MEETING SUMMARY

Welcome

Patty Elkis, Director of Planning at the Delaware Valley Regional Planning Commission, welcomed meeting participants. She noted that today's Healthy Communities Task Force (HCTF) meeting is the second of a series addressing social justice and health in 2018. She thanked DVRPC staff and the co-chairs of the HCTF, Montgomery County Commissioner Valerie Arkoosh, MD, MPH and Christina Miller, MSS, Executive Director of the Health Promotion Council, an affiliate of the Public Health Management Corporation. Lastly, Ms. Elkis encouraged the audience to promote DVRPC's forthcoming Request for Proposals (RFP) for providing future trainings dealing with racial equity.

Keynote Presentation

Dr. Lee M. Pachter, DO
Director of Community and Clinical Integration, Nemours/A.I. DuPont Hospital for Children

Dr. Pachter began his presentation by comparing and contrasting the Philadelphia neighborhoods of Society Hill and Strawberry Mansion. Despite being only 2.5 miles apart, discrepancies persist across indicators of income, poverty, educational attainment, unemployment, and race. Perhaps most astoundingly, there is a 20 year difference in life expectancy. Dr. Pachter explained that 50 to 70 percent of health outcomes are determined by behavioral, social, and environmental determinants, stating that "your ZIP code is more important than your genetic code." In spite of this, only three percent of the $2.9 trillion spent annually on health is linked to these determinants, with medical health care receiving the remainder.

Dr. Pachter has focused his work on a determinant for which there is very little health-related research: racism. Of the 40 papers found on the topic, most relate to the effect of racism on social and mental health with few covering physical health. To determine whether perceptions of racism are common in children of color, Dr. Pachter and a colleague surveyed 277 children in Hartford, Connecticut and Providence, Rhode Island. A questionnaire listed 24 different negative experiences tied to race, asking whether the youth recalled—for example—being followed or watched closely by security guards in a store, people holding their bags tightly while walking past, or receiving poor or slow service at a restaurant. Almost 90 percent had experienced at least one of those listed, and the average number that the children reported having experienced was six.

Next, Dr. Pachter touched upon the ways these experiences can affect health at many levels. From a macro perspective, residential segregation and structural racism lead to increased exposures to health and safety hazards and resource inequalities. On an intermediate scale, interpersonal racism can increase psychological distress. At the micro level, where the rest of Dr. Pachter's presentation focused, racism represents a chronic psychosocial toxic stressor that leads to physiological dysregulation. These

acute stressors, such as day-to-day microaggressions, can occur so frequently that they do not give the body time to reset to its baseline stress-response hormone levels. Hormones may remain at a constant high, or burn out completely, which can shrink nerve cells in the brain affecting physical and emotional growth, executive function, immunity, and metabolism. By breaking down allostatic systems, racism increases risk for chronic diseases like diabetes, obesity, asthma, cardiovascular disease, and depression. All of these conditions are known to have higher prevalence among people of color and ultimately lead to higher rates of morbidity for nonwhites.

Dr. Pachter rounded out the discussion by returning to the topic of children, and specifically, how racism can be considered an Adverse Childhood Experience, or ACE. The concept of ACEs originated in a Kaiser Permanente study in San Diego, where 17,000 adults were asked about the presence of stressors such as abuse, neglect, violence, substance use, and incarceration during childhood. It was shown that reporting more ACEs corresponded to more health problems in adulthood. Dr. Pachter has explored and expanded upon this concept locally through the Philadelphia ACE Project. A Philadelphia ACE Score was developed that incorporated the traditional ACEs from the Kaiser Permanente study and supplemented them with additional ACEs, including racism, bullying, and foster care. Many ACEs were more common in Philadelphia than in San Diego, and a high prevalence was observed for the new categories tracked in the local study.

Dr. Pachter closed his talk on a hopeful note, reminding the audience that, though they are cause for concern, these health data and trends do not represent pre-destiny. Despite his focus on *challenges* related to racism and health, there are also many neighborhood and personal *assets* that can alleviate and mediate stressors, including the support of family, friends, and other social capital, as well as coping skills and grit.

