Mid-America (HHS Region 7)
ATTC Addiction Technology Transfer Center Network
Funded by Substance Abuse and Mental Health Services Administration

Considering Culture and Self

Provider Bias and Cultural Influences in Behavioral Health and SUD Settings

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Objectives

After the presentation, participants will be able to:

- Describe the ways in which provider bias can affect client assessment
- Describe how culture may frame an individual/client's experience of health and/or illness
- Conduct a culturally responsive assessment by asking questions to explore how culture impacts an individual/client's experience of mental health, SUD, and related services
- Develop/advocate for treatment plans that are culturally responsive

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What we'll be covering

- Why does culture matter in behavioral health?
- What does culture really mean?
- Multicultural practice: cultural humility versus cultural competence
- Culture in micro-level practice
- Culture in mezzo- and macro-level practice

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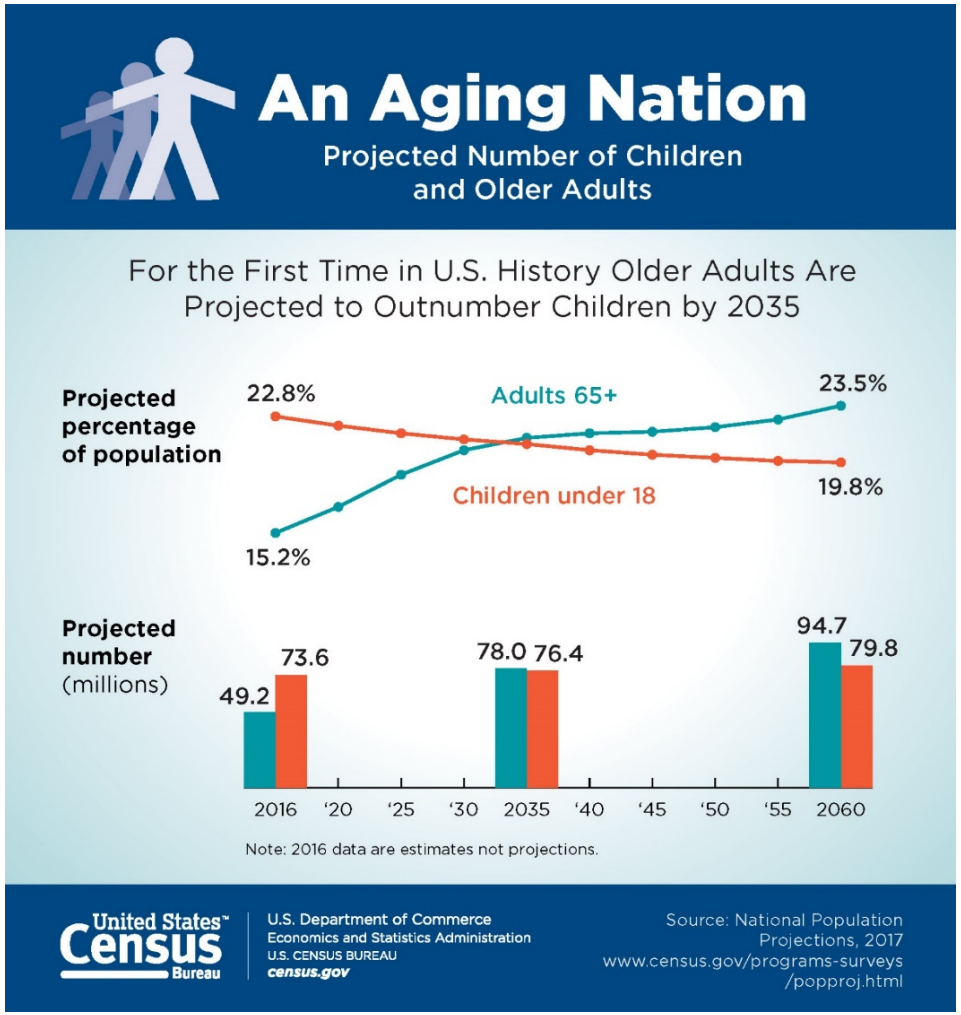
Demographics in the US are changing



