Mindful
Continuing Education

Ensuring Cultural Competence in Behavioral Health

Introduction 4
Section 1: Why is it important? 4
Introduction 4
What is culture? 5
What is cultural competency? 6
Agency 7
Target status 7
Intersecting identities 9
Why is cultural competency important in behavioral health? 10
Summary 11
Section 2: Understanding diversity in the United States 11
Introduction 11
How diverse is the United States? 11
Why is this diversity important? 12
Summary 12
Section 3: Disparities in mental and behavioral healthcare 13
Introduction 13
What are the disparities in behavioral health? 13
Cultural barriers to accessing behavioral healthcare 14
Ways to eliminate the barriers to accessing treatment 14
Summary 16
Section 4: Core elements of cultural competence 16

Introduction....16
The core assumptions of cultural competence....17
The core elements of cultural competence....17
Cultural awareness....17
Cultural knowledge....20
Culturally appropriate clinical skills....22
Supervision for cultural competence....25
Summary....26
Section 5: Culturally Responsive Evaluation and Treatment Planning....26
Introduction....26
Step one: Engage clients....27
Step two: Familiarize clients with the treatment process....27
Step three: Endorse collaboration in an interview, assessment, and treatment....28
Step four: Integrating cultural norms and relevant information....29
Step five: Gather culturally relevant information from collateral contacts....32
Step six: Selecting appropriate screening tools....32
Step seven: Determine readiness for change....32
Step eight: Provide case management that is culturally responsive and appropriate 33
Step nine: Incorporate cultural factors into treatment planning....34
Summary....34
Section 6: Organizational cultural competence....35
Introduction....35

Organizational values 35
Governance tasks 35
Planning tasks 36
Evaluation and monitoring tasks 37
Language services 38
Workforce and staff development 38
Organizational infrastructure 40
Summary 41
Section 7: Working with specific groups of people 41
Introduction 41
Counseling for Black Americans 41
Counseling for Asian Americans, Native Hawaiians, and other Pacific Islanders 42
Counseling for Latino and Hispanic individuals 43
Counseling for Native Americans 44
Counseling for white Americans 45
Summary 45
Section 8: Case studies 45
Kamel 45
Laren 46
Teresa 46
References 46

Introduction

To be competent and helpful mental health professionals, clinicians must do more than simply understanding therapeutic modalities and getting to know their patients. Professionals cannot rely only on their educational experiences and abilities to relate, validate, or see the individuals that they are supporting. Humans are complicated and patients who access mental health services are often more complex than a person who may not have a mental illness. Mental health professionals must understand the complexities of the human brain and the human body and how they relate to the world. Cultural competency is one of the most essential ways to understand that complexity.

Cultural competency is not simply making space for differences. It is not celebrating diversity. To be culturally competent in behavioral health, professionals must understand their privilege, the privileges of their patients, and the target or marginalized status of their patients. They must understand or attempt to understand how those marginalized identities impact the patients, their health, their mental health, and all aspects of their lives.

This course will review necessary components of cultural competency for mental health professionals, provide an overview of agency versus target status for populations, and offer interventions for how to understand the experiences of patients whose cultural experience is different than that of the clinicians that they work with.

Section 1: Why is it important?

Introduction

Imagine being a young female patient raised in a low-income neighborhood with a black single mother. This patient has been having anxiety and depression but is afraid to talk with her peers and family about her experience because her culture tells her to “grind” until she stops having these feelings. Her mother and her aunts say things like “we don’t have time to be depressed.” These statements are invalidating and painful to her. She decides to meet with a therapist without her family knowing and the therapist she meets with is white, middle-class, and has never worked in low-income neighborhoods.

Imagine how she might feel going into this therapy session: anxious, ostracized, and perhaps different. She might not want to come back to therapy because she cannot see herself in the mental health professional sitting across from her.

This is a good example of why providers must be culturally competent. Without understanding that she is anxious, worried, and feels different, the provider might simply jump into therapy excited to get started. The clinician may do so without understanding that help seeking is a huge step for this patient and that it goes against the statements she heard growing up, which were that the single, black woman doesn't have time to be depressed and that she simply needs to keep working towards something better.

Without being culturally aware and competent,, the provider might have made this situation even more stigmatized for this patient.

What is culture?

Before a person can understand cultural competency, it must be understood what culture is. Culture is a collection of the behaviors, values, and beliefs that are held and shared by a group of common people (UPenn, 2017). Common examples of those groups of people might be people that share the same ethnic background, racial background, geographic area, religious preference, gender identity, class belonging, or age group. This is further complicated by the fact that all people belong to multiple groups above. Culture often includes how people dress, speak, believe, what they eat, what laws they follow or do not follow, their manners, their behavioral standards or norms, their sexual interactions with others, etc. Culture will impact all areas of an individuals' lives. For example, it will influence the way that they experience the world, how they understand communication, how they express themselves, how they understand their mental health and emotional health, and how they express joy, etc. (UPenn, 2017)

Key definitions to understand where culture is concerned are as follows (Northwestern University, 2021):

- Race: a socially constructed idea that groups are individuals who together have similar characteristics such as skin color/complexion/facial features
- Ethnicity: refers to a group of individuals who share the same heritage, country of origin, or ancestry
- Language: refers to the specific dialogue used in communication
- Sexual orientation: refers to the romantic, sexual attraction between individuals of the same or opposite sex and/or gender. Common sexual orientation identities

are gay, lesbian, bisexual, and queer but this does not capture all of the sexual identities whatsoever

- Gender: refers to the individuals' beliefs about themselves where male, female, neither, or a combination of the two are concerned. This often influences how the person relates to the world and others. It is not inherently connected to the sex that was assigned at birth
- Age: refers to the biological age of the individual
- Disability or ability refers to the functional status of the individual where physical and mental functioning are concerned. For example, a person with a physical or mental impairment must have substantial limits in functioning in one or more life areas to have a disability
- Class/socioeconomic status: refers to the financial income and status of the individual. This is generally broken into low, middle, and upper class. Class position largely impacts the services and systems that a person does or does not have access to
- Education: refers to the amount of education that a person has including high school educated, some college, college, or post-college education
- Religious/spiritual orientation: refers to the "beliefs, actions and institutions which assume the existence of supernatural entities with powers of action, or impersonal powers or processes possessed of moral purpose"

What is cultural competency?

Cultural competency is an essential skill for all behavioral health professionals and community members generally. Being culturally competent is how we can create systems that serve, recognize, validate, and love all people. Cultural competency is defined as "the ability to relate effectively to individuals from various groups and backgrounds" (UPenn, 2017). It responds to the different needs of marginalized individuals and is sensitive to their experience in the world. Cultural competency requires that all behavioral health professionals understand the following (UPenn, 2017):

1. What is agency?
2. What is target status?
3. What are intersecting identities?

Agency

Agency refers to the individuals who hold dominant status in a specific group and therefore are the recipients of unfair advantages compared to those who do not have agency or are referred to as 'targets' (Goldbach, 2020). Examples of people with agency are as follows by group (Goldbach, 2020):

- Race: white people
- Ethnicity: people born in the United States
- Language: people who speak English as a first language
- Sexual identity: people who identify as straight
- Gender identity: cisgender people (people who identify with their born sex)
- Age: people under 40 years old
- Ability: people with no physical or mental impairments
- Class: upper-class individuals
- Education: college-educated individuals
- Religious affiliation: Christian

Individuals who have agency can hold power (Goldbach, 2020). They often name and define their realities and identify what is normal, real, and correct. People with power and agency are often those who determine systems, write laws, and interpret the law. They have access to the best resources and therefore often hold positions of power. For example, white, heterosexual men often have access to the best education and therefore the best employment opportunities. Individuals who have agency often target the culture, language, history, and other components of the groups who do not have the same agency as they do. This oppression is both individual and systemic. For those who are not agents, their lives are largely dependent on the advocacy of those with agency to create systems that better see and serve them. It is the inherent responsibility of behavioral health professionals to fight for all people to have agency (Goldbach, 2020).