KEYNOTE Q&A

Q: You mentioned the genetic effects of racism; can these impact current and future generations?
A: Environment can affect genetic expression and turn on dormant genes for something like diabetes. There are also telomere links associated with biological aging, so stressors may be decreasing life expectancy in this way.

Q: With regard to lead poisoning, studies connect neurotoxins with aggressive behavior. Can we track children exposed to lead in a way that also gets at any long-term involvement with the criminal justice system?
A: One study has looked at this in Cincinnati; however, it would be interesting to know if additional studies existed.

Q: Will connections between racism and health receive more attention and be studied further?
A: It is becoming more common. More studies in medical literature are using racism as a variable, and there is an increasing use of the Philadelphia ACE Project questionnaire. Since the San Diego study was in the 1990s, it is taking a long time but it is definitely important to continue to expand this conversation and research and change practices accordingly in the planning and education communities.

Panel Discussion

Moderator: Phil Fitzgerald, Director of Grantmaking, The Philadelphia Foundation

Question 1: Describe your organization and work

Andrew Stober, Vice President of Planning and Economic Development, University City District:
UCD is a twenty-year-old organization with goals to improve public safety and cleanliness. In the last five years, we have been working on public space and workforce development.
One of our initiatives is Just Spaces, which focuses on social justice in public space.

Valerie Jackson, PEAK Coordinator, Pottstown School District:
Pottstown Early Action for Kindergarten Readiness (PEAK) is an early education initiative with support from the Scattergood Foundation and Yale University. We use trauma-informed practices to get kids kindergarten-ready. 100 percent of students in this program qualify for reduced or free lunch. We noticed an increase in behavioral challenges among students, and in response, we have changed our language and how we approach communication with these students.

Zoe Van Orsdol, Public Health Program Manager, Impact Services:
We have three focuses: housing for dual-diagnosis homeless veterans, post-incarceration workforce development, and community development in the Kensington neighborhood. We are working with New Kensington Community Development Corporation on a trauma-informed community engagement curriculum.

Dan Rhoton, Executive Director, Hopeworks 'N Camden:
Our program working with Camden youth is 17 years old. We train them in high-demand technologies including GIS and front-end development, hire them to work at Hopeworks, and then they move into industry. We also are a partner of Healing10, a group of organizations in Camden focused on building a trauma-informed community. Hopeworks instituted a trauma-informed approach, and in the last 6 months, the youth participating in the program took on higher-wage jobs than in past 10 years. Subaru, a major funder, supports this trauma-informed training.

Q: Why use a trauma-informed approach?

> DR: We were bad at our jobs without it. Youth-serving programs operated like a doctor recommending "grit" and "trying hard" to heal a broken foot. We are trying to get away from the "try harder" approach and look at the root cause. The first approach was not helping.
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> ZVO: My new boss is an expert in trauma-informed care. Addressing these barriers systematically enables people to trust their neighbors and begin planning in their neighborhoods. These initial steps fit with our model, which builds from a small, block level out to community-wide needs.
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> VJ: The strategy was recommended by United Way. We looked at the demographics of the community we were working with and they showed awesome kids and families, but also awesome challenges. It was an effort to do work *with* the community instead of doing work *for* the community. We need to address everything that affects a child's life.
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> AS: Just Spaces is not explicitly trauma-informed, but we have a diversity of residents, workers, and visitors in our community. Since I joined, there has been a large investment in public space across the city, and a lot of conversations about equity in public space, but these discussions have ranged from sincere to lip service. This led to conversations about justice in public space, and we adopted a self-evaluating framework, based on work by City University of New York Graduate Center Professor Setha Low, to explore where the tensions are. There are five main categories in this framework:
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> 1. Distributive justice: Where are public spaces distributed? Does everyone have access to a public space?
> 2. Procedural justice: How do people feel about the say that they have in how space is designed and managed? People expect different levels of involvement at different phases. Consultation at the design phase helps but design happens once. Maintenance, operations, and programming go on forever and can lead to feelings of being welcome or unwanted.