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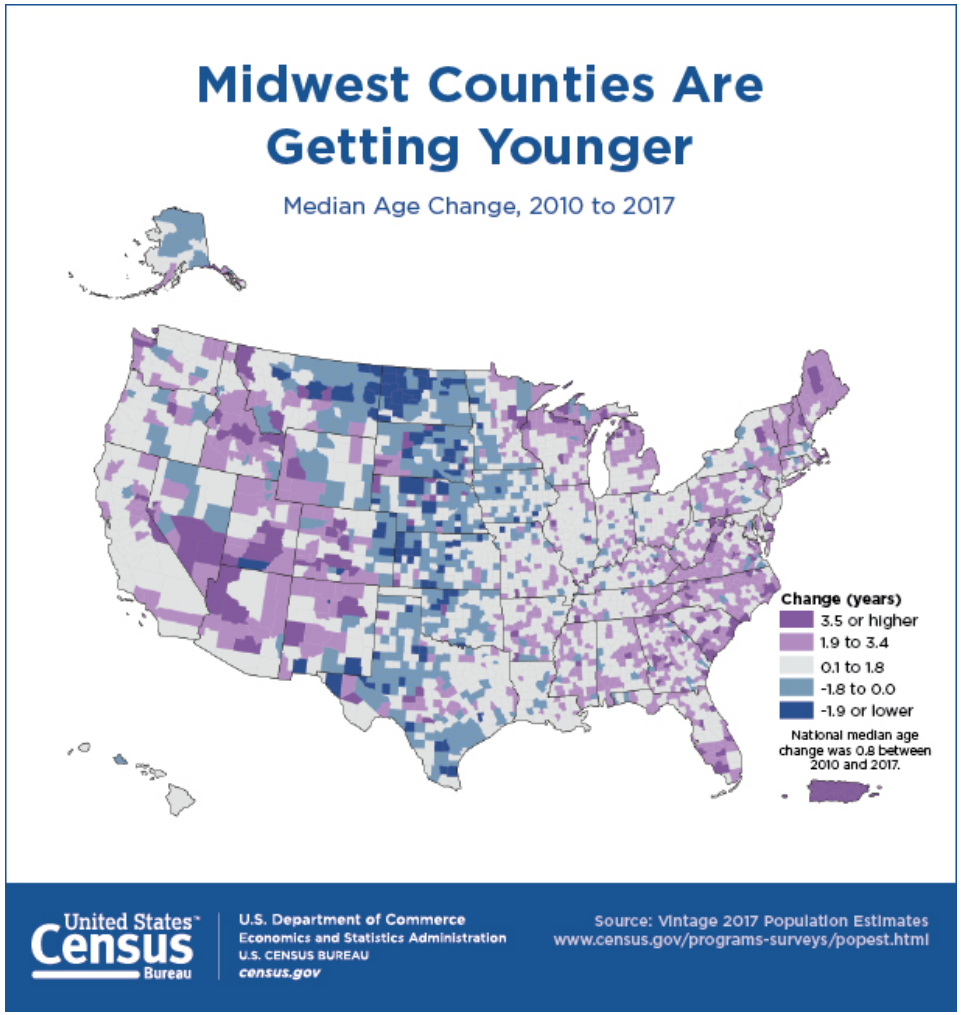

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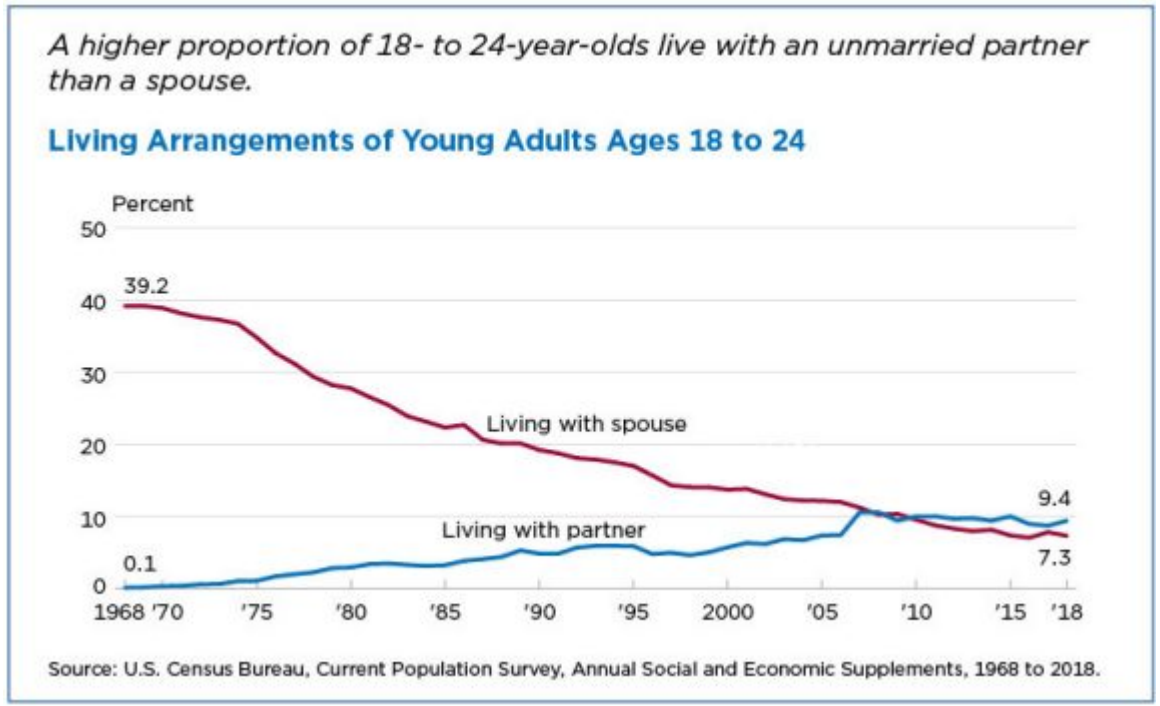

