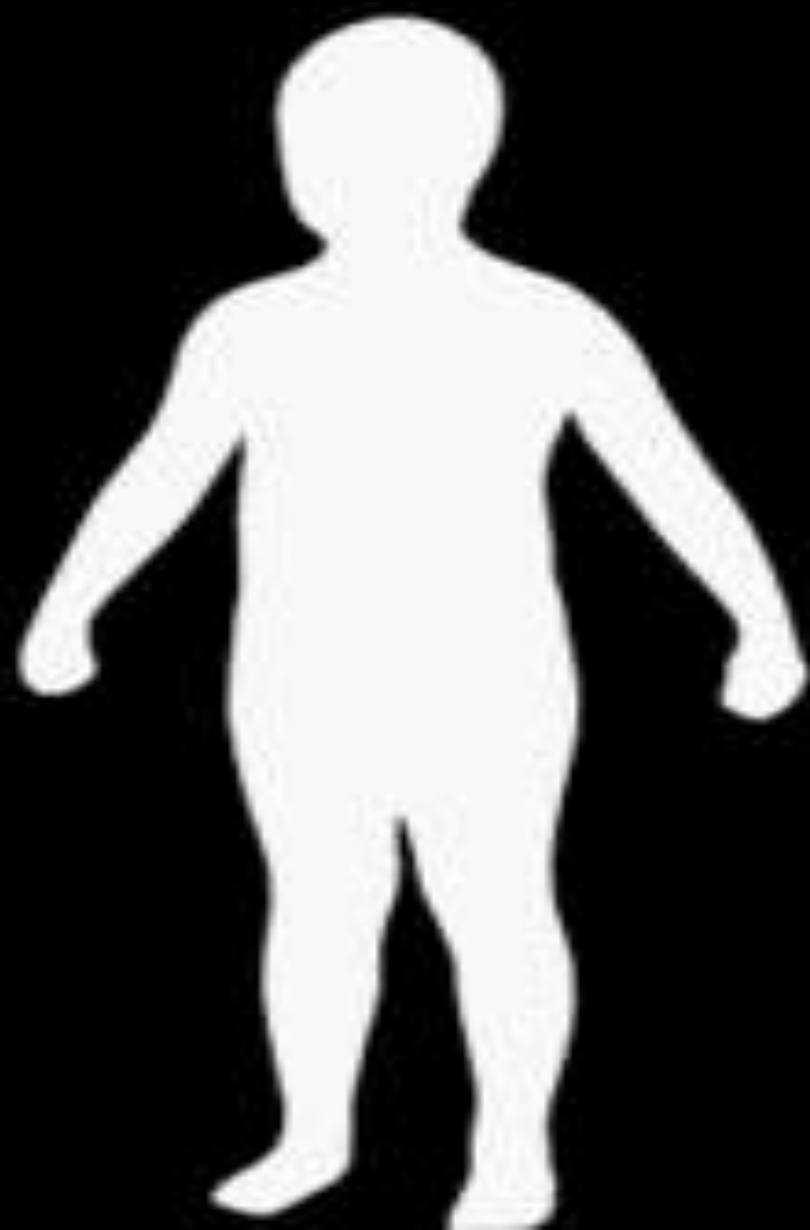
HOW DO YOU VALUE YOURSELF?  
HOW DOES COMMUNITY VALUE YOU?

A sense of dignity is understood through a network of individual, interpersonal, institutional, organizational, and societal experiences.



# Dignity and Respect are Different





“A person is a person through other persons.”

Desmond Tutu, *No Future Without Forgiveness* (2002)

