Applying Systemic Racism Theory to Social Service Provision:

an Evaluation of the Texas Model for Addressing Disproportionality and Disparities

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EXECUTIVE SUMMARY

INTRODUCTION AND POLICY QUESTION:

Clear racial inequity exists in virtually every measure of social, political, and economic well-being in the United States. The persistent and pervasive nature of the inequity calls for new theories to explain it and new interventions to address it. My client, the Center for the Elimination of Disproportionality and Disparities (The Center), has designed a theory-based intervention to address racial inequity in outcomes associated with the Texas Health and Human Services Department (TXHHS or HHS). This MP attempts to answer the question: ***How should the Center for the Elimination of Disproportionality and Disparities evaluate its intervention?***

THE CENTER'S INTERVENTION, THEORY, AND GUIDELINES FOR ENGAGEMENT

To effectively evaluate the Center's theory-based intervention, one must define the intervention itself and understand the theory behind it. In this case, it also helps to understand "The Texas Model for Addressing Disproportionality and Disparities," a set of guidelines for engagement that the Center has developed to guide its work.

The intervention is based in anti-racist training, community engagement (including engagement of systems leaders and institutional gatekeepers), and an examination of the role of systems in creating disparate outcomes. Center staff will work in partnership with existing community leadership to address disparate outcomes at the level of communities. Communities are defined geographically, and are approximated by ZIP codes or clusters of contiguous ZIP codes. Training, engagement, and analysis will contribute to changes in decision-making at all levels, which lead, in turn, to changes in measureable outcomes in the systems of health, child welfare, juvenile justice, and education.

The intervention was designed based on the Center's theory that institutionalized racism is a root cause of the disparate outcomes. According to the Center, all-inclusive social systems create and

perpetuate racial inequity, so effective interventions must address the social systems themselves. The theory is articulated and clarified in Eduardo Bonilla-Silva's analysis of "racialized social systems" (Bonilla-Silva 1997).

The Texas Model was developed as a set of guidelines for engagement that will help any practitioner attempting to address systems-level factors. Although developed organically, the intervention is supported by social capital theory, empowerment theory, and evidence from interventions examining the importance of anti-racist community organizing, cognitive diversity, and provider bias.

PROPOSED EVALUATION DESIGN AND FINDINGS:

Initially, I proposed a basic evaluation model that would compare pre and post outcomes in a set of control ZIP codes and a set of test ZIP codes. Any changes observed in both control and test ZIP codes would be assumed to have been caused by state-wide on national trends. Additional changes would be assumed to be caused by the Center's work.

We would measure the prevalence of poor outcomes by comparing ZIP codes on rates like children classified as 'at-risk' per total children enrolled in school, and the number of children referred to juvenile court per total youth population. We would measure racial disparities by using relative rate indices for the same outcomes (relative rate indices measure the times more or less likely than whites that a person of a particular race is to experience a particular outcome).

In order to use this method, I would help the Center to select test ZIP codes by finding three to five communities that had significant disparities and experienced poor outcomes in health, child welfare, education and juvenile justice (to become the test ZIP codes). I would then finding matching control ZIP codes based on racial make-up, socio-economic measures, and institutional outcomes. The design was predicated on a major assumption; that poor outcomes across systems were concentrated in particular geographic areas – in our case, ZIP codes.

I found little to no correlation between poor outcomes across systems in the data as analyzed. As a result, it was impossible to select test and control ZIP codes as I had planned.

Still, there correlation between race, ethnicity, education, income, wealth, and juvenile justice outcomes as we expected, which suggests that the Center should pursue further research along these lines.

IMPLICATIONS AND RECOMMENDATIONS:

The findings can be explained in several ways. The Center's theory may be wrong, the sample size may be too small, the data may be inaccurate, or the data may have been analyzed incorrectly.

Most of these explanations can be easily examined and the challenges overcome. The correlations we did find suggest that the theory is largely correct, so I suggest tweaking the current evaluation design and testing the theory further. The Center can request additional data to verify whether the current TEA and DFBS data are correct. With this first pass at analysis complete, the Center can adjust ratios and models to ensure correct analysis moving forward.

The biggest challenge will be if the sample sizes are indeed too small to draw conclusion on TEA and DFBS outcomes. If the data are too noisy to show even correlation between outcomes from different systems, the Center likely will not be able to show the impact of its intervention by looking at ZIP code level rates. While the Center could consider aggregated contiguous ZIP codes or using data from multiple years to increase the study power, both options would significantly dilute the usefulness of any findings.

In summary, I recommend the following:

1) The Center double-check the DFBS and TEA data that was provided for this study.
2) The Center redo the ZIP code analysis with 5 years of data to look for correlation between institutional outcomes. Even if the Center cannot document changes year to year, showing the

geographic intersection of poor outcomes would give significant credence to the Texas Model's focus on community level interventions.

3) Rather than examine relative rate indices within particular ZIP codes, the Center look at poor outcomes by ZIP code, and how the correlate with racial / ethnic make-up and socio-economic indicators.
4) The Center further explore methodologies from feminist research and community based participatory research for insight on how to best evaluate community-organizing-based interventions.

Although the evaluation did not come together as originally planned, the components of this MP should prove useful to the Center in the following ways:

1) We have developed a conceptual model that accurately describes the elements of their intervention.
2) I have linked each piece of the intervention and the Texas Model with supporting academic research.
3) The Center has identified target ZIP codes and I have provided some suggested 'control' matching ZIP codes.
4) We have uncovered significant challenges with the evaluation as originally designed, which can help guide the final evaluation plans.

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INTRODUCTION AND POLICY QUESTION:

Clear racial inequity across every measure of social, political, and economic well-being has been a challenge to the democratic principles of the United States since the country's inception. Although continued resistance by people of color and allies has led to significant gains (like the abolition of slavery, the end of legal segregation, and increased political representation for minorities), racial inequity persists. By many measures (including wealth and school segregation), racial inequity has worsened over the past three decades (Bonilla-Silva 2001).

Future forward movement will be particularly challenging because racial inequity in the post-civil rights era has been institutionalized and made mostly invisible. Many policies and practices today disproportionality benefit white communities, even though they do not explicitly target any particular racial group. As a result, today's interventions must have a clear and explicit understanding of how white privileges are created and maintained.

My Master's Project client – The Center for the Elimination of Disproportionality and Disparities (the Center) – aims to play a significant role in this effort. The Center is charged with reducing and eventually eliminating racial disproportionality and disparities that affect Texas children in child welfare, education, juvenile justice, mental health, and health. Established as part of the Texas Health and Human Services Commission (HHSC) in 2010, the Center hopes to apply a theory of systemic racism to the work of the HHSC, so that all Texans have equal opportunities and life chances, regardless of their race.

To do this, the Center has developed a set of guidelines of engagement for social service practice called "The Texas Model." The Model is designed to help practitioners who apply it be more effective in reducing racial inequity in their systems and communities, by addressing the underlying systemic causes of inequity.

Any social service provider can apply the model to their work. Center staff, however, specifically aims to eliminate racially disproportionate outcomes in Texas Health and Human Services through a unique intervention that embodies the components of the Model. This MP attempts to answer the

question: ***How should the Center for the Elimination of Disproportionality and Disparities evaluate its intervention?***

As is the case with any *theory-guided* intervention, an evaluation can serve multiple purposes; it can help improve programs, it can help improve policy, *and* it can create new or refine existing theories that undergird the methodology (Glasgow and Linnan 2008). A successful innovation may result in changes in outcomes, or a change in theory that leads new methodologies, which lead to a change in outcomes (Glasgow and Linnan 2008).

My client is applying existing theory in a new way. 'Institutionalized Racism,' they argue, is a root cause of racial disparities and disproportionality across systems and a primary obstacle to improving outcomes for *all* children. Therefore, institutions can only significantly change outcomes if they understand what racism is and how it works, and make corresponding changes at the institutional level.