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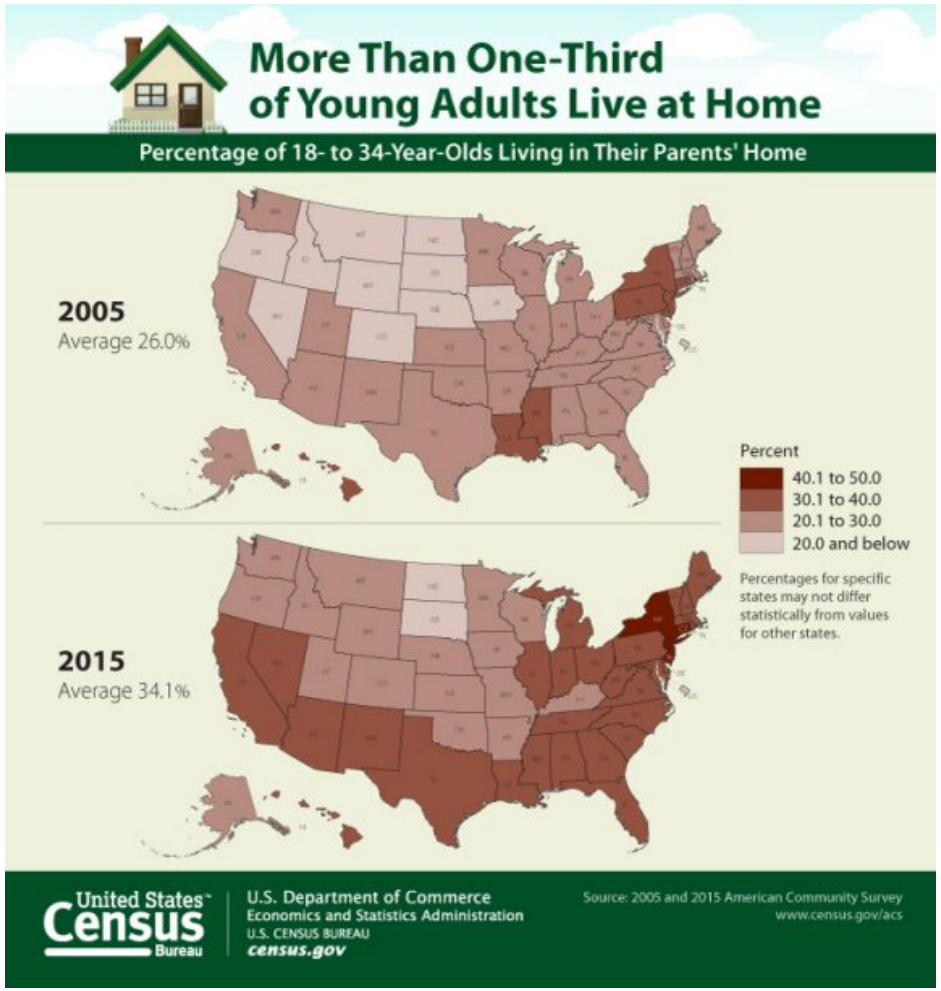

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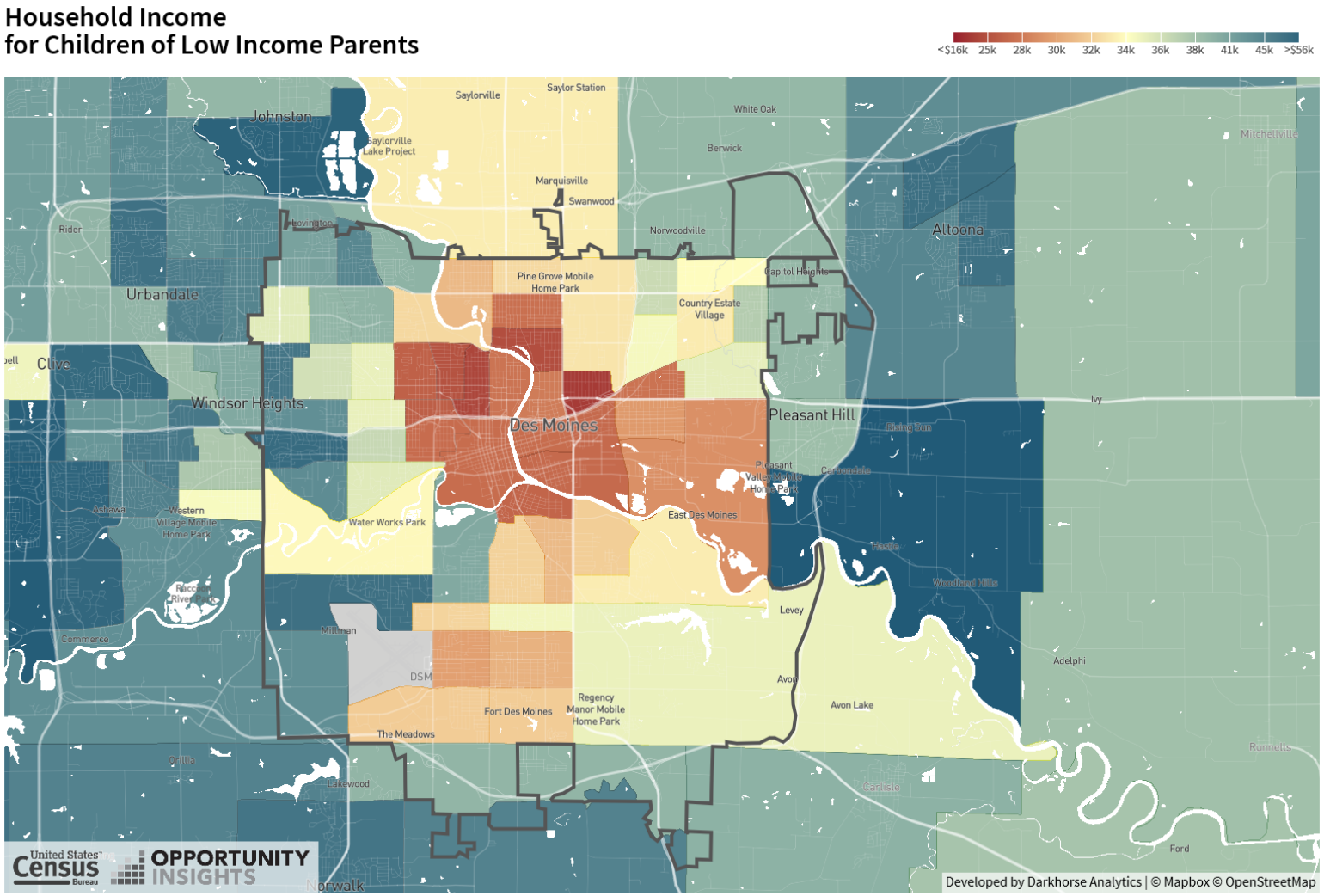
Opportunity Atlas