Target status

Individuals who are targets in one or more domains are those who are discriminated against, marginalized, oppressed, and exploited by those who do have agency

(Goldbach, 2020). This is often both covert and overt, meaning that some people intend to marginalize and some do not but they simply do because they benefit from being an agent. People who are targets often look and act differently than those who hold power. For example, people who immigrated to the United States from the Middle East might eat different foods and speak differently. This "othered" behavior makes individuals very obvious targets, despite it being something they cannot control about themselves. These young students who bring "different" food to school are often the target of bullying because of said differences (Goldbach, 2020). Examples of targets based on domains are as follows (Goldbach, 2020):

- Race: people of color
- Immigrant status: people who immigrated to the United States
- Language: people who do speak English as a first language or use American Sign Language
- Sexual identity: gay, lesbian, bisexual, and queer people
- Gender identity: transgender or non-binary people
- Age: people over 40 years of age
- Ability: people with physical, mental, or intellectual disabilities
- Class: lower-class individuals
- Education: people who lack a college education
- Religious affiliation: People who adhere to non-christian practices

People who are targets are generally discriminated against. The following are examples of common discrimination (UPenn, 2017):

- Racism: discrimination based on a person's race or the belief that another race is superior to that individual's race
- Ageism: discrimination based on age. For example, the belief that older individuals cannot drive well is ageist
- Sexism: discrimination based on a person's sex or gender
- Heterosexism: perpetuating the belief that homosexual people or people who hold a non-heterosexual identity are not normal or correct

- Classism: the belief that people who are members of lower socioeconomic classes are less than those in higher socioeconomic classes
- Religious intolerance: the unwillingness to support or love other people because their beliefs are different than what is considered normal. This is generally referring to all beliefs outside of the traditional Christian beliefs

Intersecting identities

Behavioral health professionals must understand that all individuals have intersecting identities. This is to say that no one identity is the only identity that a person holds. While one may be more seen or more important to them than others, they all interact with each other in a way that is unique to that individual.

Intersectionality is defined as "the interconnected nature of social categorizations such as race, class, and gender, regarded as creating overlapping and interdependent systems of discrimination or disadvantage; a theoretical approach based on such a premise" (YWCA Boston, 2021). For example, the individual's identities might look something like this: black, female, citizen, college-educated, and heterosexual. This person's experience would be different than a person with these identities: black, female, citizen, college-educated, and lesbian. It is important to understand that those within the white culture may interpret and respond to a person being a lesbian differently than the black culture would. They may or may not be less likely to be supportive of that individual. This is an example of intersecting identities impacting a person's reality (YWCA Boston, 2021).

Intersectional theory assumes that people are often disadvantaged by multiple identities and that these identity markers are not homogenous, meaning that they impact one another (YWCA Boston, 2021). For example, if a white man makes 1$, a black man will make $0.74 to his dollar, a white woman will make $0.78 to his dollar, and a black woman will make $0.64 to his dollar (YWCA Boston, 2021).

What is important for behavioral health professionals to understand about intersectionality is that, as evidenced above, no one group of people will experience something the same way because of their intersecting identities. It is important to be willing to listen and hear other people when they talk about their experiences without assuming that there is knowledge of what their life has been like. Other suggestions for behavioral health providers where intersectionality is concerned are as follows YWCA Boston, 2021):

1. Avoid simple language: language should not be singular because people's identities are not singular. It is important to ask patients how they want to be referred to and then adhere to said language. Assuming that the professional knows and understands the language that the patients want them to use is dangerous because if the professionals are wrong, their trusting therapeutic relationships can be damaged by the assumption

2. Understand their own identities: behavioral health professionals should recognize their own identities and the spaces they occupy. They should seek to be in as diverse spaces as possible. For example, in their communities, churches, gyms, etc. Here they will become more used to intersecting identities, culture, and norms and will more appropriately respond in sessions because of this. They will find intersecting identities less abnormal in sessions when it is present in their own lives

3. Seek different points of view: understanding the beliefs and narratives of other people helps to differ between identities and how they weave together. Listening to other people is crucial in being an advocate in diverse spaces

Why is cultural competency important in behavioral health?

Cultural competency is not only built into the ethical standards for all behavioral health positions, but it truly is the bones of healthcare and behavioral healthcare. Not one simple profile or person will interact with the mental health system. The patient pool will always be diverse and patients will be profoundly different from one another. While individuals may present with similar diagnoses or backgrounds, how they respond to therapists and providers in treatment will be largely influenced by their cultural background. Because of this, behavioral health providers must understand the cultural influences and impact that culture has on the therapeutic relationship and treatment process.

It is essential that patients feel safe, comfortable, and understood by the clinicians who are working with them (National Alliance on Mental Illness, 2021). Patients need to feel as though their identity is understood and supported to adequately open up in treatment. When clinicians can understand the role that culture plays in diagnosis, symptomatology, and treatment, they can treat the entire person and not just the mental illness or symptoms. This allows the clinician to develop with patients a treatment plan that serves them and is person-centered. This greatly improves

outcomes in treatment and helps patients to meet their goals and objectives (National Alliance on Mental Illness, 2021).

Summary

The life experience of individuals is largely dependent on their background and culture. Who raised them, where they evolved, the access to resources they had, and their racial/sexual/gender identities result significantly in who they are and become. Because who they are will impact the way they relate to behavioral health professionals, professionals must display a level of knowledge, understanding, and awareness in the workplace and beyond. This level of cultural competence is not only mandated ethically but shows individuals in treatment that they are valued, seen, and heard. This results in better health outcomes for individuals.

Section 2: Understanding diversity in the United States

Introduction

The United States was historically thought of as a "melting pot" because of its diversity and history with both immigration and, unfortunately, colonization. Mental health professionals are ethically and morally required to be culturally competent because they work in a culturally diverse nation.

How diverse is the United States?

The following statistics show how diverse the United States is (UPenn, 2017):

- 1 in 10 Americans were not born in the United States
- 1 in 3 Americans belong to a minority group (UPenn, 2017)
- In 2019, 12.2% of individuals were black (Kaiser Family Foundation, 2021)
- In 2019, 28.5% of individuals were Hispanic
- In 2019, 5.6% of individuals were Asian
- In 2019, 0.7% of individuals were American Indian/Alaskan Native
- In 2019, 0.2% of individuals were Hawaiian/Other Pacific Islander
- In 2019, 2.8% of individuals were of multiple races

- By 1990, 28.3 million people in the U.S. spoke a language other than English - 45% of this group had a difficult time speaking English (UPenn, 2017)
- One-third of millennials report being “somewhere in the middle” of the straight to gay scale, whereas 8% of people over the age of 45 report this (Time Magazine, 2021)
- There are a total of 1.4 million transgender-identified individuals living in the United States (Gates, 2016)
- 24% of Americans are unaffiliated with a religious preference or belief system (Cox & Jones, 2017)
- 10.5% of the population lives in poverty as of 2019 (Census.gov, 2020)
- 26% of adults living in the United States have some kind of disability (CDC, 2020)

Why is this diversity important?

Diversity is essential not only to behavioral healthcare but also to communities as a whole. It is through diversity that community members experience different perspectives and can exchange different points of view and ideas (VanAlstine, Cox, & Roden, 2015). When these ideas are exchanged, the opportunity for creativity and innovation becomes astronomically higher than it is when the human population exists in a vacuum.

Diversity supports better problem solving by bringing multiple ideas and ways to understand solutions together. Many studies have found that diversity is positively correlated with economic growth and prosperity, which supports the development of jobs and education opportunities. It supports better health and income for all. It reduces stigma, promotes relationships, and improves communication. Overall, diversity is positively associated with human development and should be encouraged across all systems (VanAlstine, Cox, & Roden, 2015).

Summary

Mental health professionals in the United States should have a general understanding of diversity trends, such as the ones mentioned above. This will help them understand the broad demographics of individuals they can expect in mental health services. They should also understand the importance of diversity in the workplace, communities, and

other environments. They should seek to create diverse spaces and participate in diverse settings.

Section 3: Disparities in mental and behavioral healthcare

Introduction

Unfortunately, there is a significant resource distribution issue across different locations and demographics. It is widely known that communities that are well funded and have adequate behavioral healthcare resources are often middle to upper class, white, and Christian dominant. Because there are fewer resources in neighborhoods that are low-income or predominantly housing people of color, there are large disparities in mental health services.

What are the disparities in behavioral health?

