Holistic Healing Framework for Boys and Men of Color

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for **REACHING VICTIMS**

Table of Contents

Overview

Historically, boys and men of color (BMOC) have disproportionately been victims of violence and are underserved by victim service providers. Due to a combination of factors resulting from systemic and interpersonal violence, historical trauma, racially-based and state-sanctioned violence (i.e. discriminatory policies, police brutality, mass incarceration) their experience of interpersonal violence and trauma is intensified. As a result, healing for BMOC becomes a complex process that is not linear, nor can a simple application of treatment approaches designed to reduce symptoms of Post-Traumatic Stress Disorder or even Complex-Traumatic Stress Disorder suffice. As defined by Shawn Ginwright, "healing is understood as a regenerative process that is inclusive of the mind, body, and spirit, and that aims to restore and renew the individual and collective emotional and spiritual wellbeing [of an individual]" (Chavez-Diaz 2015). This description of healing helps to centralize the experiences of BMOC within a sociopolitical and historical context. It lays the foundation for understanding the need for a holistic approach to healing, which can address and shape their psychological, social, and spiritual experiences, promote restoration and regeneration, and become a protective factor that can buffer the impact of future harm and traumatization.

The National Resource Center for Reaching Victims and one of its partner organizations, Common Justice, developed a Holistic Healing Framework using a Restorative Integral Support model, an application of Integral Theory specific to addressing accumulated adversity and trauma to foster resilience and recovery. This paper conceptualizes a framework for a holistic approach to healing, called The Holistic Healing Framework, and offers a theoretical perspective on why it should be applied in victim service provision.

Introduction

Historically, boys and men of color (BMOC)[1] have disproportionately been victims of violence and are underserved by victim service providers. Due to a combination of factors resulting from systemic and interpersonal violence, historical trauma, and structural racism, boys and men of color face many obstacles to healing from trauma. Traditional practitioners are typically not trauma-informed or culturally responsive, and, accordingly, they are not equipped to serve this demographic and address their specific needs. There is also a widespread misunderstanding that BMOC are solely perpetrators of violence, and as a result their status as victims is largely overlooked. Additionally, because of the stereotypes that BMOC are labeled with, they are barred from accessing victim compensation almost by default. In several instances, BMOC were barred from receiving victim compensation because they were wrongfully affiliated with a gang due to their neighborhood being considered "gang-affiliated". Additionally, BMOC are not socialized to seeking services like therapy or trauma care and cannot be relied on to seek services for themselves. Moreover, BMOC often don't know they are in need of healing. A lot of young men don't realize they're experiencing trauma and that it can even be helped and healed. On the other end, traditional service providers haven't done enough to reach this population and don't employ outreach strategies that work. These are just some of the factors that explain why they are underserved.

The National Resource Center for Reaching Victims and one of its partner organizations, Common Justice, brought together a team of experts to conduct a national listening tour[2] in 2018; the Needs Assessment Findings Report was the result of this listening

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1   The term "boys and men of color" (BMOC) is used to recognize males with an identified minority status, including race or ethnicity (Graham, 2017).

tour and is referenced in this document frequently. The Needs Assessment Findings Report underscored the importance to further evaluate healing services provided to boys and men of color. It found that BMOC are uniquely positioned in society and there are a number of factors that hinder or obstruct their ability to heal that is not addressed by traditional services offered. Some of the factors are lack of safety (many live in environments that are unsafe and triggering), lack of support (broken households, negative relationships), and lack of security (housing precarity, economic insecurity) in the lives of BMOC. Others include lack of basic skills (i.e. resume writing, cooking simple meals) and lack of sufficient education–attendance at comparatively under-resourced public school systems leave BMOC under-prepared for the next stages of their lives. Many services focus on a single aspect of an individual's life, for example, conducting cognitive behavioral therapy weekly, when the reality could be that this individual is currently homeless living in a shelter, and the debilitating stress of this reality is impacting the effectiveness of the cognitive behavioral therapy.