https://www.opportunityatlas.org/

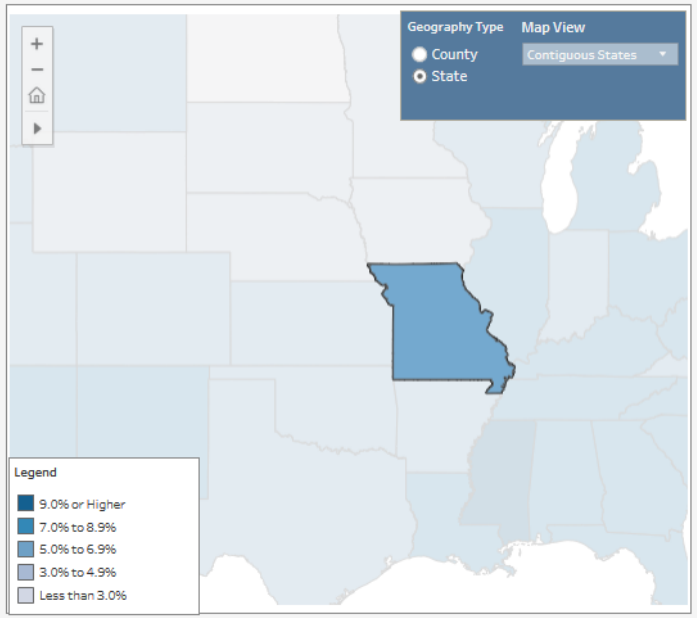
Missouri

2016 American Community Survey
5-Year Estimates

Table View
Click on a characteristic to have it displayed in the map.

Characteristic	Missouri State	Missouri U.S.
Total population	6,059,651	318,558,162
Average household size	2.48	2.64
Below poverty (%)	15.3	15.1
Foreign born (%)	3.9	13.2
High school graduate or higher (%)	88.8	87.0
Mean travel time to work (minutes)	23.4	26.1
Median age	38.3	37.7
Median home value ($)	141,200	184,700
Median household income ($)	49,593	55,322
Unemployment rate (%)	6.6	7.4
Veterans (%)	9.4	8.0

Unemployment rate (%)
Civilian labor force 16 years and older



Click here for more information about employment.

United States Census Bureau | U.S. Department of Commerce
Economics and Statistics Administration
U.S. CENSUS BUREAU
census.gov

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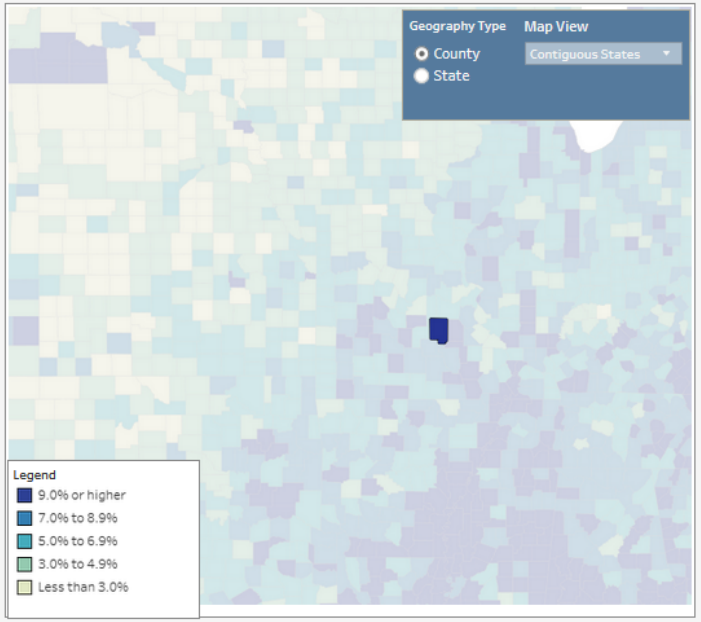
Yes
No

