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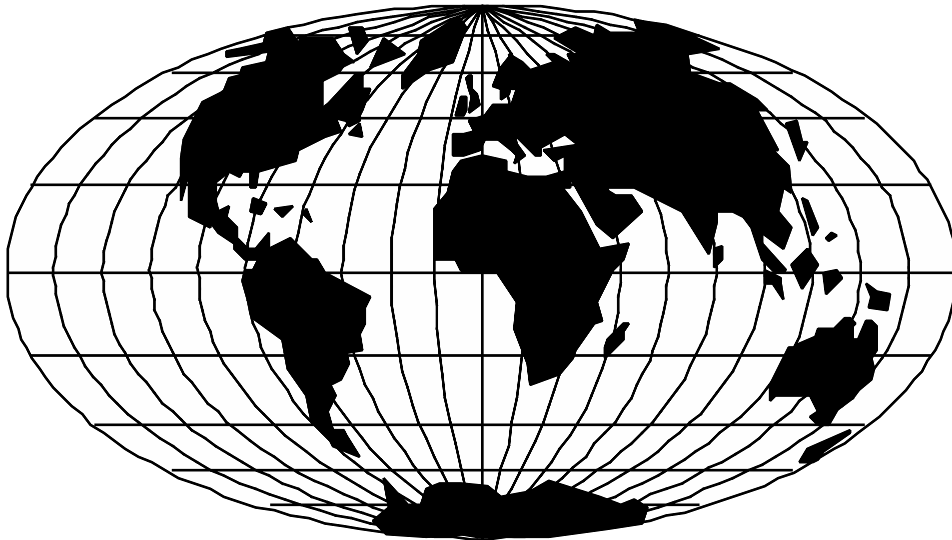

CULTURAL COMPETENCY
in the Age of Managed Care

May 14 & 15, 1997
Holiday Inn
Worcester, MA

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Arthur Evans, Ph.D.
Co-Chair
Addiction Technology Transfer Center
of New England Conference Planning Committee

Billl Walker
Co-Chair
Addiction Technology Transfer Center
of New England Conference Planning Committee

Susan Storti, RN, MA, CDNS
Co-Director
Addiction Technology Transfer Center
of New England

Neill Miner, MSW
Co-Director
Addiction Technology Transfer Center
of New England

Cheri Avery-Black
Temple University
Philadelphia, PA

Wonjen Bagley
MA Bureau of Substance Abuse Services
Boston, MA

Norma Baker
Northern Educational Services
Springfield, MA

Robert Bick
Champlain Drug and Alcohol Services
South Burlington, VT

Sallie Brown
VT Office of Alcohol and Drug Abuse Programs
Burlington, VT

Edgar Colon, Ed.D
Southern Connecticut State University
New Haven, CT

Lauren Corbet, MSW
VT Office of Minority Health
Burlington, VT

Joy Connell
Department of Mental Health
Refugee Assistance Program
Boston, MA

Carolyn D'Avanzo, D.N.Sc.
University of Connecticut
School of Nursing
Storrs, CT

Sherry Dorris
CT Department of Mental Health
and Addiction Services
Hartford, CT

Jerry Fougere
Somersworth, NH

Sue Graham
CT Department of Mental Health
and Addiction Services
Hartford, CT

Jim Gorske
AdCare Educational Institute
Worcester, MA

Dick Gott
Mashantucket Pequot Health Department
Ledyard, CT

Jan Scott Harris
Region 1 Office of Minority Health
US Department of Health & Human Services
Boston, MA

Della Hennelly
CT Department of Mental Health
and Addiction Services
Hartford, CT

Norman Hoffmann, Ph.D.
Brown University
Center for Alcohol and Addiction Studies
Providence, RI

Rose Marie Ingegneri, LCDP
Drug and Alcohol Treatment
Association of Rhode Island
Providence, RI