# Elements of Dignity

Acceptance of  
Identity

Inclusion

Safety

Acknowledgement

Recognition

Fairness

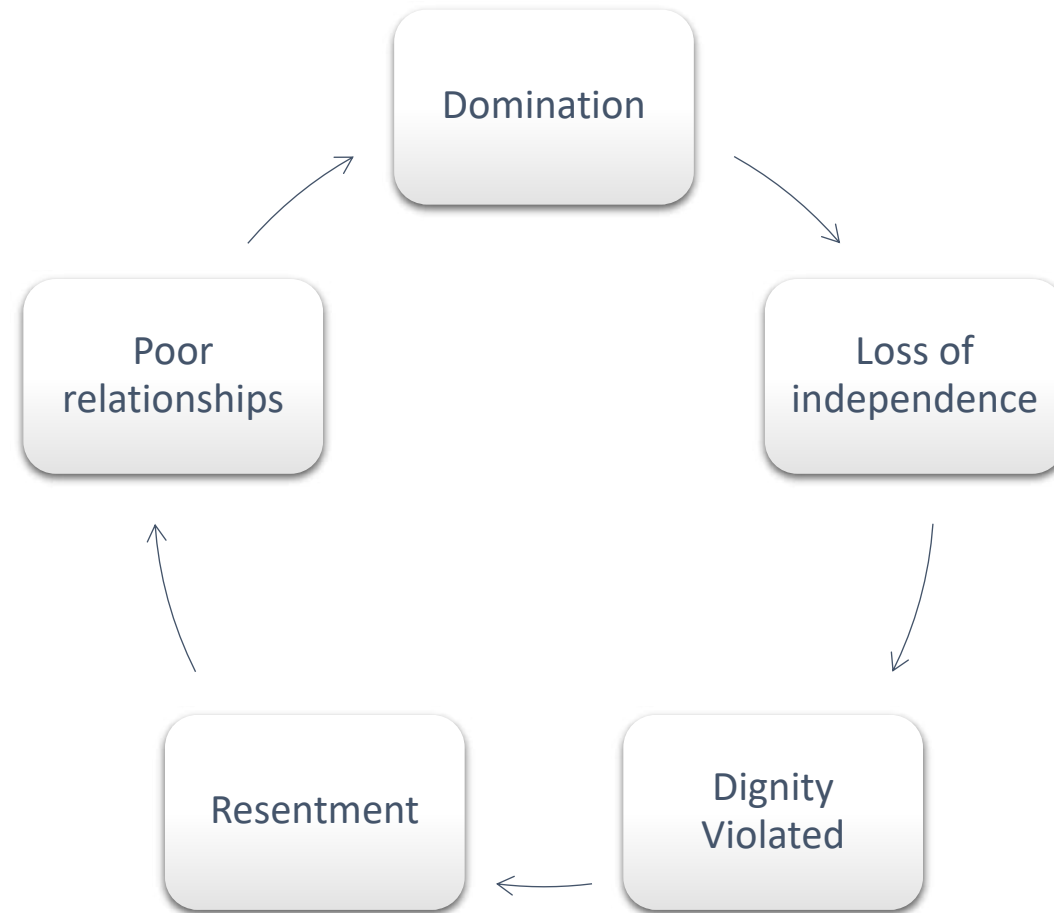
Benefit of the  
Doubt

Understanding

Independence

Accountability

# Cycle of Indignity



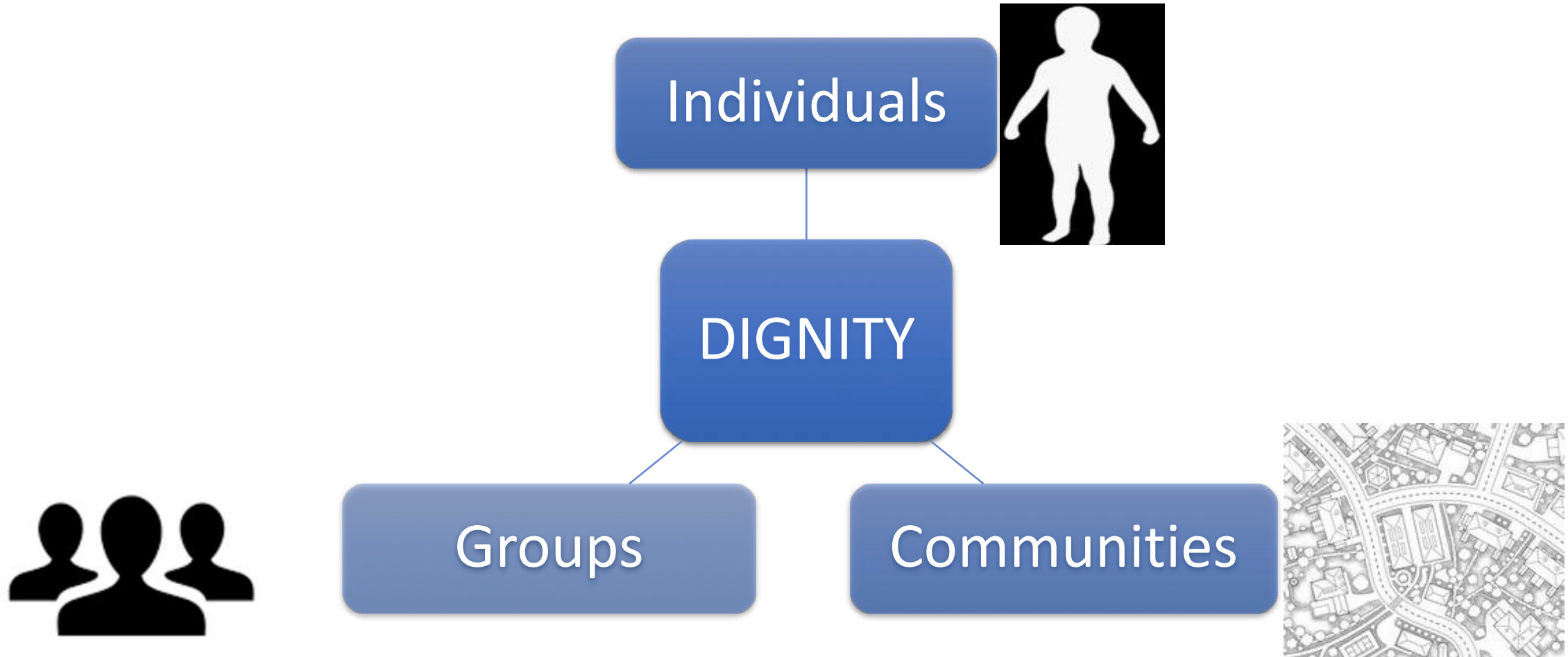


# Equity Approach

- Respect
- Protect
- Fulfill

A sense of dignity for individuals and families

# Centering dignity to achieve equity



“Relationships matter: the currency for systemic change was trust, and trust comes through forming healthy working relationships. People, not programs, change people.”

Bruce Perry, The Boy Who Was Raised As a Dog

# Small Group Instructions

- Reflect on a personal indignity (2 minutes individually)
- Each partner will have up to 5 minutes, uninterrupted
  - Listener - just listen, no response
  - Reminder - confidentiality
- Describe the problem using a dignity framework
  - What is the indignity on a personal, interpersonal, organizational, and structural level?
  - What are the root causes?

# Invitation to Share

Share a connection or feeling  
you experienced

## Process Reflections

- How did it feel to listen?
- How did it feel to be heard?



Part II.

Root Causes:

Childhood Adversity and Structural Racism



# Friday, January 29, 2021

## 911 Call

9 year old child  
with mental  
health crisis

01

02

## Police

Arrive at the home,  
child flees, caregiver  
requests mental  
health support

## Intervention

Handcuffed, and  
pepper sprayed

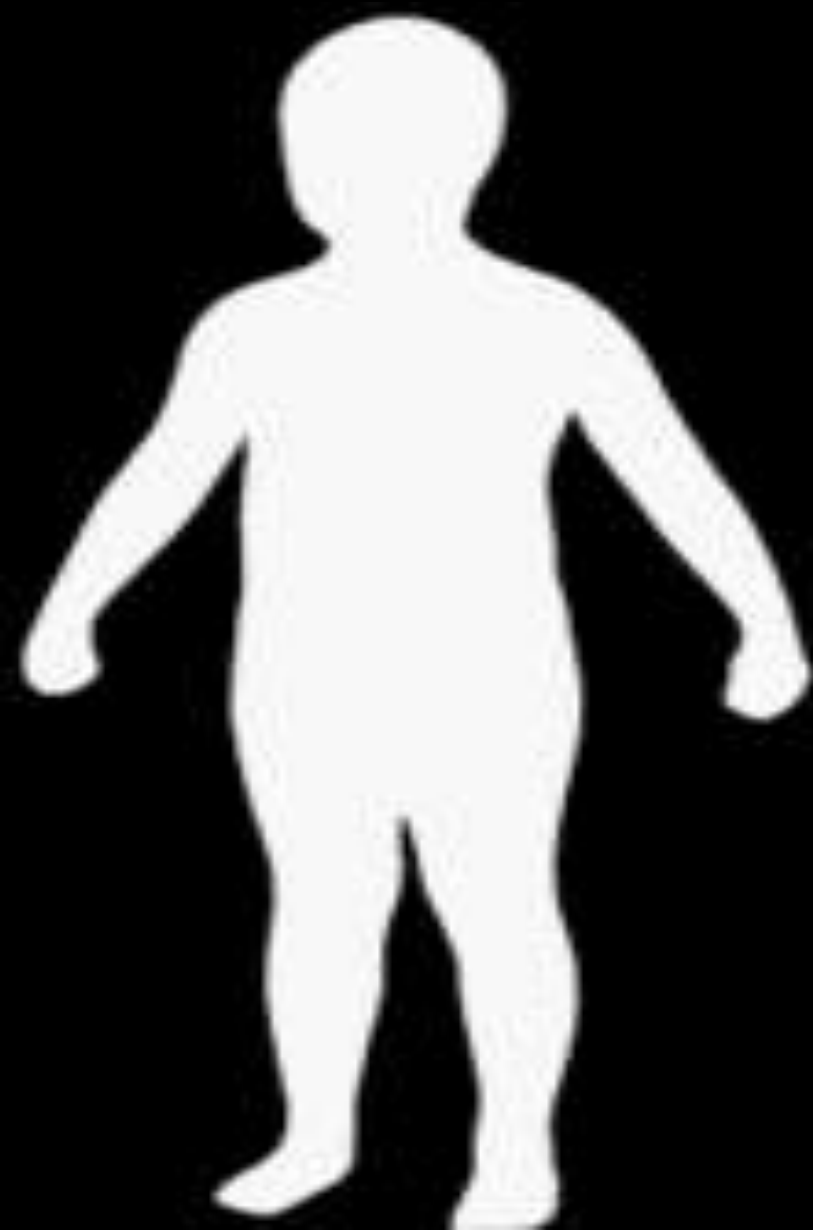
03

04

## Impact

Child  
Family  
Community





# IMPACT

## Adultification

Criminalization  
Loss of legal  
protections

## Indirect & Direct Contact

Long-term Mental  
health and physical  
health

## Race-Related Events Online

Depression, PTSD

## Racist Policies

Training, data  
collection and  
reporting, judicial  
system

## Parent-Child Relationship

Distrust for law  
enforcement

## Academic

Decline in GPA. Lapse  
in attendance

Cause of death	Mortality rate
Assault	94.2
Accidents	52.1
Suicide	17.5
Heart disease	14
HIV	6.8
Cancer	6.2
Police use of force*	3.4
Diabetes	2.8
Influenza and pneumonia	2
Chronic lower respiratory disease	2
Cerebrovascular diseases	1.9

**Fig. 1.** Lifetime risk levels. Dashes indicate

Annual mortality rates are reported as deaths per 100,000 black men ages 25 to 29.