2016 American Community Survey
5-Year Estimates

Table View
Click on a characteristic to have it displayed in the map.

Characteristic	Crawford County, Missouri County	Crawford County, Missouri State	Crawford County, Missouri U.S.
Total population	24,545	6,059,651	318,558,162
Average household size	2.6	2.48	2.64
Below poverty (%)	21.4	15.3	15.1
Foreign born (%)	0.8	3.9	13.2
High school graduate or higher (%)	78.3	88.8	87.0
Mean travel time to work (minutes)	27.2	23.4	26.1
Median age	41.6	38.3	37.7
Median home value ($)	116,500	141,200	184,700
Median household income ($)	36,983	49,593	55,322
Unemployment rate (%)	11.9	6.6	7.4
Veterans (%)	11.4	9.4	8.0

Unemployment rate (%)
Civilian labor force 16 years and older



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census.gov

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Demographics of our field(s)

Occupation*	% Female	Median Age	% racial minority
Psychologists	66.5	50.3	5.1
Psychiatrists	30	55.7 (46% are 65+)	19.2
Social Workers	80.8	42.5	17.5
Counselors	71.2	42	10.3

Race	% of counselors*	% of social workers**
White	55.8	68.8
African American	27.9	21.6
Hispanic/Latino	11.1	11.0
American Indian/Alaska Native	.7	.8
Asian/Pacific Islander	2.8	3.8

*U.S. Department of Health and Human Services. Substance Abuse and Mental Health Services Administration. *Report to Congress on the Nation's Substance Abuse and Mental Health Workforce Issues.* January 2013.
** Salsberg, E., et al. Profile of the Social Work Workforce: A Report to Council on Social Work Education and National Workforce Initiative Steering Committee. George Washington University Health Workforce Institute. October 2017.

Missouri Treatment Demographics

Demographic	Missouri*	Treatment Admissions in MO**
% Female	50.9	38.6
Race		
White (non-Hispanic)	83.1	76.5
Black (non-Hispanic)	11.8	17.8
Hispanic origin	4.2	1.6
American Indian/Alaska Native	.6	.2
Asian/Pacific Islander	2.2	.2
Other	--	3.7

*Iowa QuickFacts. U.S. Census Bureau. (V2018) https://www.census.gov/quickfacts/fact/table/mo,US/PST045218

** Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality. *Treatment Episode Data Set (TEDS) 2016: Admissions and Discharges from Publicly Funded Substance Use Treatment.* Rockville, MD: Substance Abuse and Mental Health Services Administration, 2018.

Why this all matters in behavioral health

Individual-level factors

- Substance use initiation, patterns of use, trajectory, treatment utilization and completion differ by gender, race, socioeconomic status, acculturation and age

Organizational/systemic factors

- Access to treatment and recovery supports vary and may impact populations differently
- Counselor characteristics, low treatment alliance, culturally sensitive management, and perception of discrimination by staff are all associated with treatment completion.
- Treatment completion/success is also based on clinical judgment

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What we'll be covering

- Why does culture matter in behavioral health?
- **What does culture really mean?**
- Multicultural practice: cultural humility versus cultural competence
- Culture in micro-level practice
- Culture in mezzo- and macro-level practice

What is culture anyways?

Is the conceptual system that structures the way we view the world

- Beliefs
- Norms
- Values
- Behaviors

"Culture is *a process* through which ordinary activities and conditions take on an emotional tone and a moral meaning for participants." (Kleinman, 2009)

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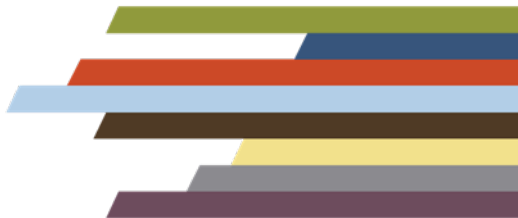

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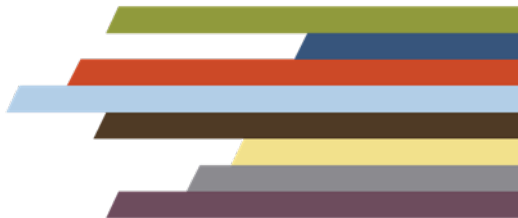

Competence and humility (from Tervalon & Murray-Garcia)

Competence: “an easily demonstrable mastery of a finite body of knowledge, an endpoint evidence largely by comparative quantitative assessments.”