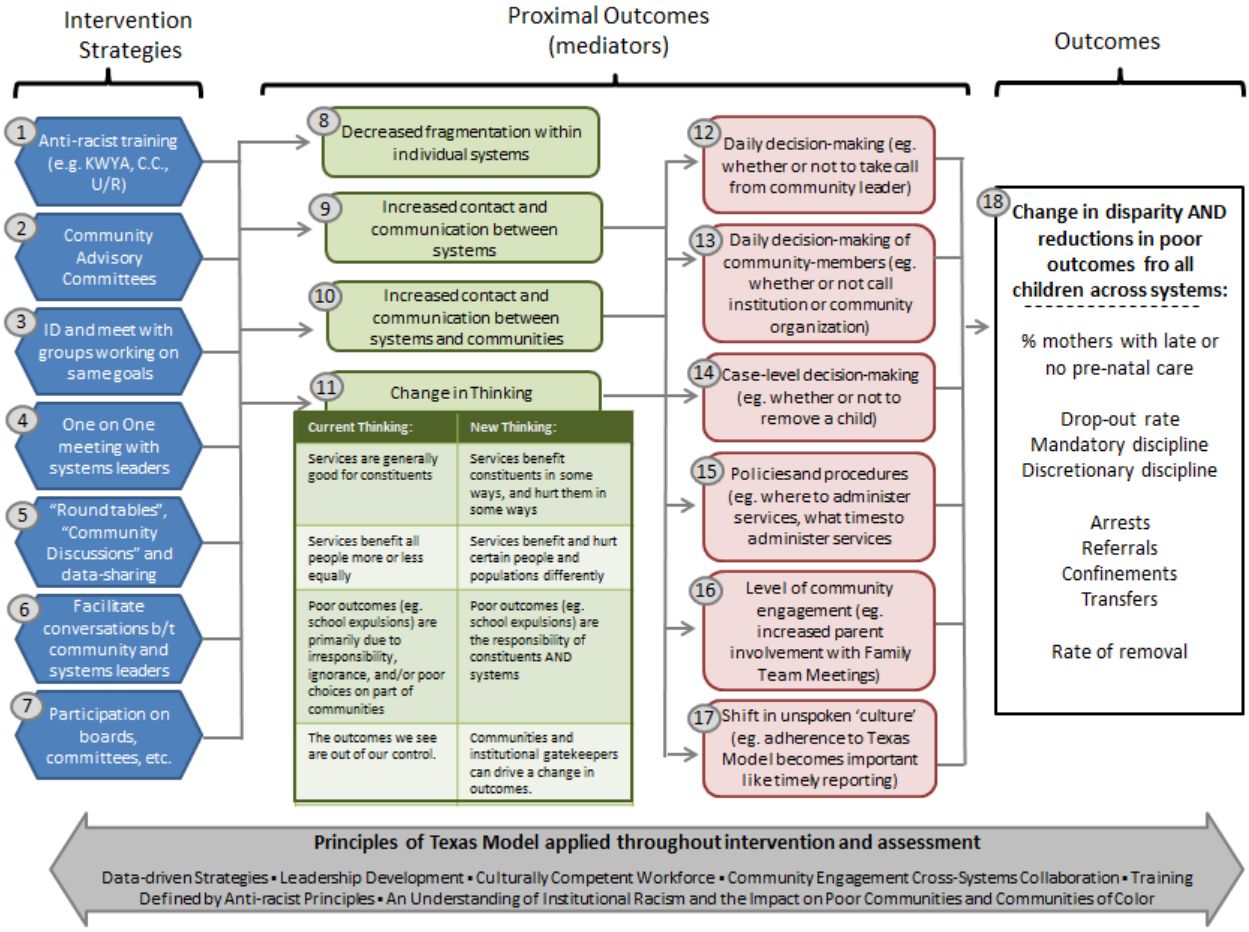
To create an evaluation of their *theory-guided intervention*, I had to work with the Center to clarify their intervention and the theory behind it. From there, we defined a methodology aimed to be politically and financially feasible, while maximizing the power and validity of the evaluation.

This MP serves as an explanation and analysis of the Center's intervention, the Texas Model and corresponding theory, and offers key insights for developing an evaluation. While I had intended to deliver a complete ready-to-implement evaluation plan, we were unable to verify several assumptions underlying the evaluation model, and the Center will need to make several corresponding changes .

DEFINING THE CENTER'S INTERVENTION

The Center's intervention was designed based on the Texas Model for the Elimination of Disproportionality and Disparities as applied to the elimination of disparities and disproportionality in the Texas health and human service systems of health, child welfare, juvenile justice, and education. The Center staff will engage in seven direct intervention strategies which are designed to impact health and human services outcomes over five years (see figure 1 for a conceptual model of the intervention).

Figure 1: Conceptual model of the Center's intervention



Seven direct intervention strategies will be implemented in the focus communities: 1, anti-racist training, 2, community advisory committees, 3, identifying and meeting with groups that have the same goals, 4, one-on-one meetings with systems leaders, 5, "round tables," "community discussions," and data-sharing, 6, facilitating conversation between community and systems leaders, and 7, participation on related boards, committees, etc. A core staff of 13 disproportionality specialists, plus Center managers and support staff will carry out the bulk of the work.

Anti-racist training is the first intervention strategy and is a cornerstone of the intervention. The training provides a common language and theoretical analysis for all involved, changes thinking of participants, and provides an opportunity to build relationships across and within systems and

communities. Participants will include systems leaders, systems workers, community leaders, community members, and those served by TXHHS systems.

The training modules the Center currently uses are the "Knowing Who You Are" training (KWYA - a day-long workshop developed in partnership with Casey Family Programs), "Crucial Conversations" (a three hour program developed by the Center) and the "Undoing Racism Workshop" (URW - a 2 ½ day training facilitated by the People's Institute for Survival and Beyond). The modules work together, complement one another, and are often offered in sequence. Crucial Conversations can help recruit people to participate in a full URW. KWYA often functions as a pre-cursor or follow up to the URW as it provides a more individualized experience that complements the content of the URW.

The Center qualifies all three programs as 'anti-racist' training because they embody the principles of anti-racist organizing as defined by the People's Institute. The principles include undoing racism, learning from history, sharing culture, developing leadership, maintaining accountability, networking, analyzing power, gatekeeping, undoing internalized racial oppression (internalized racial inferiority and superiority), and identifying and analyzing the manifestations of racism (The People's Institute).

Although the Center's definition of "anti-racist" grew from their relationship with the People's Institute, the concept is well established in other health and human service fields (Troyna 1987, Jones 2002, Nairn, Hardy et al. 2004). Anti-racist training is notably different than multi-cultural training in that it analyzes history, power relations, and institutional, cultural, as well as personal manifestations of racism. Fundamentally, anti-racist training uses an institutional analysis of racism rather than defining racism as primarily individual or psychological in nature.

In a review of anti-racist and multi-cultural training models in the context of nursing, one group of researchers summarizes key aspects of anti-racist and multi-cultural training in table 1.

Table 1: Multiculturalism vs. anti-racism

Multiculturalism	Anti-racism
Self-identity. Self-awareness of own culture.	Impact of racism on self-identity
Cross-cultural communication	Institutional racism. Communication influenced by power relations
Identifies cultural variations, misunderstandings between cultures, cultural insensitivity.	Identifies racism, prejudice and bigotry, and oppressive practices.
Emphasizes cultural knowledge	Emphasizes socio-political context

Source: (Nairn, Hardy et al. 2004)

While academics have argued back and forth significantly about the value and pitfalls of anti-racism training (Lawrence and Tatum 1997, Jones 2002, Nairn, Hardy et al. 2004, Niemonen 2007) a number of studies show its effectiveness. Studies in education, child welfare, and child health services showed anti-racist education changed thinking for participants and impacted future actions in ways that are consistent with the Center's model (Lawrence and Tatum 1997, Webb and Sergison 2003, Johnson, Antle et al. 2009).