Source: Centers for Disease Control and Prevention, 2015. \*Figure is the median of 2013-2018 mortality rate calculated in PNAS study led by Frank Edwards.

at 2013 to 2018 risk  
n 2013 to 2018 Fatal

# Racialized Trauma

## Do the Numbers Speak for Themselves?

### Informed of racial disparities in executions

**52%** strongly favored the death penalty compared with **36%** in the baseline

### Black prison population of 45% vs. 25%

**27%** signed the petition to lessen the severity of CA's 3 strike law compared to **52%**

### Black prison population 60% vs. 40%

**12%** signed a petition to end NY's stop-and-frisk policy compared to **33%**

**“Sometimes people hold a core belief that is very strong. When they are presented with evidence that works against that belief, the new evidence cannot be accepted. It would create a feeling that is extremely uncomfortable, called cognitive dissonance. And because it is so important to protect the core belief, they will rationalize, ignore and even deny anything that doesn’t fit in.”**

—Dr. Frantz Fanon, *Black Skin, White Masks*

## What happens when inequities are presented without context?

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### NATURALIZE

Assume these differences cannot be changed. Identifying racial/ethnic disparities may reinforce the status quo

### INTRACTABLE

Acknowledge differences and assume they are durable and do not devote attention to understanding why


### NOT OF INTEREST

Lack of personal stake in racial disparities.

### ENDEMIC

Ubiquitous disparities do not elicit concern or response even when alarmingly high



A photograph of an airport terminal interior, featuring a long moving walkway. A person is walking away from the camera on the right side of the walkway, pulling a suitcase. The ceiling is high with several directional signs. The left side of the walkway has a glass railing, and the right side has a wall with posters. The overall lighting is bright and modern.

“In a racist society, it’s not enough to be non-racist, we must be anti-racist.”

—Angela Davis

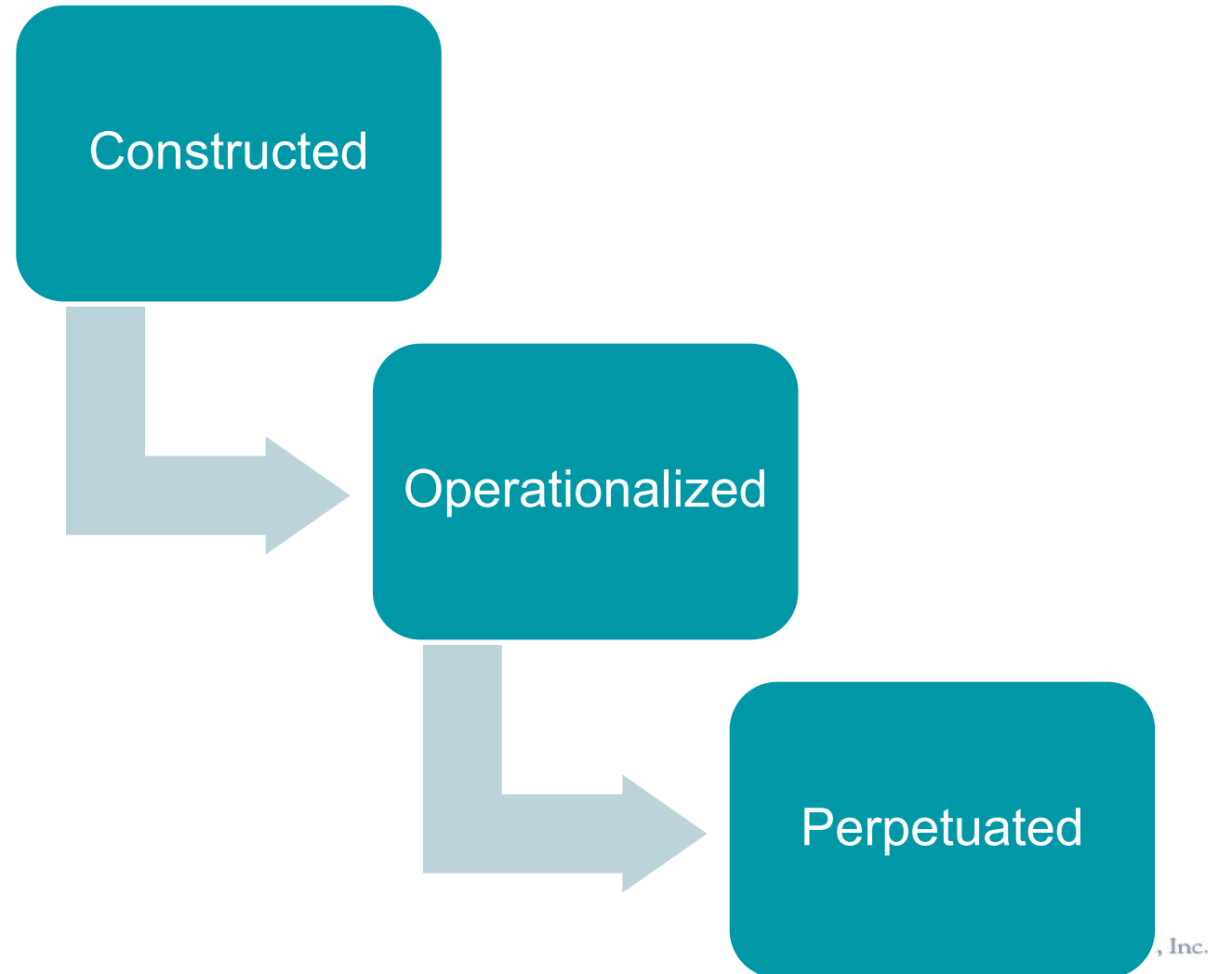


# Strategies: Structural Integrity



# Structural Integrity for Anti-racist Practices

**How is inequity:**



## Strategies



### Naturalize vs. Contextualize

In the absence of framing of inequities with regard to their root causes disparities may be naturalized.

What if we are more progressive about providing context?



### Individuals vs. Structures & Institutions

Race is measured at the individual level.

Can we draw attention to structures, institutions, systems that may be unmeasured?