Humility: “a commitment and active engagement in a lifelong process that individual enter into on an ongoing basis with patients, communities, colleagues and with themselves.”

Tervalon, M. and Murray-Garcia, J. “Cultural humility versus cultural competence: a critical distinction in defining physician training outcomes in multicultural education.” Journal of Health Care for the Poor and Underserved 9 (2). 1998.

Core concepts of cultural humility (from Tervalon & Murray-Garcia)

Self-reflection

Lifelong learning

Patient-focused interviewing and care

Community-based care and advocacy

Institutional consistency

Tervalon, M. and Murray-Garcia, J. “Cultural humility versus cultural competence: a critical distinction in defining physician training outcomes in multicultural education.” Journal of Health Care for the Poor and Underserved 9 (2). 1998.

Self reflection (from Tervalon & Murray-Garcia)

Awareness of self

Self-critique and exploration

Awareness of power dynamics inherent in practice

Tervalon, M. and Murray-Garcia, J. “Cultural humility versus cultural competence: a critical distinction in defining physician training outcomes in multicultural education.” Journal of Health Care for the Poor and Underserved 9 (2). 1998.

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Self reflection: my multicultural self

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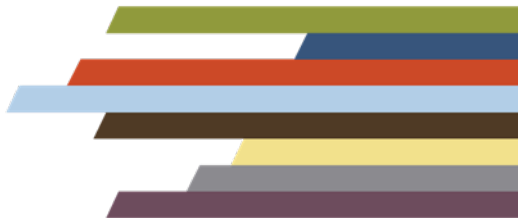

Lifelong learning (from Tervalon & Murray-Garcia)

- Knowledge, on the one hand, and curiosity on the other.
- We are striving to be “flexible and humble enough to let go of the false sense of security that stereotyping brings”

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Patient-focused interviewing and care (from Tervalon & Murray-Garcia)

- "language-focused" process that demonstrates the provider values "both the biomedical and nonbiomedical,"
- provides space for the patient to articulate their values and own "illness or wellness story."

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Community-based care and advocacy (from Tervalon & Murray-Garcia)

- How much do we as providers know about our clients' communities?
- How might this knowledge inform our services and knowledge of self?
- What context matters and to what extent can we advocate to change the context?

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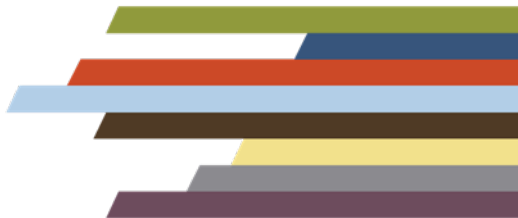

Institutional consistency (from Tervalon & Murray-Garcia)

- Important to remember: institutions have cultural identities (roles, norms, beliefs, meaning, etc.) too
- To what degree does the institution as a whole reflect cultural humility?

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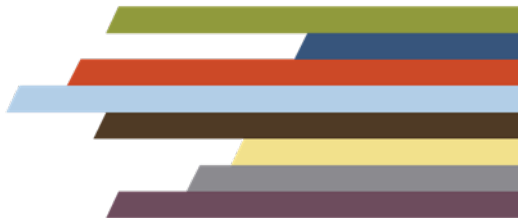

How Culture Affects Treatment

"The explanatory models approach does not ask, for example, "What do Mexicans call this problem?" It asks, "What do you call this problem?" and thus a direct and immediate appeal is made to the patient as an individual, not as a representative of a group."

The provision of treatment is like completing a puzzle, which requires providers to take time to find the pieces and place them in the correct position so they fit properly together.

Kleinman A, Benson P (2006) Anthropology in the Clinic: The Problem of Cultural Competency and How to Fix It. PLoS Med 3(10): e294. https://doi.org/10.1371/journal.pmed.0030294

Skills: Ethnography and explanatory models (from Kleinman)

Ethnography

the practice of “intensive and imaginative empathy” to gain insight into how somebody “understands, feels, perceives, and responds” to a condition/illness/event

Explanatory model

“mini-ethnography” and approach to interviewing that explores “how the social world affects and is affected by illness.”

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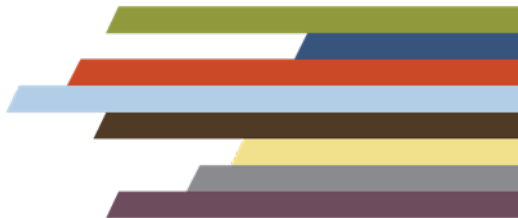

Piecing together a cultural formulation (from Kleinman)

Step 1: Ethnic identity

Step 2: What is at stake?

Step 3: Illness narrative

Step 4: Psychosocial stress

Step 5: Influence of culture on clinical relationships

Step 6: Ongoing attention to culture(s)

Building an explanatory model (from Kleinman)

- What do you call this problem?
- What do you believe is the cause of this problem?
- What course do you expect it to take? How serious is it?
- What do you think this problem does inside your body?
- How does it affect your body and mind?
- What do you most fear about this condition?
- What do you most fear about the treatment?