Individuals who belong to racial or ethnic minority groups are less likely to have access to the same supportive services as individuals who are not minorities. These groups are (UPenn, 2017):

- Less likely to have access to necessary mental health care services
- Less likely to receive necessary mental health care services
- Often exposed to poorer quality of treatment
- Underrepresented in mental health research
- Less likely to seek treatment until issues are significant because of the disparities
- More likely to utilize involuntary services because of acute status when they do interact with behavioral healthcare
- More likely to experience racism and discrimination during their experience in behavioral healthcare (which often causes worsening of the mental illness itself) (UPenn, 2017)
- Less likely to have access to adequate transportation to and from services (NAMI, 2017)

- Less likely to receive services that affirm or validate their cultural norms and preferences
- Less likely to receive services consistent with their language preferences
- Less likely to have adequate healthcare coverage for necessary services (NAMI, 2017)

Cultural barriers to accessing behavioral healthcare

As mentioned briefly above, there are many barriers to accessing appropriate behavioral healthcare services for minority groups. Examples of these are (UPenn, 2017):

- Mistrust for the providers offering care
- Fear about treatment - what it looks like
- Alternative ideas about health that are not validated or appreciated by the providers
- Language barriers that make communication difficult
- Access barriers such as transportation, coverage, etc.
- Lack of diverse employees within the behavioral healthcare system (UPenn, 2017)
- Stigma within cultures around accepting behavioral healthcare services (NAMI, 2017)
- Symptom presentation makes diagnosis difficult in different cultures
- Interpretation and insight about mental illness may be or may not be present depending on the cultural background of the patient (NAMI, 2017)

Ways to eliminate the barriers to accessing treatment

Because there are so many barriers to treatment, there must be systemic plans for how to address such barriers. The following recommendations are made by NAMI (2017) for how to eliminate the cultural barriers preventing individuals who hold minority status from accessing necessary behavioral healthcare (NAMI, 2017):

1. Follow the standards set by the National Culturally and Linguistically Appropriate Services

a. Provide equitable, easy to understand, and respectful care and services

b. Provide services that are responsive to the health beliefs held by different cultures and practices that are specific to the patient

c. Offer free and accessible language supports to ensure the patients understand their rights and responsibilities while accessing care - this should be done verbally and in writing

d. Encourage the hiring and retention of staff that are diverse and bilingual - all patients should be able to see themselves in the staff members at the behavioral healthcare clinic

2. Train staff on how to be culturally competent

    a. Regular, ongoing training should be provided from the employer that teaches to various backgrounds of the clientele that the staff members see

    b. The training should teach staff how to build and establish trusting, therapeutic relationships with the clientele

    c. Training should teach to the different cultural beliefs about mental and behavioral healthcare including how symptoms are presented, what attitudes and beliefs are held about diagnosis and treatment, and the stigma that is or is not associated with behavioral healthcare

3. Education tools that are culturally-specific must be accessible

    a. Public education should be used to reduce community stigma and shame that is often held around mental illnesses (pamphlets, videos, etc.)

    b. These materials must be available in as many different languages as possible

    c. These materials should be strategically placed so that all individuals can access them, especially those who are high-risk (for example, low-income neighborhoods)

4. Ongoing research must be completed

    a. More data is needed to understand cultural beliefs and attitudes about behavioral healthcare

b. More data is needed to understand minority-specific experiences with mental illness and accessing behavioral healthcare (NAMI, 2017)

c. Increase research that examines the intersections of different and multiple identities and the impact these complexities have on health outcomes (American Psychological Association, 2017)

5. Partnerships should be created between different professionals (medical doctors, therapists, skills trainers, case managers, teachers, etc.) to ensure cultural competence and evidence-based prevention, early education, and treatment
6. Create positive relationships with minority groups in communities
7. Increase funding for additional services in underserved areas
8. Create policy and programs that support and empower minorities in accessing services through evidenced-based practices and linguistically-supportive care (American Psychological Association, 2017)

Summary

Understanding the biases and barriers that exist within the behavioral health field and fighting them is an ethical obligation that all behavioral healthcare providers have. It is essential to ensure that behavioral healthcare professionals are properly trained on cultures outside of their own and know how to best support a diverse audience. The above recommendations are made and should be implemented by all behavioral health agencies. If professionals notice their agencies are not offering such training and cultural competency support, they must advocate for better education, tools, and services for minority groups.

Section 4: Core elements of cultural competence

Introduction

Cultural competence is an essential component for ensuring that all people have access to appropriate behavioral healthcare that sees them, supports them, and serves them. While this is the goal, it certainly is not the current state of behavioral healthcare and there is a long way to go to ensure that this system does serve all.

Teaching providers and behavioral health professionals to be culturally competent is one step in a long list of ways to create appropriate and validating services for all.

The core assumptions of cultural competence

There are core systemic assumptions of cultural competence that must be taught to clinicians who offer behavioral health services. They are identified by SAMHSA (2016) as:

1. Counselors and other behavioral healthcare providers cannot sustain culturally competent treatment and services without allocation of funds and resources that support these practices
2. Individuals must understand their race, ethnicity, and culture to support and appreciate these features in others and to treat them effectively
3. Cultural competence changes the treatment planning process by finding alternative methods to support outcomes and goal achievement. The treatment plan must be developed by both the provider and the client together
4. Culture must be considered at all levels of the system including the micro, mezzo, and macro levels. All activities should be culturally competent including outreach, contact, screening, assessment, placing clients with providers, ongoing treatment, continued care, and recovery support as needed
5. Racially and ethnically diverse groups must be involved in the development of a culturally competent organization and a team of clinicians. They should help to identify the practices, program structures, designs, treatment services and strategies, approaches, and define professional development
6. When public advocacy is prioritized by behavioral health agencies, there is trust established within the community, agency, and staff. This empowers community members because they have a voice in the development of the agency or operation (SAMHSA, 2016)

The core elements of cultural competence

SAMHSA (2016) identifies three core elements of a culturally competent behavioral healthcare professional. They are cultural awareness, cultural knowledge, and culturally appropriate clinical skills. These are further defined below.

Cultural awareness

To be culturally aware means that professionals are understanding of their cultural backgrounds and therefore understand how their own culture and experience impacts

their relationships with clients (SAMHSA, 2016). If clinicians do not do this, then they will have a difficult time providing services that address issues specific to race, heritage, and culture - all of which are essential. Clinicians also understand their own biases and definitions of what is appropriate and normal behavior versus what is inappropriate and atypical behavior. This allows them to understand and check their biases when working with patients who are different from them to ensure that they are not placing their values onto others (SAMHSA, 2016).

When providers are not culturally aware, they may prejudge or assess patients in ways that are not appropriate, right, or acceptable.

Two valuable models exist to help clinicians understand their own cultural identities. The first is the R/CID model, which incorporates the following stages (SAMHSA, 2016):

1. Conformity: professionals have a positive attitude toward their dominant cultural values. They may have negative views of values that are not dominant or toward groups that are not their own race/ethnicity
2. Dissonance: professionals begin to question their own identities and understand that different messages do not support the stereotypes previously identified or believed. They begin to develop a sense of their heritage and any racism that may impact it. They move away from seeing and believing in a dominant culture
3. Resistance and immersion: professionals hold a positive attitude toward their own cultures and begin to reject the values that society holds toward dominant groups. They focus on reducing and eliminating oppression within their groups. They begin to develop a love and appreciation for other cultures outside of their own
4. Introspection: professionals question the impact of having strong feelings toward dominant groups and prefer to focus on their cultural groups and norms. Their understanding and knowledge broadens
5. Integrative awareness: professionals have a secure sense of themselves and their culture. They understand that they are multicultural and have pride in their identities, appreciate all other diverse groups, and can recognize and call out racism when they see it

The second model is the WRID model, which identifies the following stages for cultural identity development (SAMHSA, 2016):

1. Naivete: professionals have minimal awareness of race or culture and may not pick up on the messages about other cultural groups outside of their own. They likely hold an ethnocentric understanding of culture

2. Conformity: professionals have minimal awareness of themselves and believe in universal norms and values. They can justify the disparities in treatment and they believe that white Americans are dominant or hold more value

3. Dissonance: professionals look at their own biases and prejudices. They begin to understand that society identifies dominant groups and tends to shame underrepresented groups. They start to question their own beliefs that shame or perpetuate oppression toward other groups

4. Introspection: professionals begin to redefine culture and understand that being diverse is a positive thing for everyone. They begin to feel disconnected from the dominance of white America

5. Integrative awareness: professionals appreciate diversity, are aware of and understand their diversity, and are aware of the influences of racism. They begin to normalize societies being nonracist

6. Commitment to antiracist action: professionals are deeply invested in eliminating oppression and disparities in services. The object to inappropriate jokes, language, and anything racist in nature. They do not conform and instead develop relationships with people outside of their own

The RESPECT acronym is helpful for clinicians in reinforcing the strategies in cultural awareness with clients (SAMHSA, 2016):

R (respect): professionals must understand how respect is shown in other cultures and use those norms within sessions with patients

E (explanatory): professionals should be invested in understanding the way that clients view their illnesses/symptoms. They should explore their clients' understanding of the origin of their symptoms, their views about substances, and their views about treatment

S (sociocultural): professionals must understand how race, class, ethnicity, gender, education, status, orientation, immigrant status, gender roles, and other domains impact the care being provided

P (power): professionals must understand the power differences between clients and themselves

E (empathy): professionals must be as empathetic as possible in how they communicate, both verbally and nonverbally, with their patients. Their patients must feel understood and supported

C (concerns and fears): clients should always be able to express any concerns they have with the treatment process and their clinicians

T (trust): professionals must be invested in behaviors that improve trust between themselves and their patients. Trust is not simply given but must be earned

Cultural knowledge

Culturally competent providers must not only understand their own cultural identities and background but must seek to be knowledgeable about the cultural backgrounds and experiences of others.