In addition to the Needs Assessment Report Findings, over five hundred practice documents related to victimization experiences and needs of victims who do not access services were reviewed (Needs Assessment Findings Report 2018). Specific historical trauma of minorities involved unsettled conflicts with no reconciliation or spaces for healing, and the pain and grieving from systematic loss that was passed on as legacies from generation to generation (Grayshield, Rutherford, Salazaar, Mihecoby, & Luna, 2015). Therefore, it was concluded that healing for this population requires a holistic approach (involving the individual and larger community), which can further shape

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2   The primary intent of this listening tour was to assess the use of victim service agencies by victims of crime and to develop an understanding of barriers these individuals may encounter when receiving services. Approximately one hundred and three informational interviews were conducted with victim service providers, advocates with lived experiences and experts in the crime victims field. Additional information was found from forty-five stakeholder groups and fifteen interviews with administrators. In order to reach professionals in the crime victims field, a survey was distributed and over fifteen hundred responses were received.

their psychological, social, and spiritual experiences. A whole person, recovery-oriented approach, involving simultaneous attention to biological, psychological, social and spiritual experiences of BMOC is called for in order to promote healing and prevent further trauma. The Holistic Healing Framework is a conceptual framework for practitioners that focuses on the uniqueness of BMOC, including their history, cultural identity, the communities they live in, and the effects of structural racism.

The framework was developed in an academic setting and used the Restorative Integral Support (RIS) model. The RIS model is an application of Integral Theory specific to addressing accumulated adversity and trauma to foster resilience and recovery (Larkin & Records 2007, 2011). It provides a useful guide to support holistic healing for BMOC and is regularly applied to grassroots practice as it recognizes the value of different perspectives and multiple healing modalities. RIS is employed to bring together evidence-supported interventions and emerging practices within intentionally developed restorative community contexts – involving leadership capacity development, peer supports, policy advocacy and system re-design (Larkin, Beckos, & Shields, 2012; Larkin & Records, 2007). Following a review of adverse childhood experiences, trauma, health disparities, and mental health concerns specific to BMOC, the RIS model is set forth for both a comprehensive understanding of how these root causes play out in the lives of BMOC and to demonstrate the way in which diverse approaches to healing can work together for a holistic response strategy. .

About the National Resource Center for Reaching Victims

Funded by the federal Office for Victims of Crime, the National Resource Center for Reaching Victims (NRC) is a one-stop shop for victim service providers, culturally specific organizations, justice system professionals, and policymakers to get information and expert guidance to enhance their capacity to identify, reach, and serve all victims, especially those from communities that are underrepresented in healing services and avenues to justice. The NRC works to increase the number of victims who receive healing supports by understanding who is underrepresented and why some people access services while others don't; designing and implementing best practices for connecting people to the services they need; and empowering and equipping organizations to provide the most useful and effective services possible to crime victims. The NRC is a collaboration among Caminar Latino, Casa de Esperanza, Common Justice, FORGE, the National Children's Advocacy Center, the National Center for Victims of Crime, the National Clearinghouse on Abuse Later in Life, Women of Color Network, Inc., and the Vera Institute of Justice. The NRC's vision is that victim services are accessible, culturally appropriate and relevant, and trauma-informed, and that the overwhelming majority of victims access and benefit from these services.

1 Trauma Experienced by Boys and Men of Color

Boys and men of color living in urban poverty are disproportionately affected by trauma throughout life (RWJF, 2017). While the causes of violence are complex, there are salient factors associated with the presence of community violence in urban neighborhoods, which manifests in further exposure to violence. Violence is correlated with low socioeconomic status (SES), higher rates of crime, deficient housing, minimal resources and unemployment. Young men of color residing in such neighborhoods experience higher rates of crime and community violence (gun violence, murders, physical attacks, fighting, and police related incidents), which results in high levels of victimization (Teitelman et al., 2010; Attar, Guerra, & Tolan, 1994). The intersection between race and low SES clearly places BMOC at the greatest risk for exposure to community violence, in turn becoming victims and witnesses of violence and having greater risk to become victims of homicide (Voisin, 2007). The negative consequences are often expressed by internalizing symptoms and externalizing behaviors. Internalization can be defined as a predisposition to convey psychological distress internally and is evidenced by the following: depression, posttraumatic stress symptoms, anxiety, low self-esteem and decrease in cognitive functioning (Cosgrove et al., 2011; Cooley-Quille et al., 2001). Manifestation is the external behavioral expression of psychological distress — i.e. negative views of the environment, self or others, sadness, anxiety and sometimes mental illness. Moreover, relational proximity to victims, chronicity of violence, perception level of threat and ability to cope has been shown to negatively impact mental health (Lambert et al., 2012; Zinzow et al.; 2009).