# Psychosocial Stress in Early Childhood

**Abuse and  
Neglect**

**Household  
Dysfunction**

**Material  
Hardships**

**Racism/  
Discrimination**

**Community  
Violence**

**Bullying**

## Impact Child Health and Development

**Neuroendocrine Effects**

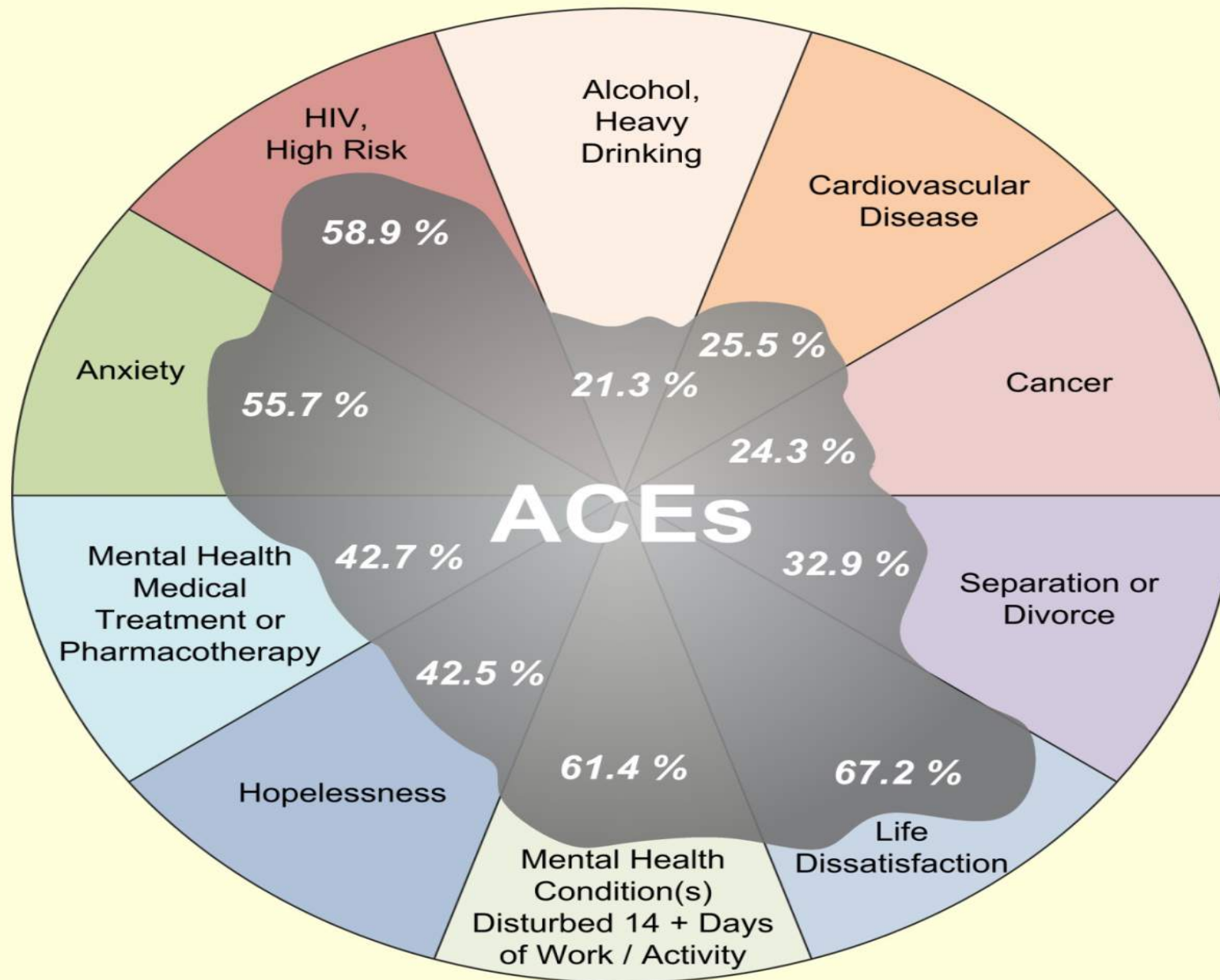
**Socio-Emotional Development**

**Health Risk Behaviors**

## Social Determinant of Health over the Life Course

**Disease and Disability**

**Psychosocial Outcomes**

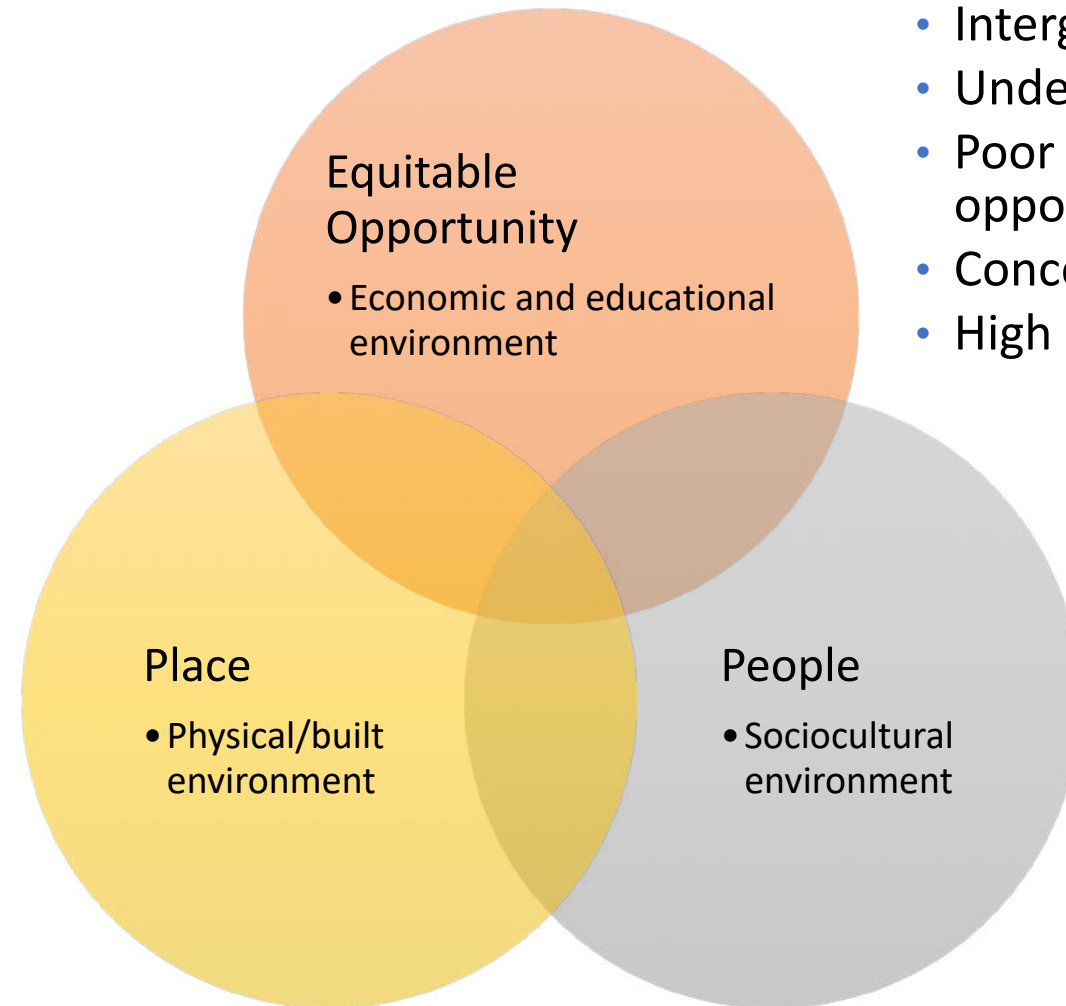


Source: Family Policy Council, 2012





# Community Environment



- Deteriorated, unsafe public spaces

- Intergenerational poverty
- Underemployment/unemployment
- Poor educational and enrichment opportunities
- Concentrated disadvantage
- High mobility

- poor social cohesion, low civic engagement, low collective efficacy and social capital