Professionals can gain some of this understanding specific to their patients in the intake and assessment process of treatment (SAMHSA, 2016). This helps professionals to understand the client-specific cultural experience versus what the professionals assume or think they know about the experience. Professionals must be knowledgeable about the following areas: language, communication style, geographic location, worldview, values, traditions, family, gender norms and roles, socioeconomic status, education, immigration status, cultural identification, heritage and history, sexual orientation and identity, religious beliefs and spirituality, and health (SAMHSA, 2016).

Professionals should understand the following where cultural knowledge is concerned (SAMHSA, 2016):

- How race, ethnicity, and other factors form personality
- How culture impacts vocational decisions and choices
- How culture does or does not manifest mental illnesses
- How culture does or does not impact the way clients ask for help and receive services

- How culture impacts the appropriateness of specific mental health services and modalities
- How policy and politics impacts minorities (for example, immigration)
- How racism and stereotyping impacts the therapeutic relationship
- How these factors impact self-esteem for patients

Professionals build this kind of cultural knowledge by doing the following (SAMHSA, 2016):

- Staying current on research on minority populations regarding mental health and mental disorders
- Seeking opportunities to learn about other cultures and groups of people
- Utilizing cross-cultural skills in the treatment
- Being actively involved or integrated into communities outside of their own (they attend community events, celebrations, etc.)

The following recommendations are made for questions to assess/ask patients to gain cultural knowledge of patients (SAMHSA, 2016):

1. How does your culture view psychological, physical, and spiritual health? Are they viewed as independent of one another or not?
2. How does your culture identify illnesses and healing?
3. How were you taught to manage stress?
4. How were you taught to express your emotions?
5. What does your culture believe to be acceptable practices for preventing poor health and mental health outcomes?
6. What kinds of words did you hear growing up to explain problems?
7. What does your culture teach you about the cause or origin of a mental health problem?
8. How does your culture communicate distress?
9. What symptoms may cause misdiagnosis in your culture?

10. How do people within your particular culture ask for help? What problems would prompt them to ask for help?
11. What traditional treatments or practices are used within your culture to promote wellness?
12. What counseling approaches are or are not appropriate in your culture?
13. Are there common health disparities, disorders, or inequities in your culture?
14. How do people provide care in your culture?
15. How do people honor others with illnesses in your culture?
16. Are individuals with illnesses seen or shunned by the community in your culture?
17. How do family members provide support to sick family members?
18. Is it acceptable to discuss the prognosis of a specific illness in your family?

Culturally appropriate clinical skills

The final core element of cultural competency requires that professionals are appropriate in their skills to use with clients where culture is concerned (SAMHSA, 2016). Not only must professionals understand and integrate their own cultural identities, they must also have skills that enable them to learn about their patients, and be appropriate in their use of treatment skills as related to the culture of their patients (SAMHSA, 2016).

Clinicians never stop learning or becoming culturally appropriate (SAMHSA, 2016). This is an ongoing process that requires professionals to always be willing to ask questions, listen to people, assess the impact of behavior, and try new approaches to providing care. Clinicians must be respectful, accepting, sensitive, committed to equality, open, have humility, and be flexible (SAMHSA, 2016). How to do so is further defined below:

Clinicians can practice being respectful by (SAMHSA, 2016):

- Learning about and validating the experiences and worldview of their patients
- Being collaborative during treatment
- Committing time to their patients' treatment processes

- Using consultation, research, and training as needed to understand culture-specific behaviors and the impact of those behaviors
- Communicate with patients in their specific languages

Clinicians can practice being accepting by (SAMHSA, 2016):

- Being nonjudgmental
- Asking their clients about what is important to them without assuming what might be important to them

Clinicians can practice being sensitive by (SAMHSA, 2016):

- Inquiring about their patients' experiences with racism, stereotyping, and discrimination
- Assess what their patients' cultural identities mean to them
- Being invested in diverse cultures and attend events that integrate them into those cultures
- Include other people in the treatment processes as needed or wanted by their patients
- Write treatment plans with the patients that are culturally specific and relevant

Clinicians can be committed to equality by (SAMHSA, 2016):

- Identifying and addressing racist practices in the treatment
- Identifying and addressing bias in treatment
- Identifying and reducing barriers to treatment
- Understanding that equality and equity are not the same. Equity ensures that patients have equal opportunity, access, and outcome
- Ensuring that counseling strategies match the needs of diverse populations to promote positive outcomes

Clinicians can practice being open by (SAMHSA, 2016):

- Understanding the importance of traditional healing methods

- Developing professional relationships with traditional healers
- Consulting with traditional healers as needed
- Consulting with religious professionals as needed
- Using different cognitive styles as needed to support the cultural background of their patients

Professionals can practice humility by (SAMHSA, 2016):

- Understanding that trust is not inherently given by clients to professionals and that it must be earned by the professional
- Understanding that the training of the professional is not all-encompassing and that they have limits that must be understood
- Seeking consultation and supervision to expand on cultural knowledge
- Being sensitive to the power differences and dynamics between clients and themselves

Clinicians can practice flexibility by (SAMHSA, 2016):

- Using a variety of nonverbal responses, approaches, or styles to support the context of clients
- Understanding the different learning styles of clients and integrating this into the treatment process
- Using cultural factors when completing assessments and evaluations
- Integrating traditional healing practices in formal treatment

The following are practices that clinicians must avoid to continue to be culturally competent (SAMHSA, 2016):

- Being informal with how they address clients - this should not happen until professionals understand cultural norms and expectations
- Not giving clients enough time to respond to questions or treatment
- Using difficult to understand language such as clinician terms
- Using statements based on stereotypes

- Using gestures without understanding the cultural impact, influence, or meaning
- Ignoring the cultural relevance in the relationship between professionals and clients
- Developing plans for treatment without including the client in those plans
- Not understanding the importance of traditional practices in treatment planning

Supervision for cultural competence

Mental health professionals who work within an agency setting, such as community mental health, will have supervision as mandated by the organization. For example, they may be required to meet biweekly or monthly with their supervisor to follow up on how their cases are going, how their workload is being managed, and to troubleshoot as needed. Supervision is an important component of ensuring that clinicians are culturally competent. Those professionals who independently operate a private practice and who are licensed may have fewer opportunities for supervision. It is recommended that they privately seek opportunities for supervision to ensure their cultural competency skills.

Supervision is a critical component of cultural competency in clinicians because supervisors lead change in the workplace (Lusk, Terrazas, & Salcido, 2017). Supervisors should ensure that the workplace is compassionate, authentic, and supportive of all. It is the responsibility of the supervisor to identify if professionals are culturally competent or if they are culturally incompetent, and to provide them teaching and training to become competent (Lusk, Terrazas, & Salcido, 2017).