Furthermore, cycles of violence are perpetuated by forced residential choices, limiting options for safety and recovery, with co-occurrence of trauma symptoms and/or limited or non-existent support systems (Harden, 2014). his is often a standard

experience for many BMOC that shapes one's view of the world. Further, this view often emerges from norms, beliefs and values affected by ongoing interchange with a disadvantaged environment that prioritizes personal and economic survival (Harden, 2014).

BMOC also experience relational disruptions caused by violence, incarceration and health related deaths, further presenting challenges to build positive relationships necessary to increase resilience. Positive relationships aid recovery from the trauma of violence and victimization, whereas trust, reconnection and safety are important elements to healing (Perry & Szalavitz, 2007). Thus, trauma and being a witness of violence can play a role in BMOC experiencing further adversity across the lifespan. Additionally, not only is the disproportionate number of BMOC experiencing trauma raising concern, but also the lack of evidenced based practices to promote resilience and recovery (Graham, 2017). As a response to this crisis, service providers will need a conceptual framework that can focus on the uniqueness of BMOC, including their history, cultural identity, the communities they live in, and the effects of structural racism.

2

Adverse Childhood Experiences and Boys and Men of Color

The Adverse Childhood Experiences (ACEs) study helps to understand how exposure to adverse experiences as a child might affect long-term health in adulthood. ACEs do not describe numbers of incidents, but rather categories of events experienced prior to age 18. The ACE study consisted of approximately 17,000 patients–a primarily middle-class Caucasian population from San Diego. Patients reported their experience with 10 ACE categories, including sexual, physical, or emotional abuse; physical or emotional neglect; loss of a parent due to death, divorce, or incarceration; mental illness in a parent; and drug or alcohol abuse by a parent. The number of "yes" responses is summed to create an ACE score, ranging from 0-10, allowing the ACE score to be correlated with later life health behaviors and conditions. The ACE study revealed powerful relationships between higher ACE scores and later life emotional and physical health problems (Felitti et al, 1998; Larkin, Felitti, & Anda, 2014). It is important to note that higher ACE scores are more common among BMOC as compared to their white counterparts (Sacks and Murphy, 2018), and it is clear that ACEs are linked to many of the health risk behaviors that contribute to the long-term health and psychosocial problems experienced by BMOC. The ACE research calls for a lifespan and intergenerational perspective when working with BMOC, to understand the impacts and manifestations of their trauma as seen today, and break the trajectory from high ACE scores to later life health and social problems (Larkin, Felitti, & Anda, 2014).

In today's society, many BMOC experience racism and microaggression on a daily basis (Frank & Franklin Boyd, 2000). Thus, overcoming obstacles connected to racism and microaggression as well as oppression has been embedded in the socialization process for the African American community, and in fact, resilience is required for individual and community survival (Geller et al. 2014; Graham, 2017). Notable movements,

such as Black Lives Matter, which offers one current social media example, highlight recent deaths of BMOC and further expose the trauma and adversity experienced by BMOC (Graham, 2017; Galovski et al., 2016). Throughout history, it is difficult to identify a single period in America within which African Americans have not been expected to overcome these obstacles and increase their own resilience (Butler-Barnes et al., 2017). It is important to note that the literature identifies this type of discrimination and expected resilience as trauma (Graham, 2017). Further, while ACEs are prevalent among boys and men of color who enter the criminal justice system (Delisi M., 2017), there is only a very limited body of ACE research on BMOC in general.