3. Interactional justice: Do you feel unwelcome or unwanted? If you feel unwanted, the experience can be traumatic. An example of this is the monuments chosen for a public space. Whose feelings or perceptions are privileged?
4. Ethic of care: How do people care for each other (for example, someone in distress) in the space? How do they care for the space itself?

Representation in public space affirms people's dignity and acknowledges their history.

Q: How have the groups you've worked with experienced racism as trauma? How has it affected the groups you serve or shaped the space you work in?

DR: Being unwanted in a professional space can trigger previous experiences. We can train our students in technological expertise but they must also be able to deal with moments of being unwanted. They need a methodology for dealing with the perception that they are unqualified, even in a private employment space.

ZVO: Our workforce development overwhelmingly serves black men and many are returning from incarceration or are veterans. We need to consider what opportunities are available to minority men, and why so many are routed to the military, which can lead to traumatic experiences and PTSD. Other traumas follow in Kensington, where the opioid crisis has led to visible encampments of about 200 people. These encampments are passed by school children. The difference in media coverage between the encampments and neighborhood is noticeable. The residents of the encampments, which are getting attention by the media, are majority white, while they are surrounded by a majority-minority neighborhood that is not covered as much by the media. The surrounding neighborhood faces neglect, with its vacant warehouses serving as visible signs of how the neighborhood is suffering from the repercussions of deindustrialization, including crime, violence, and lack of safety.

VJ: There is a discrepancy of suspensions and expulsions as early as pre-K for children of color. We are training teachers about systemic racism and breaking the cycle of generational poverty in which trauma and racism are embedded. Self-reflection in this regard is needed regardless of teacher ethnicity. We see multiple generations' worth of trauma in some families.

Q: How can planners apply a trauma-informed approach to the built environment?

AS: It's important to think about who we value people in a monetary way. Often the people showing up to community meetings are not reflective of their neighborhood, but planners base their plans on those attendees' input. People from the community have incredible value to planning efforts and should be compensated for their input. We have used market-rate focus groups, where we use professional facilitators and pay participants $50-$100, that provide incredibly illuminating information. The Temple Institute for Survey Research is a great resource.

From one focus group, we learned that while all survey respondents loved Clark Park, when asked about negatives, white respondents only noted the lack of functioning water fountains after much questioning, while African American respondents immediately noted the lack of water fountains as a problem. When asked why the water fountains don't work in Clark Park, both white and black respondents had incorrect answers, but their perceptions served as reality in terms of how they felt their presence was welcomed (or not) in the space.

AUDIENCE QUESTIONS

Q: How can we resolve self-segregation in public spaces, as has recently been happening in Kelly Pool (near the future "Centennial Commons" in West Philadelphia)?

VJ: In Pottstown, churches are combining to bring groups together. It is important to encourage people to mingle. Individuals with a trauma-informed background are best-equipped to reach out to others.

AS: Over the past four years, the Civic Commons Initiative has been working in Centennial Commons to try to engage the community around what the community wants the park to be. We will see if the engagement process has been successful. Sometimes public space can be a reflection of society's ills, but they can also be a refuge from society and the trauma and stress that it can induce. Who decides what the space is going to be is important.

Q: In the context of job training programs, how do we woo potential employers while also supporting trauma-informed care?

DR: Employers do not necessarily care about trauma-informed care. But using it creates employees who are the best at their job. Once that is seen, and the employer starts to question why certain hires are their best employees, you can let them know that these hires have benefited from a trauma-informed approach and discuss the benefits of adopting it. The employers should ask the question; you shouldn't volunteer the information. If you talk to an employer about it first, you may instill prejudices towards the potential hires. The best way to spread the trauma-informed approach is to talk about its effectiveness.

ZVO: The user end is where benefits occur. Our participants in the trauma-informed curriculum are constantly asking when the next meeting is. It's not common for people to want to come to a space to talk about their feelings, but they are excited about how the tools have changed their own lives, and they want to use them on their own blocks.