The following practices enables culturally competent supervision, which ensures that professionals are culturally competent (Lusk, Terrazas, & Salcido, 2017):

1. Supervisors operate from a strengths-based perspective: they assume that the professionals they support are highly skilled and have strong assets to offer diverse clientele. The supervisors should see the high skill level of their clinicians and guide their work to being as competent as possible, instead of trying to find faults in their clinicians. The supervisor should be kind, genuine, respectful, available, and consistent. This will allow for the supervisee to feel safe and comfortable when asking for help
2. Supervisors assume that diversity is an asset among their teams and they specifically hire a diverse staff

3. Supervisors identify and name cultural issues and can identify biases in the professionals that they supervise. They respectfully call these to the consciousness and identify strategies for how to dismantle bias
4. Supervisors work to develop an anti-oppressive agency and support organizational change
5. Supervisors identify training opportunities and offer them to their staff (or mandate them) on cultural competency. The training is provided by diverse individuals

Summary

The core elements of cultural competency ensure that clinicians are aware of their diverse backgrounds, can assess for the varied backgrounds of others, and are skillful in supporting all patients because their skills are respectful and validating of all cultural experiences. These skills are not inherently known but must be taught through training, supervision, developing workplaces that support such teachings, and creating policy and organizational change. Culturally competent therapists see, hear, validate, and seek to understand the different experiences of their patients. They are willing to build traditional practices into the therapeutic relationship, consult with other healers, and allow their clients to lead the treatment plan. They do not believe they know more or better than their clients. They are the ones who are seeking to learn with and from their clients.

Section 5: Culturally Responsive Evaluation and Treatment Planning

Introduction

While ensuring that individuals clinicians are culturally competent is an essential part of care, organizations must focus on mezzo and macro-level cultural competency. This means ensuring that policy and procedure promotes a culturally responsive workplace. This is an effort that must be consistent and evaluative. It is the responsibility of all team members to ensure that an agency is culturally responsive. There are nine steps to support a culturally responsive organization. They are as follows: engage clients; familiarize clients with treatment; endorse collaboration; integrate relevant information; gather culturally relevant information; select appropriate screening tools; determine

readiness for change; provide relevant case management; and incorporate cultural factors into treatment planning (SAMHSA, 2016).

These steps are further emphasized below.

Step one: Engage clients

While clients generally opt into care, there is not an inherently established therapeutic relationship between clients and professionals (SAMHSA, 2016). It is the job of clinicians to establish a trusting relationship. How clinicians do this initially will influence the relationship. For example, how they utilize touch and verbal communication, as well as how they address clients will impact the relationship. Clinicians must be aware of the impact of handshakes, facial expressions, and other communication strategies when meeting patients. Not all cultural backgrounds will receive this information the same (SAMHSA, 2016).

The following cross-cultural communication strategies are recommended (SAMHSA, 2016):

1. Slow down for patients
2. Use plain language that is not technical
3. Show or draw pictures as needed to effectively communicate
4. Limit information being offered at once as to not overwhelm patients
5. Explain information being offered to patients
6. Create an environment that does not shame patients
7. Create an environment that allows patients to ask questions and participate to their preferred level

Step two: Familiarize clients with the treatment process

Behavioral healthcare has its own internal culture that patients often become accustomed to. This happens gradually over time. For example, people may use humor that is only accepted in behavioral health, language only accepted in behavioral health, and refer to coping strategies that people in the community may not have heard of.

Individuals who access services eventually become accustomed to or assimilate to this behavioral health culture, but it can be difficult for diverse patients to do so. During the intake process, it can be helpful to utilize the LEARN method (SAMHSA, 2016):

L - listen: listening to patients discuss their cultural background and experiences. Clinicians should do so without asking excessive questions or interrupting patients. They should understand the way their patients think about their problems and the potential treatment process. They should assess for traditional healing practices: if they are present and how they are used

E - explain: clinicians must explain the process of onboarding to behavioral health services. This includes the intake process, assessment period, treatment planning and providing care, and ongoing management of health. Clinicians must understand that the patients' needs come before the overall process and they may need to pause as needed depending on what needs arise for patients

A - acknowledge: clinicians must identify and process through client concerns as they arise. They should call to consciousness any issues between themselves and their clients. They must understand how clients view their illnesses and their health status. These beliefs should be integrated into the treatment plan

R - recommend: clinicians should work with patients to understand the goals of the treatment period and together they must write the treatment plan based on realistic steps that can be taken by clients during the treatment period. These strategies should be evidence-based and supportive of all cultural beliefs and understandings

N - negotiate: clinicians must develop a treatment plan that includes both the practices adopted by behavioral health professionals and practices that are held within the clients' cultural beliefs and understanding

Step three: Endorse collaboration in an interview, assessment, and treatment

The majority of patients who access behavioral health services are unsure of what to expect when they ask for support (SAMHSA, 2016). It is a unique role that clinicians play in the initial appointments with new patients because they must assess important information while not overwhelming their patients in the process as this can promote distrust. The approach must be collaborative and supportive (SAMHSA, 2016).

Clinicians can promote this collaboration by reminding patients how important their feedback is (SAMHSA, 2016). Clients must know that their participation in the intake process and ongoing care is important. They must also know that they get to adjust the service plans as desired. They are in control. This includes clients being able to choose what interventions and therapeutic modalities are used, who attends sessions with them if anyone, and how often they meet with clinicians (SAMHSA, 2016).

Step four: Integrating cultural norms and relevant information

This is an important step in creating culturally competent professionals and therefore culturally competent organizations. Clinicians and organizations must seek to understand the strengths and challenges of diverse cultures . This is done through the strengths-based assessment process, which seeks to identify the following (SAMHSA, 2016):

- Reasons why people are proud of their cultural background
- Social skills, traditions, and knowledge that comes from specific backgrounds
- Bilingual or multilingual skills
- Traditional, religious, or spiritual practices held in diverse cultures
- Generational wisdom
- The relationship with extended family and nonblood family
- How cultural heritage and pride is maintained
- How individuals persevere through racism and bigotry
- Coping mechanisms taught culturally
- The level of community involvement and support

The main domains that must be understood about patients by clinicians are (SAMHSA, 2016):

1. Immigration history - length of time in the United States; ties to the country of origin; language spoken primarily and the level of English spoken; reactions to immigration laws in the United States; status changes that occurred during

immigration; differences in attitude toward drugs and alcohol; and differences in attitude toward the treatment process

2. Cultural identity - clinicians cannot assume they know or understand anything about their patients until they are taught by their patients what to understand about them
3. Subculture membership - while clients likely adhere to sweeping cultural norms or groups, they also are likely to be integrated into a subgroup. This means that their specific families or smaller communities will dissect and implement cultural norms in their specific way. This is often referred to as a "culture within a culture"
4. How the culture teaches its members to access support - some cultures are more encouraging than others where accessing behavioral health services are concerned. Clinicians must understand the stigma and shame related to help seeking
5. Trauma - many diverse groups of people have been subject to significant and repeated traumas. It is important to understand and be sensitive to these traumas in the individual treatment process and the organizational structure. For example, people of color have not historically held positions of power, so it could be traumatic for patients to access services from an organization that does not have any people of color as supervisors and/or in higher management positions. Organizations must be sensitive to this and seek to have a diverse workforce at all levels

Organizations should have a multicultural intake process. Questions should assess for the following (SAMHSA, 2016):

- Immigration history
- Relocation status
- Loss
- Languages spoken
- Individual orientations
- Racial, ethnic, and cultural identity
- Tribal affiliation

- Geographic location
- Family problems
- Acculturation stress and level
- History of discrimination
- Trauma history
- Generational trauma history
- Gender roles
- Birth order
- Relationship history and any dating problems
- Sexual orientation
- Health status and concerns
- Help-seeking history and patterns
- Wellness beliefs
- Mental illness status and beliefs about treatment
- Substance use history and beliefs about substance use
- Family substance use history and family beliefs about substance use
- Cultural approaches to healing
- Education status
- Work status and history
- Financial status and concerns
- Cultural group affiliations
- Community health issues or concerns
- Review of confidentiality
- Review of DSM-5

- Review of the related DSM-5 diagnosis (SAMHSA, 2016)

Step five: Gather culturally relevant information from collateral contacts

Collateral contacts are the people in patients' lives who are close to them and who provide support (SAMHSA, 2016). Many patients who struggle to effectively communicate may rely on their collateral contacts to meet with their clinicians and provide missing information that is helpful to the treatment process. This is often true for young patients and patients with cognitive disabilities. Additional information collected could be from family members, the court system, medical providers, parole officers, community members, and anyone else that patients consent for professionals to communicate with (SAMHSA, 2016).