By examining the intricate components that lead to adversity and trauma for BMOC, understanding their interplay as unpredictable and dynamic, we will then be well-positioned to understand how to respond as provider, agency, and community leaders. Understanding the construct of racism and oppression and how it has shaped the lenses of BMOC must inform any frameworks and methodologies seeking to strengthen resilience. Occurrences exacerbating trauma experienced by BMOC are often further compounded when BMOC rely on service agencies for support. A study completed in mental health settings suggested that African American men received less comprehensive care, had access to less experienced providers with fewer resources available to them, and reported being disrespected by providers and staff (Cusack, 2007). African Americans are more likely to be involuntarily committed and put in solitude or restraints, as well as being treated with higher doses of psychotropic medication than their white counterparts (Cusack, 2007). Consequently, many community service and systems oriented strategies are developing to express and address specific needs of BMOC (Graham et al., 2017).

3 Health Disparities

Health disparities are the result of the complex interplay of factors across the individual, interpersonal, community and policy realms (Jones, D. et al., 2012). A culmination of factors lead to disparities among BMOC–these include socioeconomic conditions, lack of health insurance, unequal access to health care, lack of quality education, inadequate housing, and lack of employment opportunities (Jones et al. 2012). Interpersonal networks are often identified as one's family or peers, who might contribute to an individual's attitudes and behaviors. Further, communities often identify with schools, employers, law enforcement, health care providers and other institutions – as a result, factors such as segregation, concentration of poverty, and limited or no access to suitable schools, employment and resources within the community further develop disparities in BMOC (Jones, 2012). Moreover, within communities of color it is likely for there to be a lack of accessible parks, fewer healthy food options to be available in supermarkets leading community members to rely on fast food and boxed items, as well as other "health robbing experiences" including visible community violence (Davis et al., 2009). Policies and laws such as punitive or mandatory sentencing for drug offenses, zero tolerance, and youth being tried as adults can further contribute to health disparities (Jones, 2012).

Evidence identified across the literature shows how historical and structural racism over time are social determinants of health and have created health disparities in BMOC–this historical and structural racism has shaped policies, practices, and programs that continue to affect BMOC (Steinberg, 2009). Thus, it is recognized that health disparities and the unequal chances of BMOC are deleterious. For example, as Davis et al. (2009) highlights, nationally the risk of contracting HIV or AIDS for African Americans is 6.9 times higher and the rate is 3.1 times higher for Latino men and adolescents than their white counterparts (Davis et al., 2009).

Although there are programs such as National Negro Health Week, developed by Booker T. Washington over a century ago, that draw attention to health behaviors and began to address social determinants of racial health and disparity early on, there is very little emphasis on men of color (Bruce et al., 2015). This further illustrates the need to continue to develop programs and interventions that seek to diminish disparities throughout all realms–individual, interpersonal, community, and policy–in order to actually reduce health disparities.

4 Mental Health

High rates of exposure to violence and explicit victimization have been linked to mental health problems among BMOC (Graham et al., 2017). There is a vast amount of literature available on depression that recognizes the correlation between environmental threat (violence, poverty and social isolation) and depressive symptomatology (Fitzpatrick et al., 2005). Although causal relationships are complicated, participants of these studies who have history of environmental threat have reported significant mental health problems and are found to be less socially competent, leading to more difficulties as they age (Fitzpatrick et al. 2005). Moreover, environmental threat has also been connected to delinquent behaviors, substance use, risky sexual behaviors and poor performance in school (Graham et al., 2017). Resource poor environments play a significant role in causing stressors, including community violence (Fitzpatrick et al., 2005). Thus, interpersonal and community factors play a crucial role in shaping individuals and decreasing stressors. Furthermore, exposure to community violence has been identified as an additional ACE category, and its consequences recognized as a public health concern (Lee, Larkin & Esaki, 2017). Youth who live in hazardous environments do not always have the same response, and in fact, many have developed coping mechanisms allowing them to adapt and succeed. These include self-esteem and social supports as well as participating in voluntary associations, all of which play a significant role in coping with stressful events (Fitzpatrick et al., 2005).