Center staff will spend the majority of their anti-racism training efforts getting the right people into the room through one-on-one conversations, resource and data-sharing, group presentations, and long-term relationship building. To date, Center staff has successfully recruited TXHHS clients, high-level administrators, and all levels of community leadership and middle management to the trainings. Center staff will also raise money and coordinate logistics necessary for the trainings.

The second intervention is to establish and maintain active community advisory committees (CACs) in the test communities. CACs enable critical vertical and horizontal communication between systems and communities. At monthly meetings, the CACs share stories, experiences, data, and strategies to enhance system performance, build social capital, and discover opportunities for collective work.

CEDD will expand and nurture established CACs[1] in addition to establishing new committees as needed. CACs must contain families and youth served by TXHHS as well as cross-systems representation from the criminal and juvenile justice systems, the education and health care systems, law enforcement, the judiciary, faith-based communities, and other community-based organizations.

As the third and fourth interventions, Center staff will identify and meet with groups that have the same goals and arrange one-on-one meetings with systems leaders. By meeting with statewide groups like the Texas Diversity Committee, the NAACP, local groups such as churches on parent teacher associations, or leaders inside of TXHHS systems, disproportionality specialists share data, find opportunities for strategic partnerships, increase buy-in for the Center's work, and recruit participants and champions for their work.

Fifth, "round tables" and "community discussions" are another way that Center staff creates opportunities to share data, develop strategies, and build relationship with the communities of TXHHS constituents. Employing techniques from community organizing, Center staff will seek opportunities to partner with organizations and community leadership that have existing grassroots constituencies.

Sixth, Center staff will facilitate conversations between community and systems leaders, when appropriate. For example, if a parent teacher association finds that a large number of its children are having trouble with the juvenile justice system, they may benefit from building a relationship with their county judge. By employing their social capital and institutional position, Center staff could help arrange a meeting.

[1] DFBS established numerous CACs are part of their disproportionality work in effect since the early 2000s.

Finally, staff may participate on boards or committees of organizations that have an impact on outcomes in target communities. By participating on a mayoral public health task force, for example, a specialist builds social capital that will benefit other activities, and can ensure that racial disproportionality and strategies that address institutional racism are consistently on the agenda as the task force attempts to address public health issues.

These seven interventions, in theory, contribute to four first-stage proximal outcomes: decreased fragmentation within individual systems, increased contact and communication between systems, increased contact and communication between systems and communities, and a change in thinking among all involved. The first three, in theory, contribute significantly to the change in thinking. The rest of the intervention depends on the change of thinking taking place.

The Center aims to cause four main shifts in thinking for stakeholders. First, stakeholders should come to understand that services and programs do not always benefit constituents. Instead, they benefit constituents in some ways, and hurt them in some ways. Second, services benefit and hurt certain people and populations differently. Third, constituent communities do not cause poor outcomes (eg. school expulsions) primarily because they are irresponsible, ignorant, and/or make poor choices. Instead, constituents AND systems are responsible for creating poor outcomes. Fourth, outcomes are not out of stakeholders' collective control. Instead, communities and institutional gatekeepers can work collectively and drive a change in outcomes.

Direct research supports the assumption that anti-racist training will contribute to the desired changes in thinking (Lawrence and Tatum 1997, Webb and Sergison 2003, Johnson, Antle et al. 2009). Social capital theory and research on provider bias also support the Center's assumption that increased communication and contact between and within systems and communities will also contribute.

Social theorists identify 3 main types of social capital: bonding (strengthening existing relationships), bridging (building new relationships), and linking (fostering new linkages between community members and community organizations) (Walter 2012). By bringing diverse stakeholders together to reflect on their work, their relationships, and their goals for their community, the Center is fostering the development of social capital.

New social capital, in turn, directly impacts thinking - perceptions of the world, self and community. Social capital can foster belief in the power of collectivity, belief in the effectiveness of one's own actions, and belief that one can influence political processes, organizations, and communities (Wallerstein 2006, Attree, French et al. 2011). In this way, increasing social capital changes thining and stakeholders come to believe they can drive outcomes by working collectively.

While examples of social capital development largely focus on the community of constituents, providers must also change *their* thinking (as opposed just patients or clients changing their thinking) to reduce racial disproportionality (Burgess, Van Ryn et al. 2007). For example, providers likely make decisions that contribute to disparities because of their implicit bias. Even controlling for client class-status, providers see African Americans as *more* personally responsible for their poverty than whites (Rivaux, James et al. 2008, Dettlaff, Rivaux et al. 2011). One way decrease provider bias is through engagement with client communities. Even outside of a formal community-building process, engagement with client communities can reduce provider fear, provider bias, and even change provider actions (Stephan and Stephan 2001, Burgess, Fu et al. 2004, Stein, Frankel et al. 2005, Pettigrew and Tropp 2006, Baumann, Dalgleish et al. 2011).

The second crucial premise of the model is that increased contact, increased communication, and changes in thinking will translate into changes in behavior. The new thinking, contact, and communication should impact: daily decision-making of systems representatives (eg. whether TXHHS staff takes a call from community leader in the middle of a busy day); daily decision-making of

community-members (eg. whether or not call an institution or community organization); case-level decision-making (eg. whether or not to remove a child); policies and procedures (eg. where to administer services, or what times to administer services); the level of community engagement (eg. increased parent involvement with Family Team Meetings); and the unspoken 'culture' within HHSC and related organizations (eg. adherence to Texas Model becomes important like timely reporting).

Providers (in education and social work) do in fact change day-to-day and case-level decision-making patterns as a result of training and increased contact with constituent communities (Lawrence and Tatum 1997, Sleeter 2001, Sheets, Wittenstrom et al. 2009, Texas Department of Family and Protective Services 2010). Constituents, likewise, are more likely to take action in their own interest when they change their perceptions as a result of increases in social capital (Minkler, Wallerstein et al. 1997, Wallerstein 2006).

Increased communication and contact change decisions and actions on a collective level as well. Theory of cognitive diversity helps explain how. A collective that is diverse in functional expertise, training, and background has a larger aggregate knowledge-base and can more effectively locate gaps and connections within existing knowledge-bases (De Dreu and West 2001, Burt 2004, Page 2008). The benefits of contact and communication between diverse team members are particularly salient when solving social problems -like racial inequity - that are influenced by a broad network of people, organizations, and communities (Gray 1989, Zuckerman, Kaluzny et al. 1995, Lasker and Weiss 2003) and when – as is the case with the Center – stakeholders seek out and value difference and strategic collaborations (Homan, Van Knippenberg et al. 2007, Mitchell, Nicholas et al. 2009).

Social capital theory also helps understand the ways that contact and communication can have significant results on decisions and actions specifically related to racial inequity. Szreter and Woolcock note in a discussion on health:

> [Social capital theory] places great emphasis on whether or not these relationships are founded on mutual respect between people, differentiated either horizontally by their varying social identities or vertically by their access to different levels of power and authority…
>
> …the linking social capital concept indicates that in addition to such physiological impacts, if relationships of trust and respect deteriorate between the poor and the range of more privileged people in their lives who are involved in delivering the essential public services of education, health, and social security, then the capacity of the poor to acquire, utilize and benefit from health-enhancing material goods will be seriously compromised (Szreter and Woolcock 2004).

Said in reverse, if relationships of trust and respect are *developed* between the poor and the people who deliver their essential public services, the poor will greatly *expand* their capacity to acquire, utilize and benefit from goods and resources. Relationships (contact and communication), in other words, cause the poor to take new actions.