## Historical Trauma

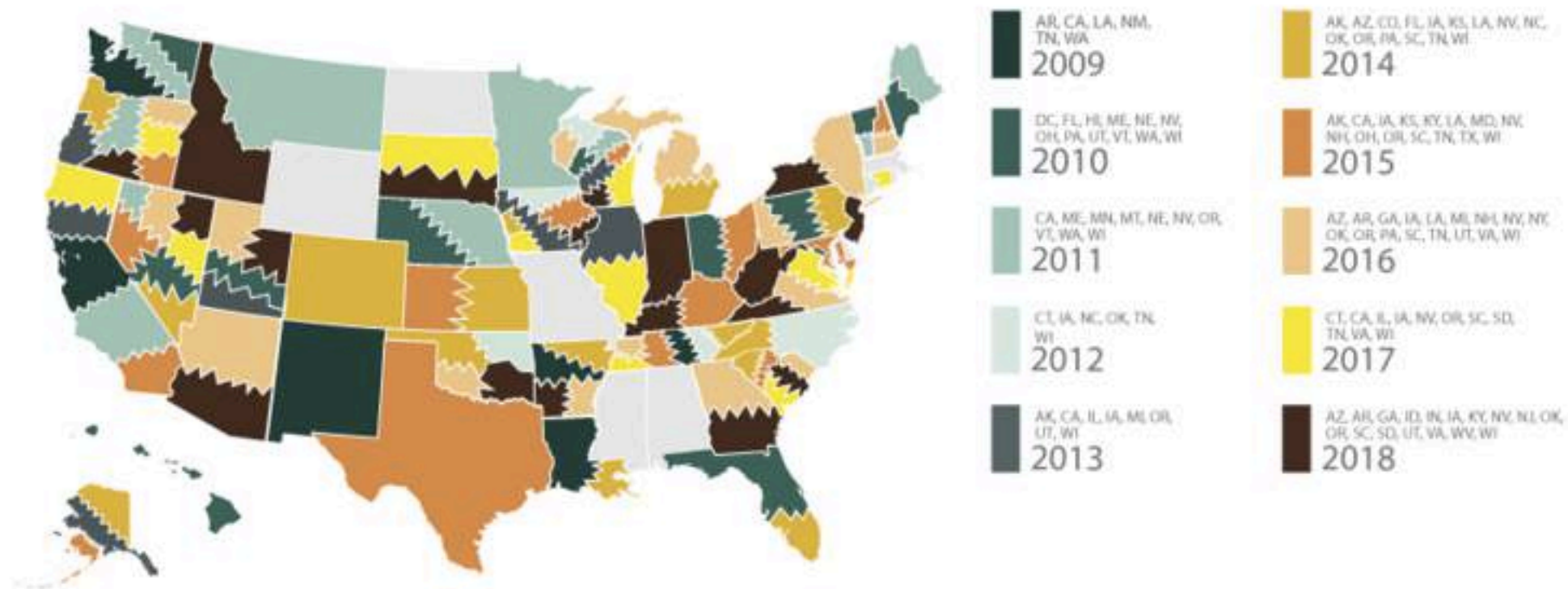
- Multigenerational
- Loss of people, culture, land
- Oppression, domination, dislocation
- Durable impact
- Both collective and accumulative





## States Collecting BRFSS ACE Data by Year, 2009-2018.

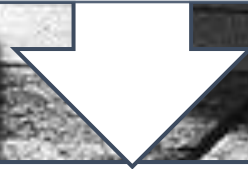
Collecting BRFSS ACE Data by Year, 2009-2018



Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System Survey ACE Data, 2009-2018.  
Atlanta, Georgia: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention; 2019.

# ACES are prevalent

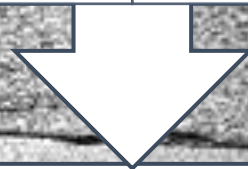
Across all socio-demographic groups



## Differential Risk

Social Conditions

Structural Conditions



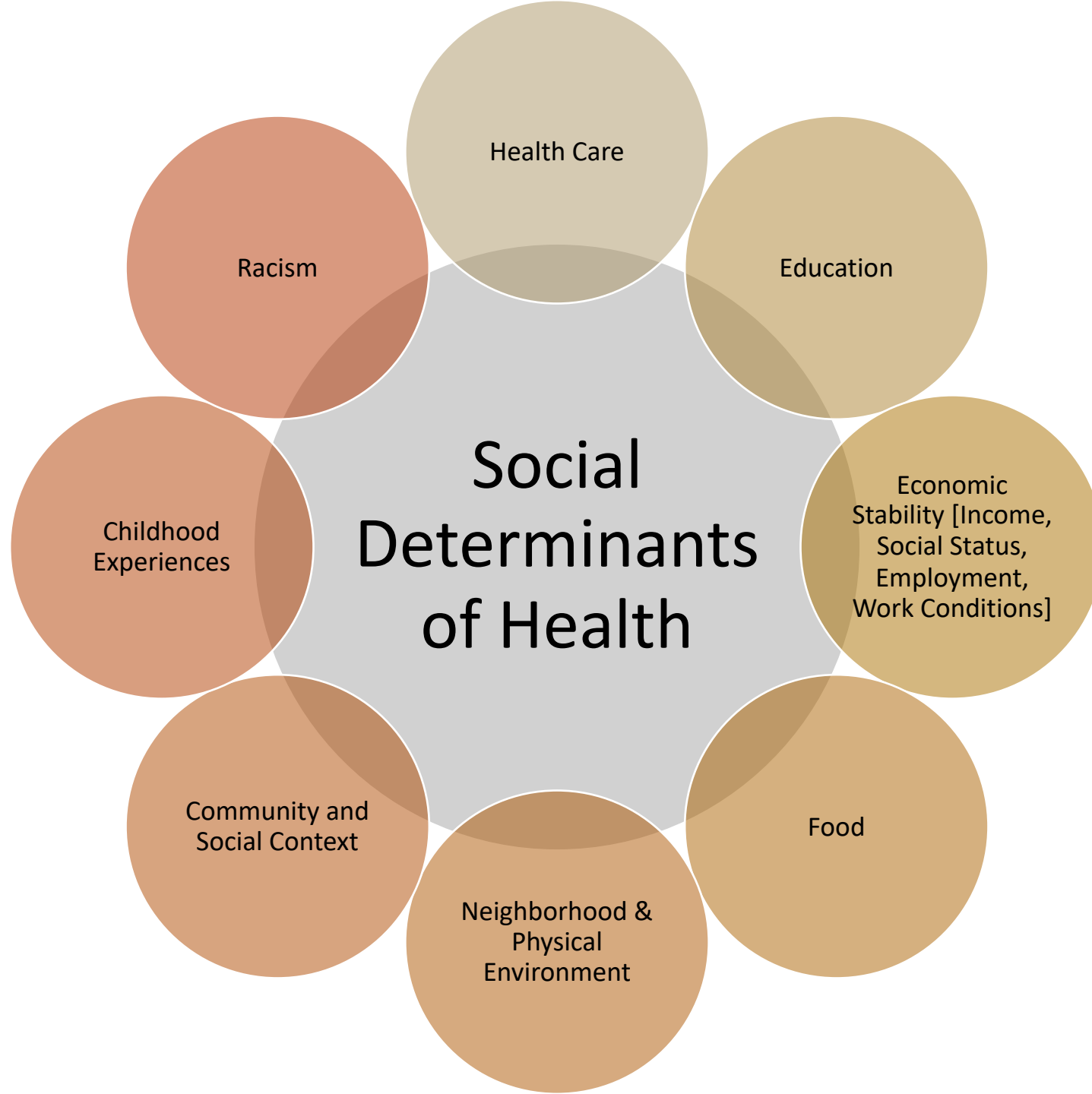
## Inequities

Health

Education

Economic

Social



# Social Connectivity

**Social and Emotional Wellbeing**  
**Social and Economic Mobility**  
**Developmental Health**

Thriving Families  
Shared resources  
Timely Social support  
Shared resources/knowledge