Levi Jackson
Bridgeport, CT

William Lowenstein
ME Office of Substance Abuse
Augusta, ME

Jazmin Miranda-Smith
NH Mintority Health Coalition
Manchester, NH

Jose Ortiz
CT Department of Mental Health and
Addiction Services
Hartford, CT

Robert Savage
West Hartford, CT

Suman Timsina
JFK Community Mental Health
and Retardation Center
Glenolden, PA

Michael Torch
Seaborne Hospital
Dover, NH

Elvira Trujillo-Schrader
Yale University School of Medicine
New Haven, CT

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CULTURAL COMPETENCY
in the Age of Managed Care

INTRODUCTION

Many practitioners, policy makers, administrators and researchers have articulated the need to provide treatment services in a culturally responsive manner. That is, in a manner that takes into account how cultural variations influence service delivery. Even though there is an increasing recognition that cultural factors are an important variable in how services are delivered, there is still a lack of specific, practical guidelines that can guide the addictions professional.

To address this need, the Addiction Technology Transfer Center of New England, in collaboration with a broad range of groups from around New England sponsored a working conference in May 1997 entitled, "Cultural Competency in the Age of Managed Care." The goal of this conference was to develop guidelines for professionals serving the four major cultural groups in the United States: African-Origin, Asian-American, Latino and Native American people. The conference addressed guidelines for the clinician, program administrator and the policy-maker or payer.

On the first day of this two-day conference, participants were divided into workgroups that focused on service delivery for each of the four cultural groups. Each workgroup identified barriers and solutions to providing culturally competent substance abuse treatment. Specific recommendations were made for clinicians, program administrators and policy-makers.

On the second day of the conference, participants focused on clinical, administrative and policy/payer issues that transcended the specific cultural groups. Specific recommendations were made to professionals working at each of these three levels in the treatment system.

The result of this work is presented here. This document represents the proceedings of a dynamic process of committed and knowledgeable professionals who have many years of experience in serving the groups of interest. It is hoped that it will assist professionals in providing culturally competent treatment services.

The conference and this proceedings document are the first step in a process that will provide further guidance to professionals who work with culturally diverse groups. Subsequent steps include the development of an annotated bibliography, program performance indicators and a user friendly "how to" manual on providing culturally competent services.

Conference at a Glance

PART I SUMMARY OF PLENARY SESSIONS

Opening Plenary	May 14, 1997	King Davis, Ph.D.
Panel on Cultural Perspectives		Frances Brisbane, Ph.D. Jeff Whelan Davis Ja, Ph.D. Nicolas Parkhurst-Carballeira, N.D.,M.P.H.
Dialogue on Advocating for Systems Change		David Mactas
Opening Plenary	May 15, 1997	Anita Pernell-Arnold, M.S.S.W.

PART II OUTLINE OF CONSENSUS-BUILDING FORUMS

A. Substance Abuse Treatment Considerations for Persons of African Origin
Fred Swan, Norma Baker, and Francis Brisbane, Ph.D.

B. Substance Abuse Treatment Considerations for Latino People
Haner Hernandez, Fernando Miranda, Rolando Martinez, and Virginia Ruiz

C. Substance Abuse Treatment Considerations for Native Americans
Richard Gott, Gerald Fougere, Michael Torch, Keith Francis, Edward Perley, and Vincent Nicholas

D. Substance Abuse Treatment Considerations for People of Asian Descent
Joy Connell, Carolyn D'Avanzo, D.N.Sc., Maryann Amodeo, Ph.D., Sonith Peou, and AnTonThat

PART III OUTLINE OF CONSENSUS-BUILDING FORUMS

E. Policy Issues in Fostering Diversity Among Substance Abuse Treatment Programs
Suman R. Timsina, M.A., C.A.C., Michael J. Finnegan, M.Ed., C.A.C., and Eravia Gutierrez

F. Program Administration Issues in Treating Diverse Populations
Arthur Evans, Ph.D., Del Oladeinde, and Edith Sanchez

G. Clinical Service Issues in Treating Diverse Populations
Alicia Munroe, M.D., Catherine Dube, Ed.D., and Roberta Goldman, Ph.D.