In the last step of the Center's model, changes in decision-making and actions should have an impact on target communities in the areas of health, education, child welfare, and juvenile justice. The intervention aims to cause an overall decrease in negative outcomes as well as a reduction in the relative rate index between blacks and whites in each example. In health, the Center hopes to impact Cesarean sections that are not medically indicated (as a percentage of total births) and inductions before 36 weeks (as a percentage of total births). In education they hope to impact students classified as "at-risk," drop-outs, mandatory discipline, and discretionary discipline (each as a percentage of total enrollment). In juvenile justice, they hope to impact arrests (as a percentage of total juvenile population), referrals (as a percentage of total juvenile population), confinements (as a percentage of total petitions), and transfers (as a percentage of total petitions). In child welfare, they will target removals (as a percentage of total investigations).

Because of the large number and complexity of factors that contribute to outcomes in these systems, the Center chose metrics that it feels TXHHS providers and policies could impact in 3 – 5 years. All of the metrics the Center plans to impact are currently being tracked by TXHHS or a related organization.

THE THEORY BEHIND THE INTERVENTION: INSTITUTIONALIZED RACISM AS A ROOT CAUSE

To evaluate the Center's work, it is important to understand the Center's theory of "institutionalized racism" as the root cause of disproportionality and disparities and the Texas Model - their guidelines for engagement.

By "institutionalized racism," the Center refers to the "racialized social system" of the United States, as defined by Eduardo Bonilla-Silva: a society "in which economic, political, social, and ideological levels are partially structured by the placement of actors into racial categories or races" (Bonilla-Silva 1997).

U.S. and Texas-level data support this theory. National disparities and disproportionalities have been documented in education, child welfare, juvenile justice, and health – each and every system the Center is charged to address. In each case, the racial inequity is classified as persistent, uncomfortably high, indisputable, pervasive, or unchanging (Courtney and Skyles 2003, Harris and Herrington 2006, Kempf-Leonard 2007, Flores 2010).

Despite the striking similarity of racial inequity across systems, different fields have developed different language to explain it. In health, researchers usually call racial inequity 'disparities;' in education, 'achievement gaps;' in juvenile justice, 'disproportionate minority contact;' and in child welfare, 'disproportionality.' The siloed language may discourage practitioners from looking to other systems for insights or for root causes that impact all systems. Table 2 outlines terms describing racial inequity, general definitions, and the systems where terms are commonly used.

Texas outcomes show the same pattern; racial inequity exists in every system. The chart in figure 2 shows data from TX agencies and a number of statewide studies in education (Fowler, Lightsey et al.

2007), child welfare (Texas Department of Family and Protective Services 2009), juvenile justice (Texas Juvenile Justice Department 2010), and criminal justice (Texas Department of Criminal Justice 2009, Texas Department of Criminal Justice 2010, Texas Department of Criminal Justice 2010).

Table 2: Terminology used to describe racial inequity in different systems

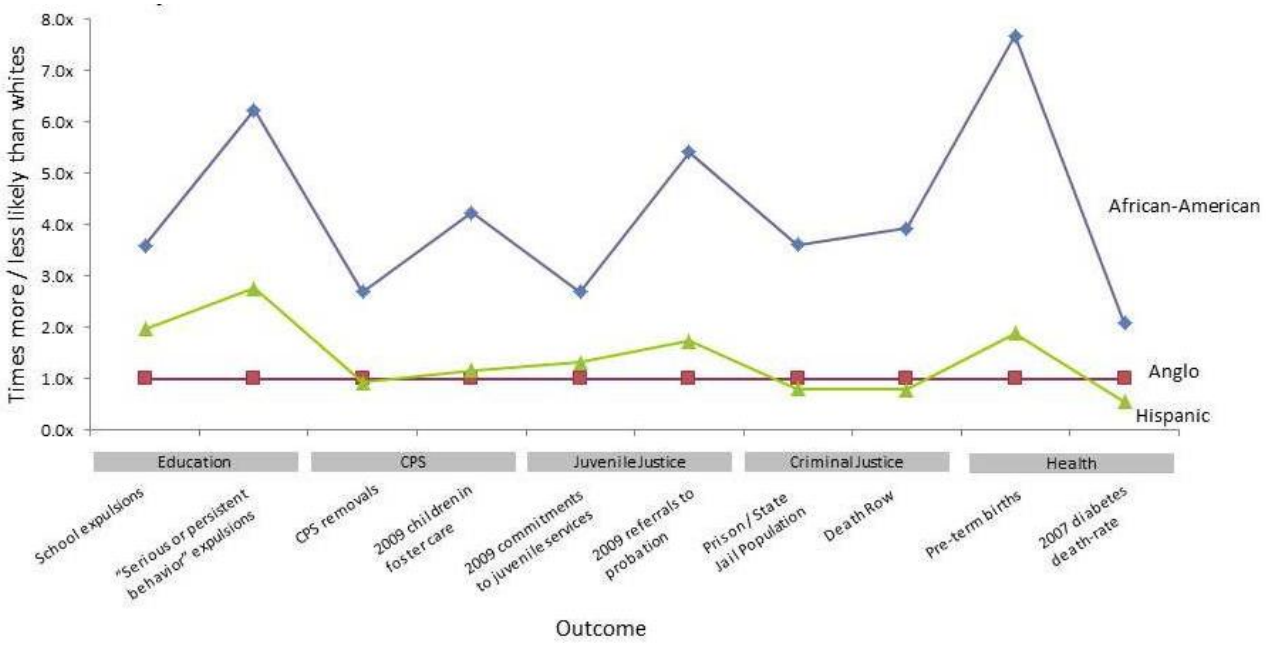
Term	**Definition***	**Commonly used in:**
Disproportionality	The fact that some racial or ethnic groups of families and children are represented in various child welfare services populations at levels that are disproportionate to their numbers in the overall family or child population.[A]	Child welfare
Health Disparity	Differences in health outcomes and their determinants between segments of the population, as defined by social, demographic, environmental, and geographic attributes.[B]	Health and mental health
Disproportionate minority contact (DMC)	The disproportionate number of minority youth that come into contact with the juvenile justice system.[C]	Juvenile justice
Achievement gap	The difference in the performance between each Elementary and Secondary Education Act (ESEA) subgroup (Overall, Asian, Black, Hispanic, White, Free or Reduced Price Meals, Limited English Proficient Students, and Special Education Students) within a participating Local Education Authority (LEA) or school and the statewide average performance of the LEA's or State's highest achieving subgroups in reading/language arts and mathematics as measured by the assessments required under the ESEA.[D]	Education

*Note: Practitioners within a discipline often disagree about precise term definitions. These examples are drawn from reputable organizations and are intended to illustrate the general degree of similarity across systems.
Sources: A - (Courtney and Skyles 2003) B - (Center for Disease Control and Prevention 2011) C - (U.S. Department of Justice Office of Justice Programs 2012) D - (U.S. Department of Education 2012)

Clear disproportionality exists in each system. The y-axis of the chart is a relative rate index, and expresses how many times more or less likely than whites someone of a particular race is to end up in each category. The x-axis is a set of metrics from education, child welfare, juvenile justice, criminal justice, and health. The two metrics from each system are intended to provide a general sense of how each racial group fares in each system. For example, for education the chart includes expulsions and "serious or persistent behavior" expulsions. In health the chart includes pre-term births and age-adjusted deaths from diabetes.

Also relevant to the Center's work (but not included in the chart), Texas children face a racial achievement gap (Linton and Kester 2003) in education, disparities in health access (Waidmann and Rajan 2000), and disparities in health outcomes (Lackey 2012).