Step six: Selecting appropriate screening tools

The assessment process is essential for treatment. It helps clinicians and patients understand any mental health diagnoses that are present as well as the treatment modalities that are generally recommended for patients with those diagnoses. It is essential to properly diagnose patients. Because of this, clinicians must use treatment tools and assessment tools that are culturally relevant and appropriate.

The following recommendations are made to clinicians and organizations where appropriate screening processes are concerned (SAMHSA, 2016):

1. Only assess patients in their primary language - do not offer an evaluation until the primary language is understood and any interpreters needed are scheduled
2. Utilize documents that are translated into clients spoken languages
3. Provide documents that speak to various literacy levels and that do not assume that clients know how to read or write
4. Educate clients on the reason for the evaluation period and assessment process
5. Understand how evaluations and tests were developed and understand that not all assessment tools were created with a diverse audience in mind. Clinicians must seek out tools that are as culturally diverse and relevant as possible

Step seven: Determine readiness for change

It is important to understand that just because individuals access behavioral health services does not mean that they are invested in or ready to change their behavior.

Determining readiness for change will help clinicians be visible in appropriate ways with their patients. For example, if patients are not ready to change, clinicians should focus on how to get them ready to change and not on the actual change itself. The readiness for change stages are identified below (SAMHSA, 2016):

1. Precontemplation: in this first stage, patients do not see a need to change. They do not believe their behavior is inappropriate. For example, patients in this stage may think that their drinking behavior is appropriate and like everyone else's, when in fact it is disordered and requires treatment

2. Contemplation: in this second stage, patients begin to consider what taking action to change might look like. They are not ready to engage in that action but they learn about or think about that action. For example, patients might learn about Alcoholics Anonymous during this stage but not find a meeting near them

3. Contemplation: in this third stage, patients prepare to engage in change behavior. They might take small steps toward change. For example, patients may find a local Alcoholics Anonymous meeting close to them and access a list of meetings that are available to them

4. Action: in this fourth stage, patients engage in the changed behavior. For example, patients would attend the Alcoholics Anonymous meeting

5. Maintenance: in this final stage, patients continue to engage in the action behaviors but they are more integrated into their lifestyles. The behavior is habitual. For example, patients attend Alcoholics Anonymous meetings weekly and continue to engage in sober behavior

Step eight: Provide case management that is culturally responsive and appropriate

Case management is an effective service for diverse patients (SAMHSA, 2016). Many individuals from diverse backgrounds may speak English as a second language, have a mistrust of systems, and be unsure of what services exist and how to access them. Assigning patients a case manager to help them navigate systems and to access necessary services is essential to supporting patients holistically. Case management must be culturally appropriate and responsive (SAMHSA, 2016).

Case management principles include (Case Management Society of America, 2017):

1. Using a collaborative approach to care

2. Facilitating self-determination for patients
3. Providing advocacy and education
4. Adhering to a holistic approach
5. Practicing cultural competence
6. Respecting diversity
7. Promoting evidence-based practices
8. Promoting client safety
9. Utilizing behavioral change practices
10. Connecting clients with community-based resources
11. Assisting patients in navigating systems
12. Providing professional excellence
13. Promoting outcomes - measure outcomes to ensure goals are met
14. Supporting local, federal, and state law
15. Supporting organizational policy

Step nine: Incorporate cultural factors into treatment planning

Treatment planning must be collaborative and clinicians must be willing to adjust the treatment plan as clients' needs change and grow (SAMHSA, 2016). To develop a culturally relevant treatment plan, clinicians must practice active listening, understand client beliefs, and adjust services to be consistent with cultural beliefs and norms.

Summary

Providing culturally competent behavioral health services is a comprehensive process. It requires that clinicians are aware of cultural practices, are willing to ask questions, are willing to advocate, and are able sit in discomfort at times. This is especially true when interacting with diverse populations they have had little experience with. Clinicians must understand that the process of intake, evaluation, treatment planning, and ongoing care heightens vulnerability for those who access it.

Section 6: Organizational cultural competence

Introduction

While much of the above steps require organizational structure and involvement (for example, ensuring that paperwork is translated into various languages), cultural competency does not end at micro-levels (SAMHSA, 2016). Organizations must be culturally competent to best serve diverse communities. Culturally responsive organizations address culture in all domains. This includes values, governing tasks, planning tasks, evaluation, language services, workforce development, and infrastructure (SAMHSA, 2016). These domains are expanded on below.

Organizational values

Tasks that are included in this domain are: being committed to cultural competence; reviewing the mission, vision, and values statements to ensure they are culturally relevant; and addressing cultural competence when planning strategically (SAMHSA, 2016). The mission statements and values are often the first things that potential clients will learn about organizations. They must capture all diverse populations and allow them to feel seen, heard, and validated in the environment (SAMHSA, 2016).

Governance tasks

Tasks included in this domain are: assigning senior managers to ensure that organizational change is culturally appropriate and responsive; developing boards that advise cultural competency; and creating a committee that ensures the organization is diverse (SAMHSA, 2016).

The following advice is for upper management personnel who oversee the development of such committees (SAMHSA, 2016):

1. Invite board members to recruit community members - this helps establish the most diverse group of individuals
2. Ensure that advisory boards assess policies for cultural relevance
3. Hold focus groups in communities to ensure that the needs of communities are understood by organizations
4. Write and implement the policy that supports multiple communication strategies and share this with the community that the organization supports

5. Provide ongoing training to staff employed by the organization on best practices for diverse patients
6. Develop outreach programs to communicate with community members - this must be done in multiple languages and should focus on various mental illnesses. Substance use needs to be a focus always
7. Ongoing analysis of community needs and trends must be completed to continue to understand the population
8. Use local goods and resources and refer patients to such resources

Planning tasks

Tasks included in this domain are engaging staff, clients, and community members in the planning process; developing cultural competence plans; reviewing policies to ensure that organizations adhere to cultural competency norms (SAMHSA, 2016).

The following must be considered when planning for care (SAMHSA, 2016):

1. How easily patients can access services
2. How readily available diverse clinicians are
3. How positive the environment is where patients access services
4. How clients are retained
5. How employees are retained

The following advice is given to organizations for developing cultural competency plans (SAMHSA, 2016):

1. Have an understanding of the social, cultural, and historical experience that the community has had
2. Understand ethical, cultural, linguistic, and social groups local to the organization
3. Document, track and assess the reasons that clients do and do not access services and why they may be turned down for services
4. Understand the rates of completion generally by the community
5. Maintain client files for individuals who do not complete treatment

6. Reduce any barriers to accessing treatment for community members
7. Develop a plan to ensure services are user friendly and diverse
8. Measure the success of programs being offered

Evaluation and monitoring tasks

Tasks in this domain include creating demographic profiles for the communities being serviced and conducting self-assessments of clinician knowledge of cultural competence (SAMHSA, 2016).

To best evaluate services, information must be collected at all levels of services. This includes organizational staff, clients, community members, and collaborative professionals (those who work with the agency to support clients but who are not employed by the agency).

These steps are recommended for how to effectively collect such information (SAMHSA, 2016):

1. Identify stakeholders who offer feedback necessary for the agency to understand how their services are received by the community
2. Develop self-assessment guidelines and assess clinicians for how culturally competent they are
3. Use consultants and outside evaluators to analyze this information when feasible. This may be difficult for many non-profit organizations, but if possible it is one of the best ways to ensure that agencies are culturally competent
4. Utilize assessment tools that support all stakeholders
5. Determine how to distribute the data collected to best implement positive practices. All assessment tools and processes must be explained to those who access them and the subjects must consent to the process. This is critical in the evaluation. Additionally, if possible, a third party should offer the assessment
6. Analyze the data
7. Identify priorities in policy development and organizational change based on the data collected. These changes should improve the cultural responsiveness of services and should be based on the quantitative and qualitative feedback received from community members and other stakeholders

8. Develop a plan for ongoing monitoring of the policy and procedural changes. Ongoing performance should be assessed to determine the quality of care

Language services

Tasks that are included in this domain are: planning for proactive language supports and services and establishing guidelines for training clinicians on the use of language services (SAMHSA, 2016).

Behavioral health organizations will have to serve all patients, regardless of the language that they speak. They must be prepared for having translation services available when necessary. The following recommendations are made for how to inform patients about language services available (SAMHSA, 2016):

1. Use language identification cards
2. Post signs that indicate language services are available
3. Use clear procedures that support telephone communication for people with limited English
4. Use statements that indicate that patients have free access to language assistance services

Workforce and staff development

Tasks in this domain include: recruiting diverse staff and promoting diverse staff; training around cultural competence; providing culturally competent supervision; and evaluating staff on cultural competency (SAMHSA, 2016).