Research demonstrates that including these cultural issues within evidence-based services for particular minority groups is key for a successful intervention. Yet, BMOC and other minority groups are often living in resource poor communities, and the training costs involved in specific treatment modalities are beyond the reach of many of the mental health professionals (Kataoka et al., 2010). Moreover, treatment modalities designed for delivery by master's

level clinicians are not feasible to implement in a system with primarily bachelor's-level professionals. Many interventions are developed without taking into account the sociocultural context affecting children, including belief systems and child rearing practices (Kataoka et al., 2010). Further, Kataoka et al. (2010) reviewed several mental health problems (depression, anxiety, Post-Traumatic Stress Disorder, Conduct Disorder, and Substance Use Disorder) that stem from hazardous environments. Cognitive Behavioral Therapy (CBT), Cognitive Behavioral Intervention for Trauma in Schools (CBITs) and Child Parent Psychotherapy (CPP) have been proven most effective with minority groups (Kataoka et al., 2010). Choosing what to implement primarily is the decision of the clinician, based on one's training and consideration of the environment.

5 The Restorative Integral Support (RIS) Model

To develop the Holistic Healing Framework, we applied comprehensive research on BMOC to the Restorative Integral Support (RIS) model, an application of Integral Theory specific to addressing accumulated adversity and trauma to foster resilience and recovery (Larkin & Records 2007, 2011). We chose to go with Integral Theory when developing the Holistic Healing Framework because it incorporates the insights of various systems of thought and research findings (Wilber, 2000) and integrates empirical findings and theories from a range of disciplines (Kerrigan, 2006; Larkin, 2006) which promotes a holistic approach.

The RIS specifically integrates an understanding of adversity and trauma with knowledge of resilience and recovery to inform those working with BMOC (i.e. practitioners, program and community leaders). It brings together a range of prevention and intervention activities for a comprehensive approach, serving as a flexible guide that attends to the ways in which leadership, service systems, and culture work together.

Two key integral theory concepts are the quadrants and development. This includes developmental lines and overall development. Each line of development involves an individual's increasing ability to function in particular areas and contributes to a person's overall stage of development. Moreover, development involves interaction between the person and the collective environment – social, cultural, and ecological. It explains how ACEs, including exposure to community violence, other social determinants of health and health risk behaviors can interfere with one's ability to resolve one stage of development and move on to the next (Larkin & Records, 2007). The four quadrants represent four irreducible perspectives (subjective, intersubjective, objective, and inter-objective) that must be consulted when attempting to fully understand any issue or aspect of reality (Esbjörn-Hargens, 2009).

All four quadrants arise together and reflect one another, which helps to consider important aspects of a whole person approach, or holistic healing. For example, the life experiences of survivors can be outlined within the four interconnected quadrants (see Figure 1). Figure one is the RIS model, which has four quadrants: "I" quadrant represents the development of perception of self (I) or a first-person perspective; "WE" quadrant represents collective values of the community or reference group, including cultural worldviews and norms, shared meanings, and social networks; this is a second person perspective; "IT" quadrant represents objective, observable aspects of the individual, including behavior and physical characteristics, or a third person perspective; "ITS" quadrant represents systems, structures, and policies, a third person plural perspective (Figure 1).

Quadrants IT and ITS represent observable qualities while the quadrants I and WE are subjective and therefore involve asking questions. The four quadrants mutually interact and evolve together – in fact, they simply represent different dimensions of experience (Larkin, 2006; Larkin & Records, 2007; Esbjorn-Hargens, 2009). Figure 1 maps adversity and trauma to the quadrants.