Q: What is the overall impact of your work on communities, health and environmental issues?

ZVO: We have developed a questionnaire about social cohesion and other similar topics, but we do not totally know. Our organization's goal is to build collective efficacy, but we are not going to resolve systemic problems like the opioid crisis. Issues like that require government intervention. We aim to give the Kensington community the tools to get involved with that process and cope on a daily basis.

DR: More people in the community have become interested in Healing10 because of its success. When a program is successful, everyone wants to be involved because they're seeing good change.

VJ: We want what is taught in our schools to carry over into home life, and we see that our students are bringing the lessons from their classrooms home to their parents--for example, skills for social and emotional learning, such as "belly breathing." This leads to change in the family and the community. We are also using a "train the trainers" model to include family members of our students, who can connect with their neighbors and expand the skills shared in the program.

Q: How are you incorporating diverse voices into your leadership? In what ways do your leaders know the history and context of the challenges they are addressing?

ZVO: We are moving from trauma-informed external work to internal as well; we are educating our staff on these topics. We now have a flattened hierarchy to bring more voices to the leadership level and are doing intentional hiring from within the neighborhood.

DR: You have to have an established structure for this to work effectively. We have a formal process called a "systems check" to bring out unspoken issues in the office that may be withheld due to a power imbalance. There is facilitation to bring out the issue in a safe space. You need a

structured way to tell the truth when there is a power imbalance, and leadership need to make it happen. New employees have to be involved early on.

Q: In terms of institutional buy-in, how do you move forward either without an anchor institution or with an anchor institution that must adjust to changing relationships?

AS: UCD gets support from institutions, and was previously perceived as a tool of the institutions. We have tried to differentiate from them, and how we act independently and encourage them to see new perspectives. It is hard to do this; they make government look nimble and entrepreneurial with their conservative decision-making. We push them to take risks, even if small, by showing the effectiveness of new programs.

VJ: Data talks. We use data to tell the story of changes that have occurred over time based on our practices.

DR: An organization can have two different relationships with anchor institutions. One is where you ask for something from an institution and provide something to them. The other exists where it is damaging for the institution to *not* be working with you, and they have to pay to be "in the club." For this to be the case, they need to see the value. Otherwise, you need to do more to promote your work to them.

Q: What is a real-life example of a "systems check"?

DR: The person with power has to be the one to make the sacrifice. Perception is everything. For newer employees, we'll stage an incident to trigger a systems check. For example, if I send an email to my staff looking for status updates on their work, it could come off as a threat, especially to new employees. They have to have an ally to support them with a systems check on me as the executive director since they will not be prepared to do so. The person with power has to be open to "losing" the systems check in order to establish trust with the other person.

AS: When you are in a leadership role in an organization, it is important to be self-aware in the understanding that your staff have experiences and knowledge that you do not--that you have blind spots. We have a program called Green City Works, which is a social enterprise landscaping company of 15 staff from West Philadelphia. In the past year, we asked these staff members to participate in a focus group to provide feedback on their work, but they were reluctant to speak openly about their work. They had had past experiences with jobs that had negative consequences if someone complained, including dismissal from the job. The failure to know this backstory was a blind spot on UCD leadership.

ZVO: People do not like to give up power once they have it. Getting people to acknowledge the ways they have power is critically important.

VJ: Make sure that everyone has a chance to speak, and that everyone's voice is given equal weight. If someone chooses not to speak in a conversation, take time to circle back later to get their thoughts.

Closing Remarks

Christina Miller closed the event by reinforcing the notion that racism is a psychosocial toxin and can be viewed an "underpinning, overpinning, and side-pinning" issue for attendees in any field. Racism and other traumas impact people's access to resources and their day-to-day operations but also affect them at the molecular level. She reminded the audience that the challenges and opportunities presented by the push for social equity are worth tackling from both a moral and business perspective. To do so, we must identify our power and share it.