PART IV NEXT STEPS: STEERING COMMITTEE PLANNING

PART I

SUMMARY

OF

PLENARY SESSIONS

MAY 14-15, 1997

OPENING

PLENARY

King Davis, Ph.D.

MAY 14, 1997

INTERFACE BETWEEN MANAGED CARE AND CULTURAL COMPETENCY

King Davis, Ph.D.
Professor of Social Policy, Virginia Commonwealth University
School of Social Work

Dr. Davis stated that he wanted to talk about and conceptualize the interface between managed care and cultural competency in terms of an intersection: the intersection of two streets, and all that occurs at intersections, positively and negatively. The transcript of his presentation is provided below:

One of the important things when thinking about the intersection is to conceptualize the nature of the health care problem, past and present, in the United States. The context within which all the activity around state government is occurring in the United States has a lot to do with cost, access, quality, policy, and profit. Without the context, one would probably accept the myth that the old fee-for-service system was great. It was not great for populations of color, or any better than what is currently being offered in managed care. A series of works put out by the Robert Wood Johnson Foundation on substance abuse and ethnic groups of color describes in detail that populations of color have suffered tremendously under fee for service. As managed care systems develop further, there are still a lot of questions that should be raised about the delivery of health care to populations of color in the United States. Doing so will provide an idea of how we should respond, regardless of the type of system we have.

A couple of characteristics about the fee-for-service system which got us in trouble were unlimited cost and unlimited access. A fee-for-service environment creates an incentive to provide more and more service. Within the fee for service environment there are no incentives for anybody to co-pay, or to pay attention to cost for the client, patient, or provider. It was to the advantage of every health care provider to bill for all services provided, and to be reimbursed.

Fee-for-service, with unlimited cost and service, tended to raise the total cost of health care in the United States to astronomical levels. The cost of health care in the United States, is 2 to 3 times greater than that of national defense. Health care cost in the United States, until 1993, was 13 to 15% of the gross domestic product, and was doubling at a rate of once every two to four years. Health care cost in the U.S. is now about 840 billion dollars, with predictions that between year 2000 and 2005 we will have an economy in which health care cost represents a 1.5 trillion dollars.

The people that pay for health care-large employers, government, and manufacturers-pass the health care cost on to their customers as part of the cost of goods. As a result, manufacturers, on an international basis, get concerned because they don't feel competitive in an international market.

In 1995, the majority of health cost went for hospital-based services. As a result, an effort is being made to reduce health care cost by reducing the percentage of dollars paid to hospitals and for hospital beds. Health care, in the United States, is big business. Therefore, it is not surprising that many organizations want to be a part of that business.

You have to conclude that, prior to 1995, health care services in the United States were unmanaged, or not managed well. Costs were excessive, quality outcomes were not demonstrated, and the health care provided did not meet the patients' needs. As managed care services emerged, companies were asked to serve people of color and other ethnic groups without really understanding their needs.

Other industries, as demonstrated by their advertising and marketing, have understood cultural competency better than health care providers. When we begin to ask questions about the perspectives of different cultures, we find out that groups differ. Cultural competency is nothing more than being specific about the nature of the market, and designing services and products to fit that particular market. You find out whether or not the services and products fit by asking people what they need, and in what form.

The success of managed care depends on the extent to which people in managed care become proficient in providing cultural competency. A trade definition of managed care is “any plan, process, or mechanism in which there is an attempt to impact the price of health care, the sites where it is delivered, or the utilization of service.” Another definition of managed care is “nothing more than an insurance plan with lots of utilization review.”

Managed health care in the United States care is not occurring in a vacuum. It is occurring along with states' rights, and the shift in Medicaid, Medicare, and welfare. States will have the right to make decisions regarding eligibility for welfare and Medicaid, and to set their own standards on eligibility, and benefit levels.