Figure 1. Adversity and Trauma

Interior Individual/Subjective (I) Strengths & Skills	Exterior Individual/Objective (IT)
• Developmental process & capacity • Emotions • Trauma experience	• Health risk behaviors • Physical health • Neurodevelopment • Self-care behaviors
Interior Collective/Intersubjective (WE)	**Exterior Collective/Interobjective (ITS)**
• Cultural values • Shared meanings • Social supports • Community resources	• Adverse events • Domestic violence • Natural disasters • Service access

Understanding development from a quadrant perspective of interconnection may be particularly useful in raising awareness of and addressing the social problems of BMOC in a way that supports culturally relevant service delivery within local resource contexts. The RIS highlights the notion that adversities co-arise with a variety of inner and outer resources, with trauma emerging as an "all-quadrant" experience. Individual development takes place within a cultural and systemic context–presented via the integral concept of the quadrants (Larkin & Records, 2007).

Adverse experiences are typically observable events taking place within systemic interactions, mapped in the ITS quadrant. Each quadrant represents a perspective on adversity, and resources (or lack of) within each dimension play a role in whether or not the adverse events are subjectively traumatic. A key aspect of the RIS is to enhance agency, community, and policymaking leadership by raising awareness of ACEs, trauma, resilience, and the contexts within which they occur. Leaders set an example through behaviors, role modeling, and relationship-building, setting the tone for the culture around them. Leaders are also in a position to change policies and procedures to facilitate healthy program and community contexts (Larkin & Records, 2007; Larkin, Beckos, & Shields, 2012). It is also important to note that we all contribute to the cultures of our programs and communities–the RIS therefore includes providers and all community members within the conceptual framework and emphasizes the importance of self-care as an aspect of intervention to prevent vicarious trauma and burnout (Esaki & Larkin, 2013). In fact, building nurturing communities is a particularly salient goal when working

with BMOC, particularly when recognizing the prevalence of witnessing community violence (Smith and Patton, 2016), a recognized ACE category (Lee, Larkin, & Esaki, 2017). The RIS includes guidance in building a healthy community by increasing societal awareness, pointing to opportunities for cultural change as well as policy advocacy and system redesign. Applying the RIS, drawing on key integral concepts of the quadrants and development, offers an all-inclusive understanding of the situation–allowing one to gauge which "hotspots" are most imperative to address given available resources (Larkin & Records, 2007).

6 The Holistic Healing Framework

To develop the Holistic Healing Framework, which focuses particularly on the needs of BMOC, we take the RIS and use knowledge of BMOC to guide a reshaping of lower right quadrant systems, procedures, and policies while identifying ways to intentionally develop restorative and healing cultural contexts. For example, this might involve streamlining care, increasing access to services and supports within neighborhoods, engaging in grassroots activism to address systemic injustices through policy advocacy, creating healing spaces, and supporting indigenous neighborhood leaders who offer role modeling, relationship building, and peer supports. Within this restorative cultural and systemic context, evidence-supported trauma interventions (e.g. CBITS and CPP) and emerging practices (e.g. sweat lodges, emerging body-oriented healing methods, mindfulness practices) can be integrated for an enhanced service impact. It is important to note that research found outreach is the most effective way to reach this population (Needs Assessment Findings Report, 2018), which suggests the importance of engagement and offering health and mental health services in the context of race, culture and gender (RWJF, 2017). CBITs, which was originally developed to serve a multiethnic inner-city population in school settings, has resulted in significant improvement of symptoms of depression and PTSD in traumatized students (Kataoka, 2010). The use of CPP with ethnically diverse children has also resulted in greater improvement of traumatic stress symptoms as the intervention builds on the assurances of traditional cultural beliefs, taking into account the effects of prejudice, destitution, and social injustice (Kataoka, 2010). As service providers begin to conceptualize the timeline of historical trauma for BMOC, they will also begin to understand how adversity has impacted this population and further caused barriers for change. Change has been connected to spirituality, hope and the culture of BMOC community throughout a history that has never been void of systemic oppression, racism and trauma. (Shavers et al., 2012).