Figure 2: Racial inequity by system in Texas



Source: Center for the Elimination of Disproportionality and Disparities, *Texas Cross-Systems Data.pdf*

Several aspects of the racialized social system framework explain the patterns in the data. First, a racialized social system is built around a racial hierarchy. In the U.S. the racial hierarchy was established with whites on top and blacks on bottom (Feagin 2006, Bonilla-Silva 2010). Outcomes in Texas - with African Americans nearly always fairing worst and whites nearly always faring best – corroborate this theory.

Second, institutionalized racism operates simultaneously in all systems at once. Racially disparate outcomes are not a failure of any one system in particular. In fact, they are not a failure or an aberration, but rather the expected outcomes of the underlying racialized social system. The persistent and parallel nature of disparate outcomes nationally and in Texas corroborates this piece of the theory.

Third, in a racialized social system whites (and some people of color) develop an all-encompassing racial frame ("an organized set of racialized ideas, stereotypes, emotions, and inclinations to discriminate") (Feagin 2006). This frame explains and interprets existing inequity, encourages actions consistent with the frame, and changes as necessary to rationalize the inequality (Feagin 2006, James 2008, Bonilla-Silva 2010). A racial frame that actively discourages whites from perceiving the systemic nature of racism (Feagin 2006, Bonilla-Silva 2010) explains why practitioners and researchers would continue to analyze racial inequity at the level of each individual system, without analyzing clear parallels in the inequity across systems.

GUIDELINES FOR ENGAGEMENT: THE TEXAS MODEL FOR ADDRESSING DISPROPORTIONALITY AND DISPARITIES

Given their analysis of the problem and the data that supports their view, the Center developed the Texas Model . The Model is comprised of seven guidelines for engagement to guide the work of practitioners who want to ensure that their interventions address the root cause of institutionalized racism. Although each component of the model has been tested and recommended by practitioners and researchers in other fields, the combination and simultaneous implementation of all seven is unique.

The first component is "data-driven strategies: all data collection, research, evaluation, and reporting includes a breakdown by race and ethnicity. Data is compared to the racial and ethnic populations of a defined area. Data is examined from a systemic and cross systems perspective and shared transparently with systems and the communities affected by the data outcomes." Data collection by race and an analysis of that data with a holistic, cross-systems, and historical perspective has been advocated by academics and practitioners working to expose the structural nature of racism as well as those working to eliminate disparities or disproportionality within a particular system (Bonilla-Silva 2001, Smedley and Stith 2003, Nellis 2005, Feagin 2006, Pager and Shepherd 2008, National Partnership for Action to End Health Disparities 2011).

The second component is "leadership development: develop both systems and community leaders grounded in training defined by anti-racist principles and who are willing to support internally and externally individuals within the same leadership framework." Community organizing, public health, and empowerment models have documented the importance of deliberate leadership development among constituents (Alinsky 1989, Chisom and Washington 1996, Minkler, Wallerstein et al. 1997, Leary 2005, Wallerstein 2006, Gutierrez and Lewis 2012) as well as system's representatives (Chisom and Washington 1996, Feagin 2006, Bonilla-Silva 2010, Baumann, Dalgleish et al. 2011). Race-conscious leadership development is particularly important when addressing racial disparities or problems affecting communities of color (National Partnership for Action to End Health Disparities 2011, Gutierrez and Lewis 2012).

The third component is "culturally competent workforce: develop workforce that reviews and examines its work through an anti-racist and humanistic lens." Although some institutions have failed to take up workforce development that is anti-racist (as opposed to multi-cultural), a growing number of practitioners and researchers are demanding it (Troyna 1987, Chisom and Washington 1996, Jones 2002, Nairn, Hardy et al. 2004, Leary 2005, Sullivan and Artiles 2011).

The forth component is "community engagement: recognize strengths of grass roots community, hear its ideas, and include community throughout process." Community engagement is consistently recommended as a necessary strategy to address racial and ethnic disparities and problems connected to poverty (Minkler, Wallerstein et al. 1997, Szreter and Woolcock 2004, Wallerstein 2006, National Partnership for Action to End Health Disparities 2011).

Fifth is "Cross-systems collaboration: share data, training, and dialogue with systems, institutions, and agencies that serve the same vulnerable populations." Due to the interconnectedness of results across systems, many researchers an practitioners demand a multi-systems approach (Gray 1989, Zuckerman, Kaluzny et al. 1995, Lasker and Weiss 2003, Feagin 2006, National Partnership for Action to End Health Disparities 2011).

Sixth is "training defined by anti-racist principles: train staff and partners in principles that ensure work at culturally, linguistically, and institutionally appropriate levels." Many recommend anti-racist training over multi-culturalism (Troyna 1987, Chisom and Washington 1996, Nairn, Hardy et al. 2004, Leary 2005, Sullivan and Artiles 2011).

Seventh is "an understanding of the history of institutional racism and the impact on poor communities and communities of color: develop common analysis of racism and history that led to current outcomes." A racialized social systems analysis clearly shows how class inequalities were formed and maintained in part by racial inequities and vice-versa (Jones 2000, Bonilla-Silva 2001, Krieger 2003, Feagin 2006). Rather than struggling to distinguish which poor outcomes are caused by race and which poor outcomes are caused by class, the Center examines how history and institutionalized racism explain *why* race and class are so highly correlated. The Center also studies and addresses the ways poverty and racism contribute to poor outcomes for all Texans. Researchers from a number of fields have stressed the importance of understanding the historic and current intersections of race and class (Krieger 2003, Daniels and Schulz 2006, Bankhead and Erlich 2008, James 2008, Gee and Ford 2011, Gutierrez and Lewis 2012).

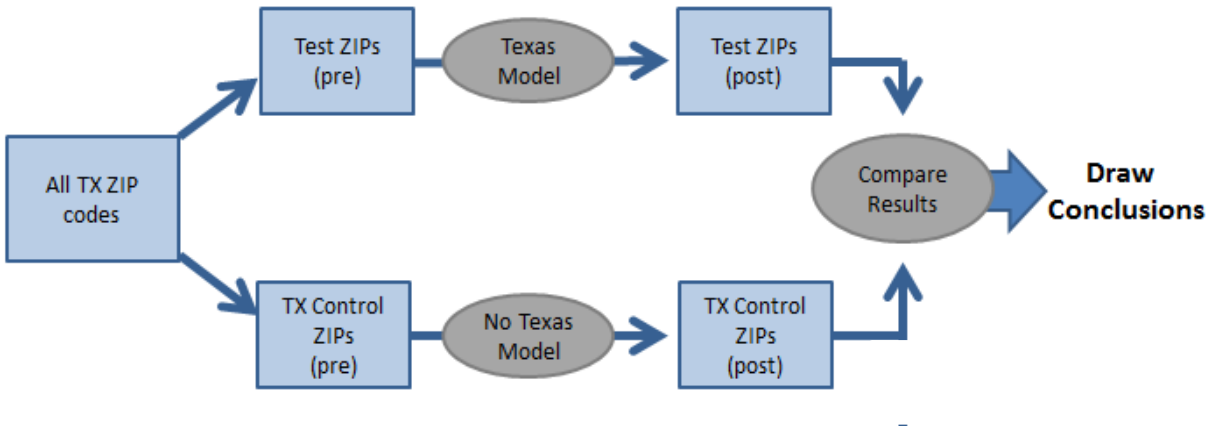
THE EVALUATION DESIGN:

Initially, I had recommended a basic model that would compare pre and post outcomes in a set of control groups and a set of test groups (see figure 3 for design). From the set of Texas ZIP codes in metropolitan areas, the center would select three to five test ZIP codes to treat.

I intended to track a series of relative rate indices comparing whites, African Americans, and Hispanics in the systems of education, child welfare, juvenile justice, health and mental health. If the test groups demonstrated a reduction in disparities (excepting a reduction in disparities cause by a worsening of outcomes for whites), an improvement in overall outcomes, or both, the intervention would be deemed a success.