Flourishing Communities  
High Social Cohesion  
Trust  
Collective Efficacy

Cross-sector Synergy  
Coordinated services,  
Robust Opportunity Structures

Collaboration  
Inclusivity  
Embracing differences



# Social Isolation

**Poorer Physical health**  
**Poor mental health**  
**Limited Social mobility**

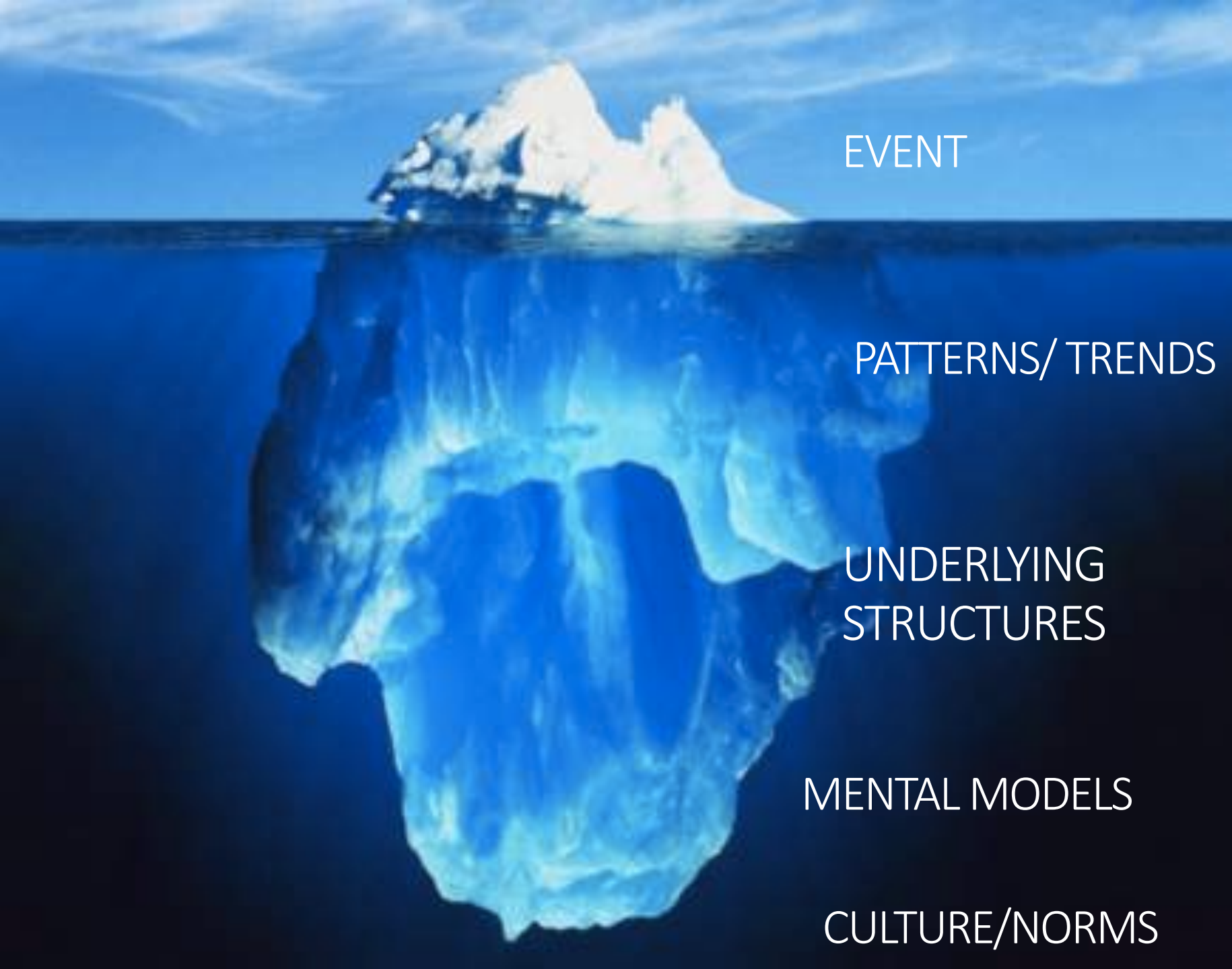
Limited social support  
Weak social networks  
Lack of access to  
resources, information

Low Social Cohesion,  
Distrust  
Violence

Silos,  
Disconnected services,  
Poor opportunity structures,  
Area deprivation,