The Holistic Healing Framework allows service providers to develop a broad understanding of the situation–both the way in which accumulated adversity, social determinants of health, and different types of trauma play out in identifying expanded options within a comprehensive response strategy. The holistic life experience of boys and men of color is broken into the four quadrants that represent the development of perception of self (I), collective values of the community or reference group (We), the individual response to trauma (It) and the collective response of the people (Its). This integral Holistic Healing Framework allows for history and culture to interact with society and infuse individual beliefs, resultant behaviors and coping mechanisms in real time.

The Holistic Healing Framework urges service provides to gain a historical understanding of the roots of the trauma that a people are intended to heal from, as much of the contemporary trauma experienced today has roots in history (Rutter, 1985). For example, there has never been a historic period in America where African Americans were not expected to overcome something or to be resilient, but there has always been a hope for healing and change (Butler-Barnes et al., 2017). This historical timeline of the African American community, which has endured slavery, post-reconstruction Jim Crow, wars, lynching, Civil Rights Protests, assassinations, the War on Drugs, and the first two decades of the 21st century referred to as "The New Jim Crow", starting the school to prison pipeline and the post-industrial and corporate prison complex (Comas-Díaz, 2016), is paramount to frame the "We" quadrant of the integral model which provides the foundation for the "I" and "It" quadrants.

 The "I" and "It" quadrants of the integral model involve understanding how a boy or man of color would come to believe in the hope of healing within the context of his culture and

history. The "It" involves understanding how and in what context the individual responds to this hope as an incentive to be excited about thriving in a future consisting of self-love, optimism about the good in ourselves, our lives, families, communities and humanity. It also offers a unique lens for morality, compassion, understanding and forgiveness. However, creating a cognitive, emotional and behavioral space for indigenous, oppressed peoples to heal has been a major historical human services dilemma for all fields of mental health and social services. There is a wide range of trauma interventions with Western approaches to suppress negative symptoms; however, there has been an emergence of perspectives of healing that included mindfulness, creative expression, arts and other holistic approaches.

By using the four quadrants when working with BMOC, we can identify trauma's effects and work within the community to raise awareness and foster resilience, recovery, and healing (Larkin & Records, 2007, 2011). For example, when working with BMOC, ACEs are observable events taking place within family and community systemic interactions (including institutionalized, systemic discrimination) so are mapped in the lower right (LR) quadrant.

Indeed, there is an interconnectedness between Adverse Childhood Experiences and Adverse Childhood Environments--children are rooted in their environments and grow from their familial experiences (Ellis & Dietz, 2017). In the lower left (LL) quadrant lies racism as well as social taboos that keep ACEs and other traumatic experiences hidden. In the upper left (UL) quadrant, overwhelming emotions, developmental derailment, lack of coping or life skills, and the actual experience of trauma would be mapped. In the upper right quadrant (UR), individual health risk behaviors may be observed (e.g. substance use or risky sexual behavior) as well as possibly physical trauma, neurological

changes, and health problems. In the lower right (LR) quadrant, healthcare, social service, educational, and other institutions may or may not respond to ACEs, social determinants of health, systematic oppression and trauma, and in fact, historical and current policies may continue to shape or limit service delivery and access (Larkin & Records, 2011).

Figure 2. RIS incorporation of trauma interventions with boys and men of color.

Interior/Unobservable	Exterior/Observable
• Processing feelings or shifting subjective experience • Identifying strengths • Identifying developmental capacity • Resolving developmental derailment from trauma • Building inner resilience • Enhancing coping skills • Developing new life skills	• Body oriented practices (e.g. somatic experiencing/body work, sweat lodges, physical exercise) • Evidence supported interventions focused on behavior change (CBT, EMDR, CPP, CBITS) • Art Therapy • Dance • Medical Model
Collective/Unobservable	**Collective/Exterior**
• Culture of recovery • Healthy social networks • Therapeutic community • Peer supports • Faith/spirituality group supports • Grassroots activism	• Engaging in policy advocacy and system re-design • Recovery oriented systems • Service access (health, mental health, education, etc) • Cross-sector linkages • Service integration