Clients must see themselves in the agency they are accessing services from. Furthermore, to develop a culturally competent staff, an agency should be following these guidelines for effective cultural competency training (SAMHSA, 2016):

1. Educate new staff on the mission, vision, and values of the agency as it relates to cultural competency
2. Address the demographics of the communities being served by the agency in the onboarding of new staff
3. Ask staff members about the needs of the clients that they serve when developing pieces of training

4. Training must be offered on an ongoing basis
5. Training should incorporate diverse ways of learning. For example, it should serve the four main adult learning styles
6. Training must be evidence-based
7. Training must be welcoming and non-judgemental for those who attend
8. Training must be professional and involve active learning opportunities such as role-play, case studies, and presentations
9. Training should be conducted by an interdisciplinary team with multiple professionals - this team should be diverse and well versed in cultural competency
10. Training should allow for question and answer and be experiential as needed

In supervision, supervisors should facilitate self-assessment for clinicians to identify how culturally competent they are. The following assessment tool is recommended (SAMHSA, 2016):

Clinicians should identify if they have in the past month or six months have done the following:

1. Recognized a prejudice they held about a group of people
2. Talked with a peer about a cultural issue that arose in services
3. Sought support from a peer or supervisor about a cultural issue that came up in therapy
4. Attended training on a multicultural topic
5. Attended an event specific to a different culture
6. Reflected on own cultural and racial identity and the impact it has in treatment with clients
7. Read about a multicultural issue
8. Read about a racial group outside of their own
9. Sought supervision on a multicultural issue

10. Talked with a friend or peer about cultural differences between them
11. Challenged an oppressive statement

Organizational infrastructure

Tasks in this domain include: planning fiscal support for cultural competence; creating environments that serve all the groups of people in the community; and improving access to care (SAMHSA, 2016).

There must be adequate resources to support the individuals who need them. This is a requirement for culturally competent organizations. Because many organizations may be state or federally funded, there will always be a need for more services. Many organizations have to become creative with how they seek additional funds for resources.

The following recommendations are made (SAMHSA, 2016):

1. Collaborating with other community resources: the ability to refer patients to other community-based resources as needs arise will be helpful, although it is important to support patients through this process so that they do not feel they are being "tossed around" between systems
2. Co-locating services: co-locating services are those that are held in one central location. For example, a person might go to one building for mental health services and in that same building is the social security office and a medical clinic. This helps to reduce the barriers associated with accessing care, such as transportation. Coordination between agencies must be completed to effectively create co-located services, but these outreach efforts help increase client access. Additionally, if translation or language services can be present in one location, this will help patients access multiple services, and utilization and understanding rates will be increased
3. Seeking community support and information: organizations should seek feedback from community members on how to improve care as needed. Organizations that build teams that focus on community outreach are generally the most successful with this
4. Supplying support: offering services that make it more accessible for individuals to access care is incredibly helpful. For example, when case managers provide transportation to and from services, patients are more likely to engage in

services. Other examples include offering bus tickets, ride-sharing, or meal vouchers

5. Utilizing culturally appropriate education services: community members must be learning about health issues, services, and positive outcomes. Different communities may prefer to learn differently. Because of this, organizations must target specific communities in ways that positively serve them

Summary

Organizations must be prepared to address cultural competence at all levels. It is not enough for clinicians to understand and be culturally competent. The organization's members must be committed to cultural competency in how they write policies, how they physically establish their clinics and offices, how they engage in the community, and how they hire staff.

The most successful organizations are those that are specifically invested in cultural competence. This likely involves hiring consultants to provide assessments of their cultural competence and suggestions for how to become more competent. It must also include asking community representatives their opinions on the organization's values, services, and policies. If individuals within communities do not feel that organizations are culturally competent, they will be less trusting and less likely to access necessary behavioral health services.

Section 7: Working with specific groups of people

Introduction

While white Americans may feel more empowered to access behavioral health services, there is no limit to the number of diverse individuals clinicians will work within a treatment. Clinicians must be understanding of how different racial groups interact with those in their profession. Culturally competent providers will have an understanding of client identities and the way their culture impacts their lives. The information below is identified by SAMHSA based on primary racial groups and how they may interact in care.

Counseling for Black Americans

According to research discussed by SAMHSA (2016), Black Americans may see substance use differently than other groups of people. These individuals may struggle to accept alcohol or substance use as a disease or dependency. This could be because their

substance use is more often related to discrimination or racial trauma than the substance use of white people. This is important for clinicians to understand in care and they must discuss substance use in a way that is consistent with this. Studies show that this group of people is more likely to receive treatment for substance use issues but less likely to receive treatment for anxiety and depression. This is likely due to misdiagnosis and understanding the root cause of substance use (SAMHSA, 2016).

Black Americans are less likely to access behavioral health services than white Americans are (SAMHSA, 2016). They are more likely to have undetected mental illnesses, have longer wait times for services, more barriers to accessing treatment, and shorter times spent in treatment programs than white Americans are (SAMHSA, 2016).

Black Americans are less likely to self-refer for services than white Americans are (SAMHSA, 2016). They have more internalized fear about the therapy process and discrimination they may experience in treatment. Because of this, clinicians must spend a good amount of time establishing a therapeutic relationship with their black clients. They should slowly request information, avoid overwhelming information-gathering, and properly pace the session to meet the specific needs of their patients. They should not force any agendas other than their clients' agendas. Clinicians should also understand that black families value strong bonds, adaptability, hierarchy, strong work ethic, and strong religious affiliations. These should be integrated into treatment (SAMHSA, 2016).

Counseling for Asian Americans, Native Hawaiians, and other Pacific Islanders

In these cultures, alcohol is often utilized in a healing capacity, however, some groups believe that illicit substance use is incredibly inappropriate and should not be discussed (SAMHSA, 2016). Counselors need to tread lightly on such topics as there may be internalized shame and disgust. Asian Americans use substances less frequently and less heavily than any other group of people (SAMHSA, 2016).

Within Asian culture, health and mental health are viewed as one in the same (SAMHSA, 2016). The ability to regulate emotions and have self-control is often associated with self-discipline, and therefore those who struggle with regulating are often seen as immature or not disciplined enough. Asian cultural groups are also more likely to be stoic in their response to trauma and are not taught to express their emotions related to traumatic experiences (SAMHSA, 2016).

The rates of Asian Americans who seek behavioral health services are low (SAMHSA, 2016). These individuals are more likely to seek support from traditional or religious healers before they do from behavioral health professionals. They are often very invested in medical care and have high confidence in their medical doctors. They will likely turn to medical doctors before behavioral health professionals for support (SAMHSA, 2016).

Asian Americans respond to kind and warm approaches for treatment (SAMHSA, 2016). Establishing a trusting therapeutic relationship will take time, similar to working with Black Americans. There is likely to be internalized shame when accessing behavioral health services and this should be understood and addressed in treatment. Shame is often a barrier to individuals accessing necessary medical services (SAMHSA, 2016).

Many Asian cultures are highly aware of the cognitive thought process and this can be helpful in treatment (SAMHSA, 2016). For example, Buddhist traditions believe that behavior is controlled by thought. Therefore, if individuals change their thoughts then they can change their behavior. Other Asian cultures are taught to suppress thoughts and behaviors. The clinicians treating these patients should complete an assessment to understand their specific client's thought patterns and how those influence behavior (SAMHSA, 2016).

Counseling for Latino and Hispanic individuals

Latino cultural groups are more likely to view substance use negatively compared to white Americans (SAMHSA, 2016). They expect negative outcomes from using substances more often than positive outcomes. They are less likely than white Americans to have a substance use disorder. Research shows that Latino individuals have fewer mental illnesses than white Americans, however, this should continue to be assessed as language barriers may impact the research and diagnosis process (SAMHSA, 2016).

Latino individuals are less likely to have insurance coverage and therefore less likely to seek necessary supportive services (SAMHSA, 2016). They are also more likely to require translation services, and these may be limited or unavailable, depending on the organization. Additionally, fear about immigration status often prevents these individuals from accessing care. This is important for clinicians to understand and be sensitive toward. This also impacts the way that Latino individuals think about healthcare. They may be frustrated by the inability to access care and its lack of affordability. Because of

this, clinicians must work to establish a trusting therapeutic relationship before approaching intimate and difficult work with patients (SAMHSA, 2016).