There are more accidents and mistakes at intersections than any place else. Like intersections, the beginning of managed care has experienced more accidents in the design and delivery of service, and more mistakes. The intersection presents the greatest opportunity for making mistakes and errors, and having accidents, but also presents the greatest opportunity for making choices and the largest number of general opportunities. If you miss the opportunity to make your choice for your group, someone will make the choice for you. Things stop at the intersection only momentarily, and then move on. Consumer groups have to be committed to making sure that the systems, as they move forward, fully understand the needs of the consumer. This includes an understanding of substance abuse and other issues, in order for the systems to respond in a market-specific way to consumer needs. The manner in which to communicate these needs is to adopt standards and guidelines.

At the intersection of managed care, are the gatekeepers, capitation, integrated services, carve-ins, carve-outs, choice, confidentiality, and networks. Managed care is an employment-based system. Many cultures have extremely high unemployment rates. Part of what is clear at the intersection of managed care and cultural competency is that men of color below the ages of 35 are likely not to have health insurance, or opportunities, in a managed care environment. These men are more likely to be involved with substance abuse. One of the critical things to understand about the intersection is that a number of the populations you may want to serve, may have a very difficult time because managed care is employment-based.

Also included in managed care are preauthorization, utilization review, information systems, and an acute care orientation. Managed care pays special attention to acute, short-term care. The service needs of the cultural population you represent in this managed care environment are often those which managed care is attempting to de-emphasize. Issues regarding cultural competency, within the intersection, are access, getting into the systems, equity of services, respect, attitudes, personal space, language, geographic distribution, and help-seeking patterns. Service providers, and college and university curriculums, need to emphasize cultural competency. Managed care will not save dollars unless the services are culturally competent.

It is important, in a managed care environment, for communities and organizations to look at special issues: the most common disorders, the presence of chronic illness, employment, HIV, substance abuse, interconnectedness and relationships of families, how families utilize services, multiple agency ties, religious-based orientations, the influence of how problems are observed, and community involvement.

Some additional special concerns of people of color, at the intersection, are loss of jobs through agency mergers, not being accepted on panels, and differences in the credentialing process. As a result, this intersection becomes a point of real tension, and populations of color become especially uncomfortable about the nature of the managed care environment.

Looking toward the future, the following things need to happen at the intersection of cultural competency and managed care:

- organizations, groups, and individuals have to insure that specific attention is paid to prevention in managed care
- creation of cultural competency certification--managed care billing and providing services should be connected to certification
- strategic planning, guidelines, and standards
- continuing education of service providers
- advocacy for populations of color to own part of the system

Ten things that will bring about cultural competency are:

1. know the existing policies
2. develop alternative policies
3. exert collective influence on national policy
4. exert collective influence on a state level
5. impact managed care plans and organizations
6. help develop standards and guidelines
7. establish cultural competency certification
8. create opportunities for ownership and investment
9. establish an internet connection
10. develop and deliver a national conference

PANEL

ON

CULTURAL PERSPECTIVES

Frances Brisbane, Ph.D.
Jeff Whelan
Davis Ja, Ph.D.
Nicholas Parkhurst Carballeira, M.D., M.P.H.

PANEL ON CULTURAL PERSPECTIVES

Frances Brisbane, Ph.D.

Dr. Brisbane identified several strategies and considerations which enhance the cultural competency of treatment for African Americans:

- The provider must be proud of the African American culture.
- Providers must utilize non-barrier language.
- The name of the service must reflect a positive result. African Americans are less likely to seek services in places that have a name that is negative.
- Solutions must be guided by cultural norms and world views.
- Solutions must be sought that consider individual uniqueness, such as family background, place of birth and growth, age, sex, religion, help-seeking behavior, and the client experiences.
- Prevention and treatment must be based on resiliency factors that define cultural norms and opportunities and recognize the ability of the client to turn adversity into assets.
- The African American community regards crying as a cleansing process, and important to the success of treatment.
- Most African Americans believe that faith and prayer work.
- African Americans are not word-dependent: they respond when allowed to actively participate in their treatment. Therefore, creative, artistic, and abstract ways must be found to break silence barriers and begin a positive relationship and a treatment that is interactive and activity-based.
- African Americans are a relational people. They have a high regard for the interpersonal relationship.
- Clinicians need to demonstrate care and concern for African American clients because African Americans care more about how much you can do than they care about how much you (the clinician) know.