Social exclusion  
Discrimination  
Prejudicial Attitudes





EVENT

REACT

PATTERNS/ TRENDS

ANTICIPATE

UNDERLYING  
STRUCTURES

DESIGN

MENTAL MODELS

TRANSFORM

CULTURE/NORMS

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BREAK





## Identifying Structural Racism in Practice



# Strategies: Structural Competency

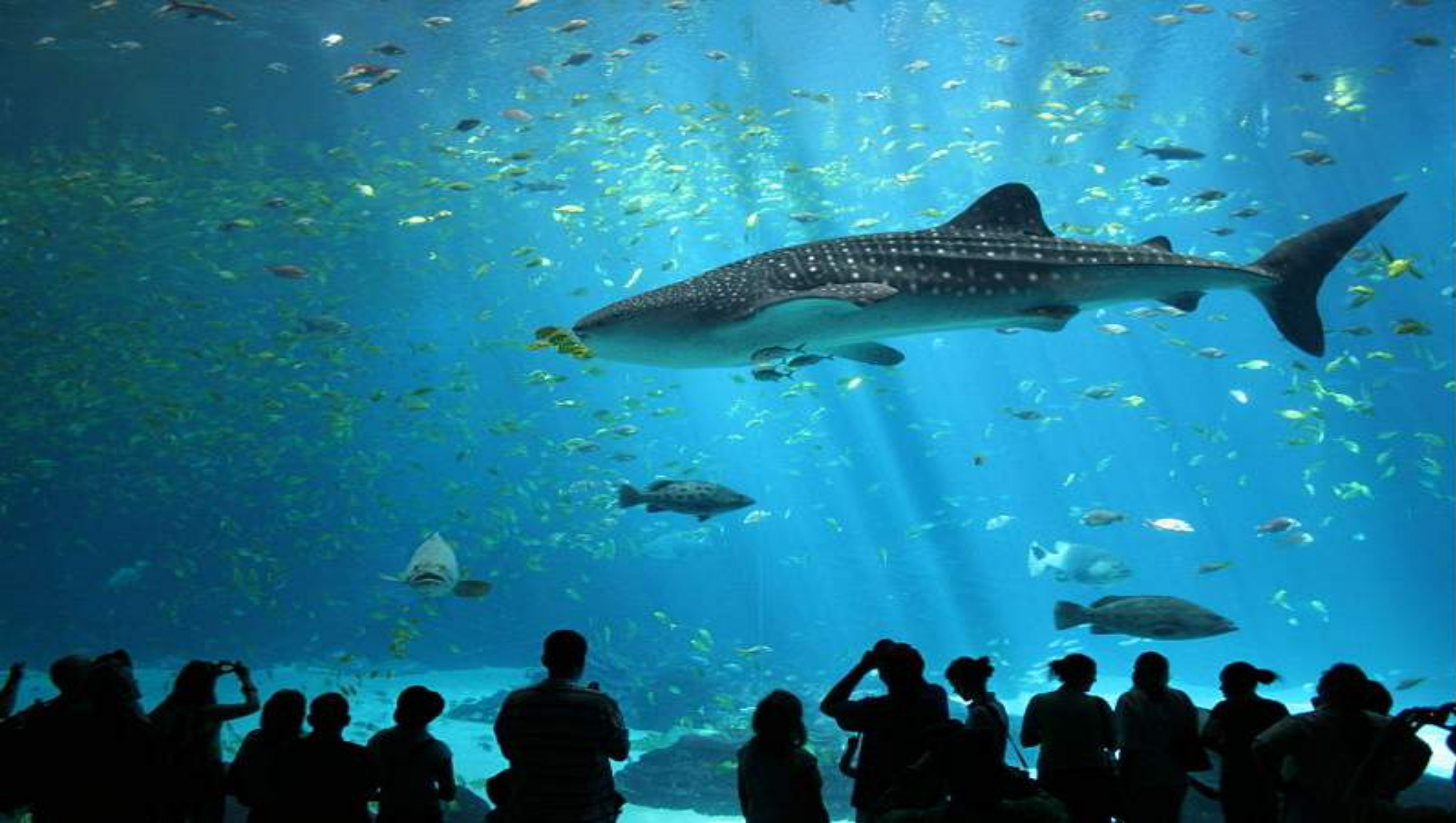




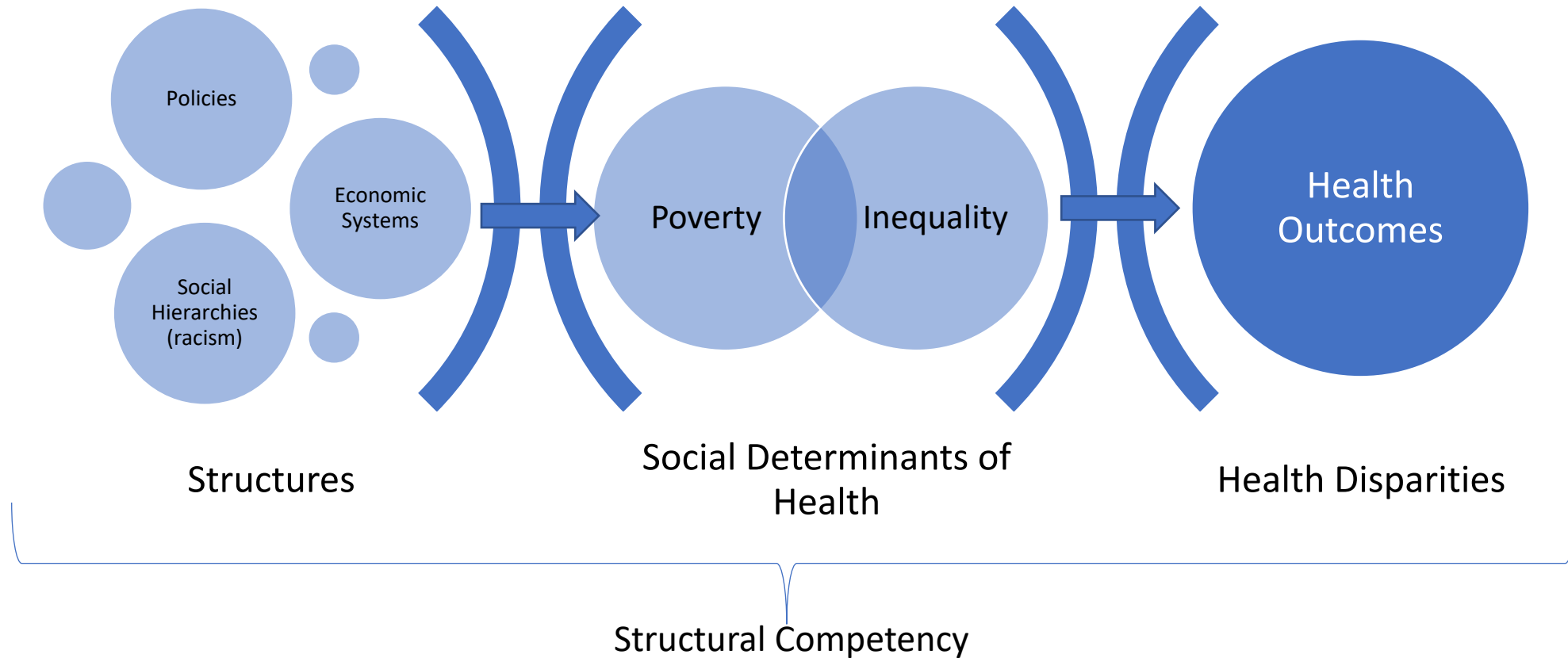
# Structural competency

- Recognition of "structures that shape clinical interactions"
- Development of "an extra-clinical language of structure"
- Rearticulation of "'cultural' presentations in structural terms"
- Observation and imagination of "structural intervention"
- Development of "structural humility"