While there are many evidence-supported interventions, protocols, and programs designed to support those who have a history of adversity and trauma, there is an identified need to improve how we address issues of culture and context in mental health services (Kataoka et al., 2010). Additionally, studies that identify trauma and adversity experienced by BMOC when receiving services are very limited. Ultimately, BMOC who have entered the criminal justice system have been depicted as the problem rather than victims of trauma (Needs Assessment Findings Report, 2018). Therefore, many service providers have not been trained to acknowledge the trauma present within this group, as a result leaving trauma untreated (Needs Assessment Findings Report, 2018). Service providers and community leaders have important roles in raising awareness of ACEs, SDOH, and trauma in later life health, addressing trauma consequences, engaging in grassroots activism and advocating for appropriate responses by policymakers and stakeholders, and forging cross-sector collaborations to achieve these goals (Larkin et al., 2018). Consequently, agency and grassroots leaders are faced with bringing together a variety of best practices to respond specifically to the needs of this population within the context of local resources, providing comprehensive, recovery-oriented services for BMOC who experienced adversity or trauma. Key training implications to support service providers are: 1) offer leadership training in The Holistic Healing Framework and 2) support the development of leaders who create programs and communities that intentionally support self-care among front line service providers and peer support leaders–recognizing this as an aspect of intervention that includes the intentional development of restorative program and community contexts.

Conclusion

Creating brave spaces and pathways for boys and men of color, who are survivors of trauma, to believe that they are valuable enough to heal, that healing and thriving is a possibility, and that they have the power to break cycles of trauma is the purpose of the Holistic Healing Framework. A holistic approach to healing, which can address and shape an individual's psychological, social, and spiritual experiences, promote restoration and regeneration, and become a protective factor that can buffer the impact of future harm and traumatization, is needed for boys and men of color, and service provision framed by the Holistic Healing Framework can be a valuable resource for service providers when specifically focusing on BMOC who have experienced trauma and adversity.

This brief concept paper evolved based on the findings from The National Listening Tour (NRC) and addresses implementation of the Restorative Integral Support (RIS) model to house the Holistic Healing Framework for boys and men of color who suffer from adversity and trauma. The Holistic Healing Framework transcends current approaches to support people who experience trauma and adversity through recovery and healing in a way that engages the person and the community and involves addressing unjust policies and systems. The literature illustrates a gap in evidence-based interventions geared to BMOC and calls us to consider the cultural and ecological factors unique to this population. The Holistic Healing Framework is presented as a way to address this gap. Furthermore, bringing awareness of social determinants of health, and trauma that lie beneath mental and physical health concerns of BMOC, coupled with the Holistic Healing Framework could potentially reduce health disparities (Larkin & Records, 2007).

NOTE – The following are freely available resources to support RIS implementation:

ACE Response webinar series

http://aceresponse.org/how_we_help/Webinars_3_53_sb.htm

RIS worksheets

http://aceresponse.org/img/uploads/file/RIS_Exercises_4_WPS_copy.pdf

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Credits

An electronic version of this report is posted at https://reachingvictims.org/resource/holistic-healing-framework-for-boys-and-men-of-color/.

The National Resource Center for Reaching Victims is a clearinghouse for victim service providers, culturally specific organizations, criminal justice professionals, and policymakers to get information and expert guidance to enhance their capacity to identify, reach, and serve all victims, especially those from communities that are underrepresented in healing services and avenues to justice. For more information about the NRC, visit the NRC's website at http://reachingvictims.org. For questions about this report, please contact reachingvictims@vera.org.

The Vera Institute of Justice's Center on Victimization and Safety convenes the National Resource Center for Reaching Victims. The Center on Victimization and Safety works with communities around the country to create healing services and justice options that reach, appeal to, and benefit all survivors. Our work focuses on communities of people who are at elevated risk of harm but often marginalized from the organizations and systems designed to support victims.

For more information on the Center on Victimization and Safety, please contact cvs@vera.org.

The NRC's vision is that victim services are accessible, culturally appropriate and relevant, and trauma-informed—and that the overwhelming majority of victims access and benefit from these services.

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