The key to the evaluation was finding three – five "control" zip-codes to leave alone so the Center could observe changes in proximate and distal outcomes between the test and control groups (see figure 3 below). Based on my clients experience in the field, we expected to find high correlation between poor outcomes in particular ZIP codes. We hypothesized, for example, that in ZIP codes where school systems were classifying large numbers of students as 'at risk', we would also find that courts were trying more children as adults, and that child welfare workers were removing more children per investigation than in other areas. The test and control ZIP codes would be those ZIP codes that showed poor outcomes and high racial disparity across outcomes. We would then match control and test ZIP codes by matching on racial makeup, educational attainment, wealth, and income.

Figure 3:Evaluation design



Unfortunately, that strategy did not work as planned. In assembling the data to determine the test and control ZIP codes and establish baseline measurements, I found that the sample-sizes at the ZIP code level were too small to provide any meaningful conclusions. The Center will need to consider other options for evaluating the effectiveness of the intervention. Still my analysis should prove useful in demonstrating the challenges associated with ZIP code-level analysis as originally proposed.

THE DATA SET:

In order to select ZIP codes and to establish baseline outcomes, I built a data set that included demographic and institutional outcome measures by ZIP Code seven major metropolitan statistical areas: Austin-San Marcos, Beaumont-Port Arthur, Corpus Christi, Dallas-Fort Worth, El Paso, Houston-Galveston-Brazoria, San Antonio, and Waco. I focused on the metropolitan areas specifically, because we suspected that the sample sizes in rural ZIP codes would certainly be too small to draw any meaningful conclusions.

I began by using ZCTA census data from 2010 for basic demographic characteristics; I included population size and density, racial and ethnic make-up, age, educational attainment, average household net worth, and median household income.

I also received institutional outcome data by ZIP code from the Texas Education Association (TEA), the Texas Department of Family Based Services (DFBS), and the Texas Juvenile Justice Department (TJJD). Due to additional institutional review board requirements, I did not receive the health data in time to include it in the analysis.

For the TEA, DFBS, and TJJD data, I created a series of ratios to examine overall prevalence of poor outcomes for a particular ZIP code as well as relative rate indices to examine the degree of racial disparity. Specifically, relative rate indices measure the times more or less likely than a white person that a Black or Latino person is to experience a particular outcome. I kept the disparity analysis to comparisons between Blacks, Latinos, and Whites because the small numbers of Asians and Native Americans in Texas make the data unreliable. I calculated the following rations (for the total population and as relative rate indices) for each ZIP code: students at risk per total students enrolled (education); students dropping out per total students enrolled (education); cases of discretionary discipline per total students enrolled (education); cases of mandatory discipline per total students enrolled (education);

removals per total number of investigations (DFBS); referrals to JJD per total youth population (TJJD); petitions per total referrals (TJJD); probations per total petitions (TJJD); youth sent to corrections per total petitions (TJJD); youth certified as adults per total petitions (TJJD); and youth receiving supervisory caution per total petitions (TJJD). With the ratios and census information aggregated into a single data-set, I could to look at the relationship of different outcomes at the ZIP code level and suggest a set of test ZIP code for the Center to focus its intervention.

In a final step of data analysis, I created a correlation table to test our hypothesis that poor outcomes would be correlated and concentrated in particular ZIP codes (Table 3). In theory, upon establishing that poor outcomes are concentrated in certain ZIP code areas, we would be able to locate which metropolitan ZIP codes in the state were facing the worst outcomes.

FINDINGS:

As analyzed, the data show little to no correlation between educational outcomes (children at risk, dropout rates, discretionary discipline), juvenile justice outcomes (referrals to juvenile detention, and petitions per referral), and child welfare outcomes (rate of removal) in the data as analyzed. 13 of 15 of the relationships between outcomes have a correlation coefficient below .12 or above -.07, suggesting very weak relationships between the outcomes in different systems. Only two relationships show stronger correlation, and even those are still relatively weak. Dropouts / students enrolled correlates with referrals / total youth population with a coefficient of .2 and referrals / total youth population correlates with petitions / referrals with a coefficient of -.33,

The ZIP code analysis does show consistent correlation between race and education, race and net worth, and race and income, as we expected. The percentage of a ZIP code population that is white is correlated with Bachelor's level education (correlation coefficient of .4), higher HH net worth (correlation coefficient of .56), and higher media HH income (correlation coefficient of .56). The percentage of a ZIP

code population that is Black is also consistently negatively correlated with higher education (-.16), HH net worth (-.26), and HH income (-.27). The % Hispanic of a particular ZIP code population is highly negatively correlated with bachelor's level education (-.51), HH net worth (-.59), and median HH income (-.56). While we expected these relationships, the results do help provide evidence that place-based interventions make sense for any problem associated with poverty or wealth.

In addition, the juvenile justice outcomes are correlated with race, wealth, education, and income in the ways we would expect. The percentage of a ZIP code population that is white is negatively correlated with referrals / total youth population (-.19) and petitions / referrals (-.18). Percentage Black (.17 and .12), percentage Hispanic (.16 and .15), percentage with only a high school education (21 and .07) and all correlated with worse juvenile justice outcomes as we expected. Bachelor's level education (-.26 and -.13), HH net worth (-.34 and -.15), and HH income (-.36 and -.15) are all negatively correlated as we expected.

Because of the lack of correlation between outcomes, I was unable to select test ZIP codes that had poor outcomes across measures. However, the data set did allow me to identify 'matching' ZIP codes for the ZIP codes where the Center is currently working (75216, 78723, 78745, 78758, 77004, 77009, 77016, 77020, 77021, 77033. 77047, 77048, 77051, and 77088).

Using a simple excel model, I identified at least three 'matching' ZIP codes for each target ZIP code. A ZIP code is considered a match if it approximates the target ZIP code on the following measures: % White, % Black, % Hispanic, % High school, % Bachelors, % Undocumented, Average HH Net Worth, and Median HH Income. Matching ZIP codes come within .3 standard deviations of the target ZIP code on at least 5 (and in most cases 7) of the above metrics. Table 4 shows the target ZIP codes, potential matches, and the associated metrics.

DISCUSSION:

The lack of correlation between institutional outcomes could be explained by a number of factors. First, the Center should consider that the hypothesis that poor outcomes are concentrated in certain communities could be false. This is unlikely, however, given that race, income, net worth, and education do show consistent correlation in our analysis, and all of those measures have been shown to correlate with institutional outcomes. Furthermore, the direction of correlation between juvenile justice outcomes and demographic and socio-economic indicators was precisely predicted by our theory, suggesting that our theory is at least partially correct.

More likely, the data we compiled was insufficient, inaccurate, or incorrectly analyzed to be able to test our hypothesis. Our sample size may have been too small. With only one years' worth of data for each ZIP code, the data may be too noisy to show any clear correlation. Another possibility is that the data we received from TEA and DFBS was inaccurate. Lastly, it some cases, it seems possible that we selected the wrong ratios for analysis. By looking at removals per investigations, for example, we do not account for the fact that in communities where children are more likely to be removed, children are probably also more likely to be investigated. Therefore, using as investigations for a denominator and removals as a numerator, the ZIP code to ZIP code variation in one may cancel out the variation in another.

In the case the relative rate indices, ZIP code analysis may also pose challenges. By comparing Blacks *in a particular ZIP code* to Whites *in that same ZIP code*, we essentially control for the effect of neighborhood segregation on racial inequity. In other words, if a majority Black school is underfunded because of institutionalized racism, white children in that school will also be more likely to be classified 'at risk.' By looking at within ZIP code relative rates, we overlooked the fact that white students are much less likely to find themselves in ZIP codes with low-performing public schools.