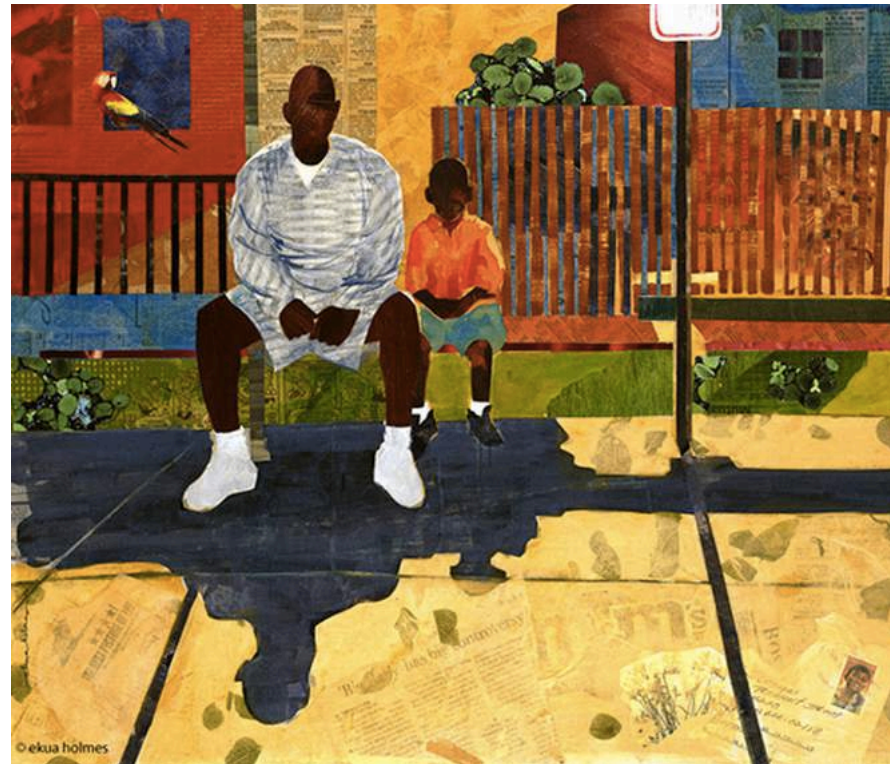




# Structural Competency



# Who are we missing?





# What do we *see*? What do we *think*?

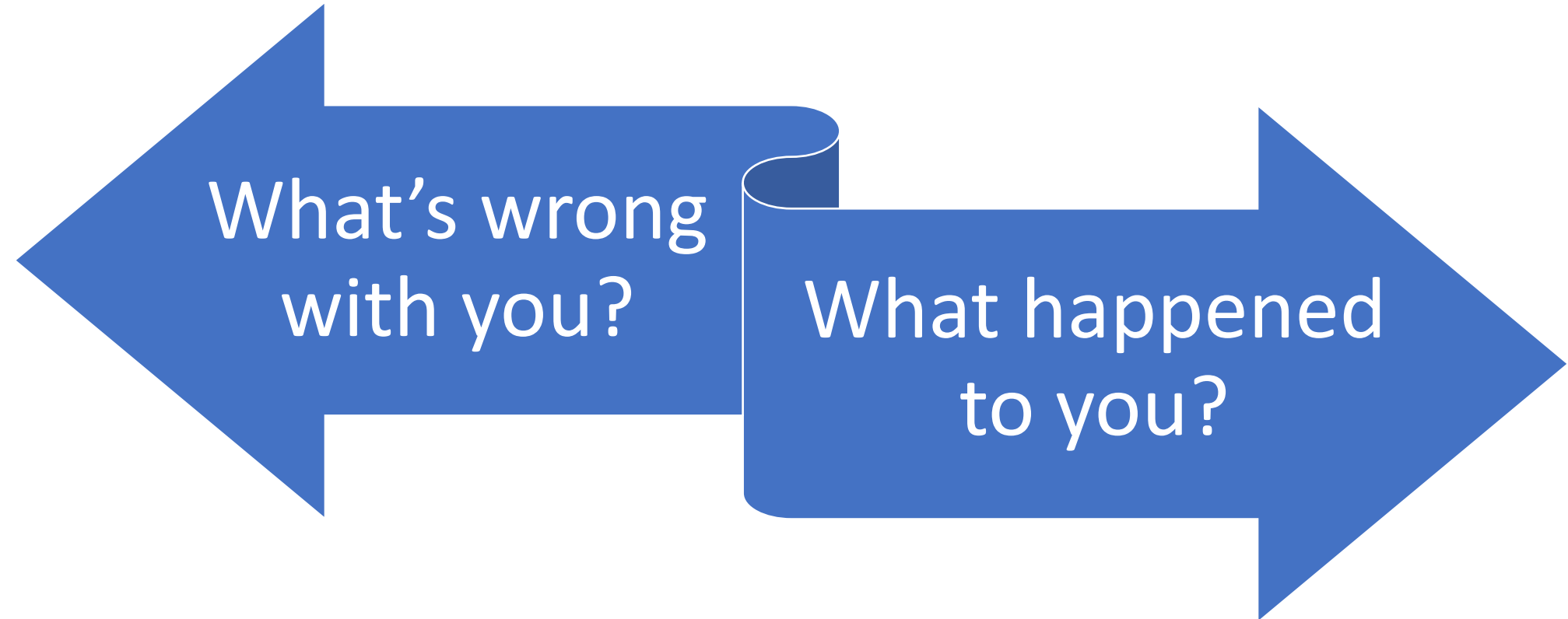
- Inconsistent
- Unreliable
- Uninvolved
- Absentee
- Neglectful
- Abandonment




- Confused
- Hurt, Vulnerable
- Disallowed
- Stereotyped
- Fear, Shame, Shielding
- PTSD/ Abandoned




# Change your question



# Change your mindset



Black people are  
a traumatized  
people.



Black individuals  
experienced  
trauma.



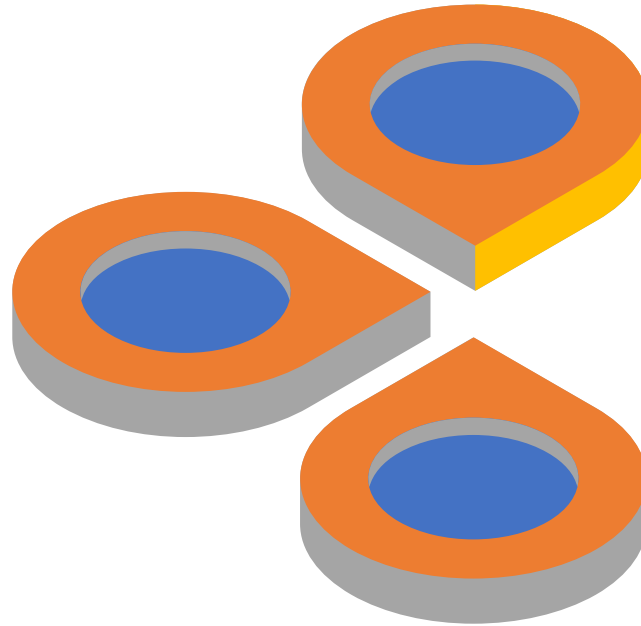
# Race is a social construct

- A social classification based on phenotype that impacts the distribution of risks and opportunities in a race-conscious society
- A societally imposed identity

# What do we measure when we measure race?

---

**SOCIAL CLASS?**  
Racial group may be overrepresented in certain social classes, but do not account for the majority in those groups



**CULTURE?**  
No homogenous race-based cultures

**GENETICS?**  
Poorly captures genetic variability

# What responsibility do we have?

## Structural Integrity:

### DECIDE

Decide if you will or will not collect data about race and state why or why not.

### DEFINE

If you will collect “race” data define the reason and your hypothesis.

### DESCRIBE

Be explicit about whether you will try to understand race-associated differences or not and explain the associated limitations.

# Measure Racism

- Structural
- Institutional
- Interpersonal
- Internalized



# Structural Integrity

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- Data sharing
  - Do not simply report race-related findings
- Research
  - Explicitly state hypotheses
  - Be explicit and clear about the implications and limitations of your decisions
  - Propose future studies
- Practice
  - Include and create pathways for leadership for people from diverse backgrounds
  - Develop equitable partnerships with communities



## FISHBOWL: Finding Solutions Together

# Fishbowl

## Inside the Fishbowl

- 1 - Presenting Group
- 2 - Peer Participant Groups

## Outside of the Fishbowl

- Observe/Listen

---

# **Presenter Overview (5 minutes)**

- Building context and providing background information
- Framing the dilemma and guiding question

---

# Clarifying Questions (3 minutes)

- Brief questions with factual answers
- Provide clarity
- Presenters may respond

---

# Group Discussion (6 minutes)

- What did you hear?
- What additional questions have been raised?
- What might you do if faced with a similar dilemma?
- What assumptions seem to be operating?
- *Presenters may not respond*



---

# Presenter Reflections (2 minutes)

- What did you hear that stood out to you?
- What might you explore more deeply?
- What surprised you?

# Observer Reflection

What did you notice about this process?

How was the process useful to the presenting group?

How might you use this process to unpack dilemmas with your peers?

# What's Next: Coach Connections

- Identify a scenario relevant to your clinic
- Identify the inequities/indignities
- How might you address this challenge within your clinic?



Vital Village Networks at Boston Medical Center  
801 Albany Street, 2-N, Boston, MA 02119  
617.414.3674  
[www.vitalvillage.org](http://www.vitalvillage.org)



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# Wrap Up





# Chat Box: Reflections & Takeaways

I like... I wish... I wonder...

# Virtual Learning Sessions Roadmap

*\*RBN Cross Cutting Themes Focus*

Year 1 - 2021

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September 9	Putting it all together	
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# Poll

## Experience

On a scale of 1-5, please select the number below that best represents your overall experience with today's session:

- 5 - Excellent
- 4 - Very Good
- 3 - Good
- 2 - Fair
- 1 - Poor

## Use of Time

Please select the number below that best represents your response to the statement:  
Today's session was a valuable use of my time.

- 5 - Excellent
- 4 - Very Good
- 3 - Good
- 2 - Fair
- 1 - Poor

# Thank you!

For questions contact:



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(she/her/hers)

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