Kleinman A, Benson P (2006) Anthropology in the Clinic: The Problem of Cultural Competency and How to Fix It. PLoS Med 3(10): e294. https://doi.org/10.1371/journal.pmed.0030294

Traditional healing approaches

- Patients ***may*** combine respect for the benefits of mainstream medicine, tradition, and traditional healing, with a strong religious component;

- They may bring a broad definition of health to the clinical or diagnostic setting. Respecting and understanding this view can prove beneficial in treating and communicating with the patient.

- Example: *Through the Diamond Threshold: Promoting Cultural Competency in Understanding American Indian Substance Misuse*

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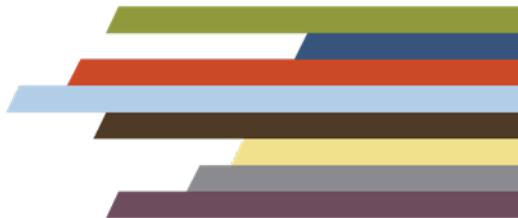


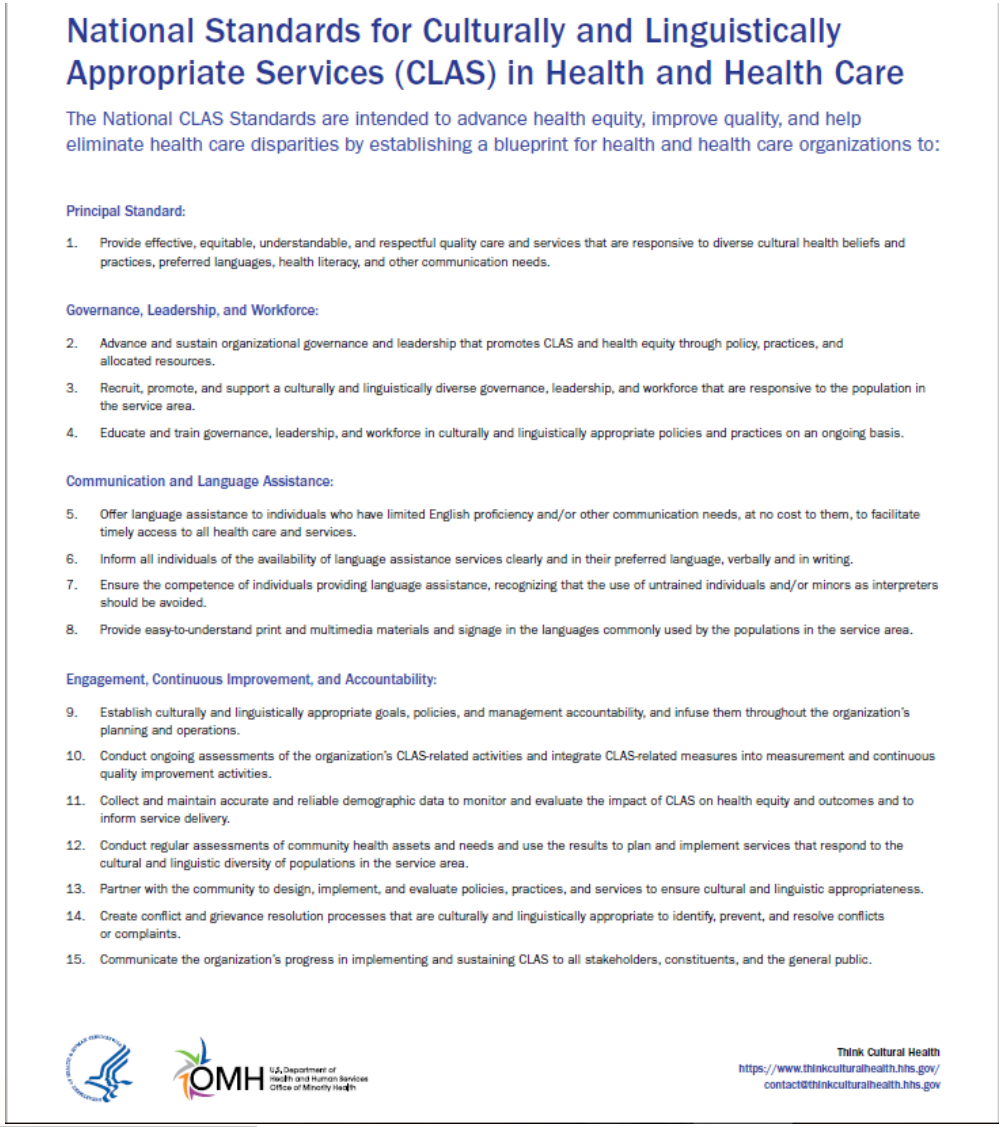
Institutional humility and CLAS Standards

Community and institutional context are interrelated and affect service delivery and experience

CLAS Standards as a tool for sustaining cultural humility

- Developed to address disparities in health outcomes and promote equity
- Provide a guide for institutional change and considerations for organizational-level practices necessary to sustain culturally humble practice

Using the CLAS standards



National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care

The National CLAS Standards are intended to advance health equity, improve quality, and help eliminate health care disparities by establishing a blueprint for health and health care organizations to:

Principal Standard:

1. Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.