Latino individuals generally view time as less structured and clinicians should consider this when scheduling appointments (SAMHSA, 2016). They should be flexible to meet this and avoid framing being late or missing appointments as not being compliant with care. Latino individuals are highly invested in the family relationship and often have a strong religious affiliation. This should be considered in care as well as traditional healing practices (SAMHSA, 2016).

Counseling for Native Americans

Native Americans are among the most diverse people (SAMHSA, 2016). In the United States, there are 566 federally recognized tribes, who speak over 150 languages. These individuals often live on reservation land, which has its own unique system to navigate. Individuals can opt into receiving services on reservation land or through Non-Native governments if they are Medicaid eligible.

Native Americans often have high levels of substance use and binge drinking (SAMHSA, 2016). Drinking and illicit drug use are higher in Native American communities than in the general population and the beliefs about substance use vary by tribe. Native American people often are subject to high levels of poverty and trauma, which compounds their experience with mental illness. Native Americans are twice as likely to have suicidal thoughts and have higher rates of major depressive episodes (SAMHSA, 2016).

Each tribe will have different beliefs about treatment and considerations to keep in mind. It is important to understand that traditional healing is essential in these communities and must be integrated into treatment (SAMHSA, 2016). Clinicians should be prepared to support patients in identifying and accessing community-based resources because of the high rates of poverty.

Native American people often establish relationships over time in a calm and slow-paced manner (SAMHSA, 2016). Clinicians must consider this and spend time establishing a connection. Native Americans also believe that health and balance are inherently connected and deeply grounded in nature. This should be integrated into treatment as well. Clinicians should use their active listening skills, avoid interrupting these patients, and refrain from asking about personal matters without the patient's consent (SAMHSA, 2016). These steps could significantly impact the therapeutic relationship in a positive way.

Counseling for white Americans

White Americans are the most likely group of individuals to access behavioral health services (SAMHSA, 2016). They readily use alcohol and believe it is acceptable unless it impacts their functional tasks and responsibilities. They use substances at higher rates than most other groups of individuals. 20% of white Americans had a mental illness in the last year and are more likely to have serious psychological distress than other groups. They are more likely to access treatment for their distress (SAMHSA, 2016).

White Americans are generally accepting of treatment and are more likely to access it (SAMHSA, 2016). They are generally the group of people for which treatment programs are developed, and therefore can easily respond to or receive treatment, compared to other groups. White Americans respond well to having as many coping tools as possible. Cognitive-behavioral therapies are well received but must be adjusted based on the individual's income and education status/history (SAMHSA, 2016).

Summary

Distinct groups of people will respond differently to treatment. Generally, people of color with diverse backgrounds will require a longer time spent establishing a relationship with clinicians compared to white Americans (SAMHSA, 2016). They also require the integration of traditional healing strategies compared to white Americans, who respond best to traditional cognitive-behavioral models of care.

Clinicians should understand general themes when working with diverse populations but not assume that they know their clients and their backgrounds before having met them and gotten to know them. This kind of assumption can further stigmatize the behavioral health field for people of color (SAMHSA, 2016).

Section 8: Case studies

Kamel

Kamel is a 29-year-old Black American who was raised in a middle-class suburb in Oregon. He recently went for therapy services for the first time to address ongoing anxiety and depression. When he met with his therapist, a white woman, she asked him during the assessment process, "Were you raised in a low-income neighborhood?"

Kamel was offended by this question as he felt her question was an assumption related to his status as Black. His parents taught him to be proud of having been raised middle-

class with access to all the necessary supports and services that he was exposed to during his life. Kamel is college-educated and works in finance. Upon the completion of the assessment process, Kamel decided to find a Black clinician to work with as he felt this question would have been worded differently had he been working with a clinician of his same race.

Kamel's case is a good example of understanding how the appropriate wording of questions during an intake is essential to being culturally competent.

Laren

Laren is a 32-year-old Native American man who served in the military and now lives back on reservation land. He is struggling with post-traumatic stress from several deployments and has begun using alcohol to cope. Laren was referred to treatment after a DUI. When he met with the clinician he broke down in tears during the first session.

Laren's clinician spent the first few sessions simply listening to him and his experiences within the military before asking "Would you like to process the trauma associated with your military service?"

Laren's case demonstrates how when working with Native American people, clinicians must spend time getting to know their clients and allow them to be as open as possible before offering a specific modality or course of treatment, as that could be overwhelming and off-putting.

Teresa

Teresa is a 17-year-old white teenager who recently met with a clinician for the first time to address substance use and self-harm. When she was going through the intake process, the clinician asked her if she was dating any "boys." Teresa was offended by this as she identifies as a lesbian and she angrily responded with, "Ew, no, why would you ask that? I'm a lesbian."

Teresa's case is a practical reminder of how clinicians cannot assume that their white clients adhere to all privileged or traditional identities.

References

American Psychological Association. (2017). Disparities in mental health status and mental health care. Retrieved from https://www.apa.org/advocacy/health-disparities/health-care-reform

Case Management Society of America. (2017). Standards of practice for case management. Retrieved from https://www.abqaurp.org/DOCS/2010%20CM%20standards%20of%20practice.pdf

CDC. (2020). Disability impacts all of us. Retrieved from https://www.cdc.gov/ncbddd/disabilityandhealth/infographic-disability-impacts-all.html

Census.gov. (2020). Income and poverty in the United States: 2019. Retrieved from https://www.census.gov/library/publications/2020/demo/p60-270.html

Cox, D. & Jones, R. (2016). America's changing religious identity. Retrieved from https://www.prri.org/research/american-religious-landscape-christian-religiously-unaffiliated/

Gates, J. (2016). Prevalence and population estimates for sexual orientation and gender identity. Retrieved from https://www.drgaryjgates.com/lgbt-how-many

Goldback, J. (2020). Diversity toolkit: A guide to discussing identity, power, and privilege. Retrieved from https://msw.usc.edu/mswusc-blog/diversity-workshop-guide-to-discussing-identity-power-and-privilege/#cross

Kaiser Family Foundation. (2021). Race/ethnicity. Retrieved from https://www.kff.org/other/state-indicator/distribution-by-raceethnicity/?currentTimeframe=0&selectedDistributions=multiple-races&selectedRows=%7B%22wrapups%22:%7B%22united-states%22:%7B%7D%7D%7D&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

Lusk, M., Terrazas, S., & Salcido, R. (2017). Critical cultural competence in social work supervision. Retrieved from https://supervisiontraining.ca/wp-content/uploads/2019/01/2017_-_Mark_Lusk_-_CriticalCulturalCompetenceinSocialWorkSupervisionretrieved_2018-09-16.pdf

NAMI. (2017). Challenging multicultural disparities in mental health. Retrieved from https://www.nami.org/blogs/nami-blog/july-2017/challenging-multicultural-disparities-in-mental-he

NAMI. (2017). Disparities within minority mental health care. Retrieved from https://www.nami.org/Blogs/NAMI-Blog/July-2017/Disparities-Within-Minority-Mental-Health-Care

Northwestern University. (2021). Social identities. Retrieved from https://www.northwestern.edu/searle/initiatives/diversity-equity-inclusion/social-identities.html

SAMHSA. (2016). Based on tip 59: Improving cultural competence. Retrieved from https://store.samhsa.gov/product/TIP-59-Improving-Cultural-Competence/SMA15-4849

Steinmetz, K. (2021). Inside the efforts to finally identify the size of the nation's LGBT population. Retrieved from https://time.com/lgbt-stats/

UPenn. (2017). Cultural competency in mental health. Retrieved from http://tucollaborative.org/wp-content/uploads/2017/01/Cultural-Competence-in-Mental-Health.pdf

VanAlstine, Jason; Cox, Steven R.; and Roden, Dianne M. (2015) "Cultural Diversity in the United States and Its Impact on Human Development," Journal of the Indiana Academy of the Social Sciences: Vol. 18 : Iss. 1 , Article 10. Retrieved from: https://digitalcommons.butler.edu/jiass/vol18/iss1/10

YWCA Boston. (2021). What is intersectionality, and what does it have to do with me? Retrieved from https://www.ywboston.org/2017/03/what-is-intersectionality-and-what-does-it-have-to-do-with-me/

Mindful
Continuing Education