These findings call for a re-examination of the proposed methodology of this evaluation. If the data are too noisy to show even correlation between outcomes from different systems, the Center likely will not be able to show the impact of its intervention by looking at ZIP code level rates.

One potential way to correct for the small sample size would be to pool multiple years of data for each ZIP code. If the Center were to use this approach, however, it would dilute any changes that happened over the three to five year period of the intervention.

The Center could also consider aggregating ZIP codes into larger clusters of ZIP codes or look at entire cities, but the larger the aggregation of geographic areas, the harder it becomes to isolate the impact of the intervention. Comparing cities to cities, for example, or counties to counties, is less helpful because 1) there are many city- and county-level factors that would contribute to differences between control and test areas and 2) the Center's intervention operates at the community-level, which is more closely approximated by ZIP-codes than by cities or counties.

If the data are inaccurate, a simple re-draw of the data will correct the problem. Problems with the analysis of the data can be rectified by reassessing the evaluation methodology.

RECOMMENDATIONS:

In light of the challenges associated with the proposed analysis, I suggest that the Center redo the ZIP code analysis with 5 years of data to look for correlation between institutional outcomes. In the process, the Center can check the TEA and DFBS data provided for this study, to ensure its accuracy.

If there are problems with the data itself, the corrections will be simple. If the problem is with sample-size, there will still be a significant benefit; showing the geographic intersection of poor outcomes would give significant credence to the Texas Model's focus on community level interventions.

In addition, rather than focusing relative-rate indices within ZIP codes, the Center should look for correlations between poor outcomes in a ZIP code and the racial / ethnic makeup of that ZIP code. With 5

years of data, the Center should also be able to test and see whether relative rates within particular ZIP code are exacerbated or ameliorated by changes in demographics and socio-economic indicators.

Finally, I suggest that the Center take explore additional approaches to evaluation – based on the methodologies created in feminist research, the field of public health, and community based participatory research. While my MP is certainly part of a larger participatory evaluation process, many organizations, research, and communities have struggled with and learned from attempts to document the success of community-organizing-based interventions(Eng and Parker 1994, Yonas, Jones et al. 2006, Minkler and Wallerstein 2010, Coombe 2012). These learning could provide invaluable insight for the Center moving forward.

Table 3: Correlation Coefficients of Census Data and Total Population Rates

	% White	% Black	% Hispanic	% Highschool	% Bachelors	Average HH net worth	Median HH income	% Undocumented	At risk / total enrollment	Dropouts / total enrollment	Discretionary discipline / total enrollment	Removals / investigation	All referrals / total youth population	All petitions / referrals
% White	1.00													
% Black	-0.50	1.00												
% Hispanic	-0.80	-0.06	1.00											
% Highschool	-0.10	0.13	0.18	1.00										
% Bachelors	0.40	-0.16	-0.51	-0.87	1.00									
Average HH net worth	0.56	-0.26	-0.59	-0.62	0.82	1.00								
Median HH income	0.56	-0.27	-0.56	-0.57	0.78	0.95	1.00							
% Undocumented	-0.64	0.12	0.59	-0.12	-0.18	-0.34	-0.41	1.00						
At risk / total enrollment	-0.05	0.00	0.07	-0.07	0.03	0.01	0.00	0.06	1.00					
Dropouts / total enrollment	-0.23	0.10	0.21	-0.10	-0.01	-0.21	-0.24	0.20	0.03	1.00				
Discretionary discipline / total enrollment	-0.16	0.03	0.13	-0.29	0.20	0.02	-0.03	0.18	0.12	0.11	1.00			
Removals / investigation	0.10	-0.03	-0.09	0.02	-0.03	-0.01	-0.06	-0.03	0.00	0.01	-0.07	1.00		
All referrals / total youth population	-0.19	0.17	0.16	0.21	-0.26	-0.34	-0.36	0.14	0.04	0.20	0.09	-0.05	1.00	
All petitions / referrals	-0.18	0.12	0.15	0.07	-0.13	-0.15	-0.15	0.07	-0.04	0.14	0.07	-0.07	-0.33	1.00

Table 4 – part 1: Target and 'Matching' ZIP codes with statistics

Category	Zip	City	Population	Population Density	% White	% Black	% Hispanic	% Highschool	%Bachelors	% Undocumented	Average HH NW	Median HH Income
Dallas	75216	Dallas	49,416	3,340	2.27	65.85	30.77	35.83	4.08	13%	$ 234,792	$ 24,690
Match 1	78202	San Antonio	11,691	5,029	5.34	27.66	65.65	36.18	3.34	16%	$ 194,621	$ 22,254
Match 2	77701	Beaumont	14,674	2,049	10.13	55.41	30.73	30.40	4.49	16%	$ 229,273	$ 29,968
Match 3	75215	Dallas	14,648	1,701	5.95	78.42	13.91	34.48	4.86	6%	$ 234,074	$ 22,641
Austin	78723	Austin	28,330	4,083	29.35	23.88	42.94	20.91	18.52	24%	$ 384,259	$ 46,704
Match 1	78240	San Antonio	51,111	4,512	35.39	6.33	47.66	20.99	23.43	7%	$ 346,679	$ 50,695
Match 2	75062	Irving	44,537	4,020	35.00	11.99	42.43	24.67	18.02	23%	$ 377,145	$ 47,657
Match 3	75231	Dallas	37,052	6,543	26.00	21.76	43.41	23.09	18.25	34%	$ 305,922	$ 35,473
Austin	78745	Austin	55,614	4,166	49.13	4.20	42.49	21.66	24.12	12%	$ 381,432	$ 53,150
Match 1	78240	San Antonio	51,111	4,512	35.39	6.33	47.66	20.99	23.43	7%	$ 346,679	$ 50,695
Match 2	75006	Carrollton	46,364	2,705	37.17	7.16	46.78	23.66	19.67	22%	$ 431,980	$ 59,529
Match 3	78155	Seguin	45,341	127	49.19	5.17	43.87	34.14	11.38	4%	$ 384,871	$ 51,890
Austin	78758	Austin	44,072	4,747	32.37	10.21	48.80	21.01	21.91	30%	$ 346,424	$ 47,961
Match 1	78240	San Antonio	51,111	4,512	35.39	6.33	47.66	20.99	23.43	7%	$ 346,679	$ 50,695
Match 2	78216	San Antonio	40,267	2,807	39.31	4.32	52.88	22.80	21.72	9%	$ 354,601	$ 51,725
Match 3	75042	Garland	37,881	5,063	24.83	9.85	51.37	23.09	9.91	29%	$ 335,560	$ 47,790
Houston	77004	Houston	32,692	5,634	21.67	57.43	12.48	21.51	20.62	10%	$ 352,877	$ 38,090
Match 1	75243	Dallas	55,406	6,359	25.28	39.78	25.61	22.87	21.25	18%	$ 344,827	$ 43,000
Match 2	76102	Fort Worth	8,111	1,799	49.90	27.57	19.34	21.77	22.11	6%	$ 382,563	$ 35,719
Match 3	77708	Beaumont	11,518	1,609	28.34	60.89	7.93	40.69	11.43	2%	$ 293,463	$ 42,577
Houston	77009	Houston	38,094	6,156	23.11	6.28	68.75	23.08	12.53	20%	$ 375,975	$ 47,138
Match 1	78404	Corpus Christi	17,236	5,548	30.19	1.89	66.38	25.76	12.73	5%	$ 325,723	$ 42,095
Match 2	76110	Fort Worth	30,434	5,264	27.07	3.62	66.67	22.48	12.00	25%	$ 336,235	$ 40,380
Match 3	77080	Houston	45,275	7,055	23.00	4.52	68.27	23.63	13.91	33%	$ 337,607	$ 44,544
Houston	77016	Houston	26,989	2,774	1.94	70.13	26.96	33.49	5.12	9%	$ 275,875	$ 33,878
Match 1	77028	Houston	16,808	1,831	2.20	74.39	22.29	39.02	4.91	7%	$ 273,176	$ 32,559
Match 2	75232	Dallas	28,682	3,468	5.00	66.33	27.46	31.25	12.26	9%	$ 332,441	$ 45,120
Match 3	75210	Dallas	7,482	3,106	0.94	70.64	27.53	31.64	2.25	11%	$ 180,194	$ 18,233
Houston	77020	Houston	25,464	3,624	3.72	24.46	70.79	31.25	4.70	18%	$ 241,726	$ 31,972
Match 1	75217	Dallas	80,324	2,839	7.63	27.20	64.20	29.60	3.31	25%	$ 278,329	$ 35,453
Match 2	77060	Houston	40,830	4,959	6.24	20.82	71.57	30.05	3.69	31%	$ 221,521	$ 34,012
Match 3	77029	Houston	17,814	1,331	7.77	25.32	66.09	28.76	2.89	19%	$ 258,573	$ 37,377
Match 4	78203	San Antonio	6,099	4,744	5.03	23.36	70.40	30.06	2.94	13%	$ 209,133	$ 26,708