Governance, Leadership, and Workforce:

2. Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices, and allocated resources.
3. Recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce that are responsive to the population in the service area.
4. Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.

Communication and Language Assistance:

5. Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.
6. Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.
7. Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.
8. Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.

Engagement, Continuous Improvement, and Accountability:

9. Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organization's planning and operations.
10. Conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities.
11. Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery.
12. Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.
13. Partner with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness.
14. Create conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints.
15. Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents, and the general public.

OMH U.S. Department of Health and Human Services Office of Minority Health

Think Cultural Health
https://www.thinkculturalhealth.hhs.gov/
contact@thinkculturalhealth.hhs.gov

CLAS Standard #1

Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural beliefs and practices, preferred languages, health literacy, and other communication needs.

Key consideration:

Do we have materials available that indicate what patients can expect and identify as effective, understandable, and respectful care?

Standards #2-4: Governance, Leadership & Workforce

Key considerations:

Are staff required to complete cultural competency training?

Are staff required to complete linguistic competency training?

Does our team reflect the diversity of the families being served (in terms of gender, race, ethnicity, linguistic capabilities)?

Standards #5-8: Communication & Language Assistance

Key considerations:

How do we inform clients?

Do we communicate everything in the language our clients understand (forms, signage, instructions, health ed materials)?

Do we offer interpreter services?

Do we use readability checkers to ensure information is at an elementary school level?

This is not just limited to other languages--can materials in English be easily read, too?

Standards #9-15: Engagement, Continuous Improvement, & Accountability

Key considerations:

Are we collecting satisfaction surveys from clients?

Do we conduct focus groups?

Do we engage key stakeholders in our planning process?

Commitment to Excellence

Organizations are often reluctant to change without sufficient evidence that the changes will improve either the quality of care or the cost of care. The initial steps in changing organizational practices must rest on:

- An ethical commitment to improvement at all levels from individual practitioners and support staff to key administrators;
- Top down and bottom up definitions of the cultural issues to be addressed and a process being established to change business as usual; and
- Improvement of the quality of communication and the ability of different levels of the organization to work together

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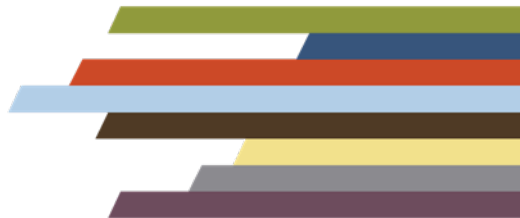

Leading Change

The first step is making the decision to act, setting up a communication process, conducting an internal needs assessment, and developing a work plan to improve cultural responsiveness.

- It is especially useful to set goals and have regular feedback using data to determine if these goals are being met.
- Different functions of the organization should focus on how their operations can become more culturally proficient.
- Often operations have developed from standard models of health care that were never intended for use with the cultural populations they serve, and certain standard procedures may be aversive for their culturally diverse clients.

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Creating change

Cultural humility requires positive change both in the clinical setting ***and*** the real-life environment in which the patient must function.

- Cultural humility replaces the earlier ideas of cultural sensitivity and awareness that were often embraced with no corresponding change in behavior.

- This process will take years, but the important thing is that it is underway already. To be effective innovation in treatment must be specific and based on developing ***new skills*** among counselors.

Source: Hanley, Jerome. (1999). Beyond the tip of the iceberg: Five stages toward cultural competence. *Reaching today's youth.* Vol.3 No.2 pp. 9-12

There is nothing inconsistent about being scientific ***and*** culturally effective in client care nor can science replace culture as essential to engaging and managing clients.

Cultural humility is not a destination, it is a journey.

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Additional resources

ATTC Website Products & Resources Catalog
https://attcnetwork.org/centers/global-attc/products-resources-catalog
(filter by keyword: “Cultural Competency/Humility”)

Through the Diamond Threshold
CLAS Standards in BH: Working with LGBTQ webinars
How to Implement Cultural Competence and the National Standards for CLAS
Easier Together: Partnering with Families to Make Recovery Possible

SAMHSA TIP 59: Improving Cultural Competence

Office of Minority Health www.minorityhealth.hhs.gov/omh

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Thank you!

"…focus on the patient as an individual, not a stereotype; as a human being facing danger and uncertainty, not merely a case; as an opportunity for the doctor to engage in an essential moral task, not an issue in cost-accounting."

-Arthur Kleinman, 2006

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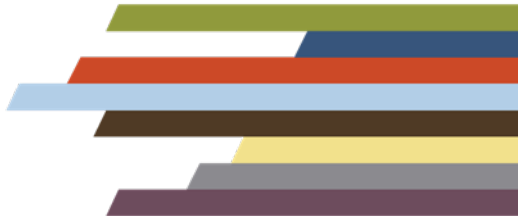

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