Table 4 – part 2: Target and 'Matching' ZIP codes with statistics

Category	Zip	City	Population	Population Density	% White	% Black	% Hispanic	% Highschool	%Bachelors	% Undocumented	Average HH NW	Median HH Income
Houston	77021	Houston	26,042	4,267	6.69	74.77	15.86	29.14	11.84	7%	$ 299,952	$ 31,853
Match 1	75134	Lancaster	20,276	1,982	8.80	71.40	17.98	31.27	12.51	8%	$ 314,598	$ 55,040
Match 2	77028	Houston	16,808	1,831	2.20	74.39	22.29	39.02	4.91	7%	$ 273,176	$ 32,559
Match 3	78721	Austin	11,425	3,062	11.28	33.62	52.96	30.29	11.90	20%	$ 295,721	$ 34,384
Houston	77033	Houston	27,965	4,665	1.16	74.41	23.13	35.73	3.94	8%	$ 263,411	$ 33,286
Match 1	77028	Houston	16,808	1,831	2.20	74.39	22.29	39.02	4.91	7%	$ 273,176	$ 32,559
Match 2	75217	Dallas	80,324	2,839	7.63	27.20	64.20	29.60	3.31	25%	$ 278,329	$ 35,453
Match 3	77060	Houston	40,830	4,959	6.24	20.82	71.57	30.05	3.69	31%	$ 221,521	$ 34,012
Houston	77047	Houston	21,077	1,500	6.78	65.81	23.38	24.96	14.66	12%	$ 375,977	$ 54,280
Match 1	79936	El Paso	111,086	4,151	10.05	1.99	86.31	25.41	14.93	13%	$ 354,758	$ 53,379
Match 2	75043	Garland	58,094	2,942	43.08	20.94	27.86	27.43	16.08	12%	$ 407,610	$ 57,901
Match 3	79938	El Paso	53,520	147	8.29	3.10	86.91	26.17	11.82	16%	$ 348,734	$ 52,873
Houston	77048	Houston	15,294	1,369	2.53	80.18	15.73	40.86	5.77	5%	$ 251,045	$ 32,838
Match 1	75241	Dallas	27,066	1,002	1.61	87.95	9.33	38.69	8.87	2%	$ 275,648	$ 31,822
Match 2	77028	Houston	16,808	1,831	2.20	74.39	22.29	39.02	4.91	7%	$ 273,176	$ 32,559
Match 3	75211	Dallas	73,146	3,933	8.96	6.44	83.04	23.67	5.37	32%	$ 280,778	$ 39,606
Houston	77051	Houston	15,085	2,049	0.89	90.61	7.56	39.40	7.60	3%	$ 232,613	$ 25,892
Match 1	75241	Dallas	27,066	1,002	1.61	87.95	9.33	38.69	8.87	2%	$ 275,648	$ 31,822
Match 2	77640	Port Arthur	16,875	233	22.64	61.52	13.02	36.55	6.77	4%	$ 262,329	$ 33,461
Match 3	75237	Dallas	17,101	2,572	3.27	81.36	13.48	32.71	14.04	9%	$ 195,638	$ 26,827
Match 4	77028	Houston	16,808	1,831	2.20	74.39	22.29	39.02	4.91	7%	$ 273,176	$ 32,559
Houston	77088	Houston	49,660	4,414	8.09	47.60	39.62	35.38	7.55	15%	$ 321,763	$ 43,567
Match 1	76117	Haltom City	30,645	2,813	46.62	2.76	41.22	38.21	7.10	17%	$ 302,274	$ 43,048
Match 2	77053	Houston	28,954	2,327	2.97	44.16	51.16	32.33	7.20	20%	$ 334,623	$ 47,112
Match 3	77014	Houston	28,684	3,986	7.74	46.37	34.47	30.26	14.23	17%	$ 338,155	$ 48,098
Match 4	75149	Mesquite	56,065	3,515	41.77	20.72	32.86	32.96	9.11	12%	$ 366,310	$ 49,511
Houston	77091	Houston	23,472	3,255	7.76	60.74	30.03	32.24	9.65	12%	$ 301,150	$ 30,990
Match 1	77078	Houston	14,777	1,369	3.34	61.14	34.70	31.17	3.03	13%	$ 256,899	$ 37,813
Match 2	77642	Port Arthur	37,111	1,725	22.13	31.33	37.09	32.75	9.28	14%	$ 265,765	$ 37,240
Match 3	78402	Corpus Christi	536	489	67.72	0.75	26.12	30.94	10.42	3%	$ 309,746	$ 37,250

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Appendix A – Anti-racist Principles from the People's Institute for Survival and Beyond

Source: www.pisab.org

Undoing Racism®

Racism is the single most critical barrier to building effective coalitions for social change. Racism has been consciously and systematically erected, and it can be undone only if people understand what it is, where it comes from, how it functions, and why it is perpetuated.

Learning from History

History is a tool for effective organizing. Understanding the lessons of history allows us to create a more humane future.

Sharing Culture

Culture is the life support system of a community. If a community's culture is respected and nurtured, the community's power will grow.

Developing Leadership

Anti-racist leadership needs to be developed intentionally and systematically within local communities and organizations.

Maintaining Accountability

To organize with integrity requires that we be accountable to the communities struggling with racist oppression.

Networking

The growth of an effective broad-based movement for social transformation requires networking or "building a net that works". As the movement develops a strong net, people are less likely to fall through.

Analyzing Power

As a society, we often believe that individuals and/or their communities are solely responsible for their conditions. Through the analysis of institutional power, we can identify and unpack the systems external to the community that create the internal realities that many people experience daily.

Gatekeeping

Persons who work in institutions often function as gatekeepers to ensure that the institution perpetuates itself. By operating with anti-racist values and networking with those who share those values and maintaining accountability in the community, the gatekeeper becomes an agent of institutional transformation.

Undoing Internalized Racial Oppression

Internalized Racial Oppression manifests itself in two forms:

> **Internalized Racial Inferiority**
>
> The acceptance of and acting out of an inferior definition of self, given by the oppressor, is rooted in the historical designation of one's race. Over many generations, this process of disempowerment and disenfranchisement expresses itself in self-defeating behaviors.

Internalized Racial Superiority

The acceptance of and acting out of a superior definition is rooted in the historical designation of one's race. Over many generations, this process of empowerment and access expresses itself as unearned privileges, access to institutional power and invisible advantages based upon race.

Identifying and Analyzing the Manifestations of Racism

Individual acts of racism are supported by institutions and are nurtured by the societal practices such as militarism and cultural racism, which enforce and perpetuate racism.