PANEL ON CULTURAL PERSPECTIVES

Jeff Whelan

Mr. Whelan stated that his Mohawk name is Teioterateh. He is a member of the Wolf Clan, and comes from the St. Regis Mohawk Indian Reservation known as Akwesasne. He stated that he was nervous speaking to the Conference participants because his brothers were seated there, and his statements will reflect back on them, and on all Native Americans across this country. He added that he must be careful and speak the truth.

Identity is the most important Native American issue. It is the understanding of who, where, and why you are that allows one to grow socially, mentally, and spiritually. Individual self-identity is what ensures that the race will continue to develop, even if that development is in oppression. There are cultural differences that providers of service need to know about Native Americans prior to treating them. The service provider could get this information by contacting Native Americans in their local areas. In the U.S., there are 2 million Indians-affiliated with 319 tribes-living on 308 reservations (American Indian Digest, 1995). This does not include the Native Americans living in urban settings and off reservations.

Father Martin stated, "In order to treat or help us, first you must touch our hearts." What is meant by this is that working with Native Americans is personal, not technical or mechanical. In all too many situations of counseling and treatment, the program and its reports are the focus, not the client. It is sad to know that what is learned in school is that answering the test question means the diploma, not the skill or heart in doing the task. In 500 years you have failed to do this. Our ancestors were told that you have a better way of life, and that we need to grasp it and embrace it. Your heads are bowed in your own shame, for this is not the truth of today.

As a result, Native Americans are a very cautious people, and very untrusting of non-Natives, because everything that has been given by Natives seems to have been used to destroy the culture, and their existence as a race of people.

Mr. Whelan gave the following as examples to demonstrate why Native Americans are cautious, and hesitant to trust non-Natives:

- In the US there are 5 types of laws-one is Treaty Law, which relates specifically to Native Americans. There are no other races of people in the United States that are subject to this law.

- No other race of people in the United States is defined by Congress, and told who can or can't be a Native.

- Many Native communities have problems writing for grants, or obtaining other funding for programs, because of mandatory population quotas.

- In 1924, Congress passed a law making all Native Americans citizens of the United States (it didn't matter if they wanted it or not).

- There are specific museums for other races of people, but in the nation's capital, Washington, D.C., at the Smithsonian Institute, the exhibit for Native Americans is located with the dinosaurs in the building for anthropology. There is no Native American exhibit in the building for United States History.

- The United States was based on freedom of religion. However, religious freedom was not granted to Native Americans until 1973 by an act of Congress.

- Modern research indicates there were 45 million Indians on this land at the time of Columbus. At the turn of the century, 1900, by U.S. census, there were only 600,000 Native American people. Hitler was a nobody compared to what happened to the Native Americans of this country.

- Blood Quantum, or the method of determining the percentage of Indian one is by blood lines, works against Indian heritage. Because of the manner in which Congress determines the percentage of Indian ancestry, somewhere in the generations yet to come, by definition, there will not be any Indians in the United States. A sample of this is: When a Mohawk man marries a Cherokee woman, the children are considered half-breeds.

Native Americans do not demonstrate for equal rights, or to be a part of anything, but they have and continue to demonstrate for exclusion. Each Native Tribe is a sovereign nation within a nation. This form of nation-to-nation treatment was guaranteed by treaty law.

Today Native Americans are looking for their own means of treating their own people. The Western methods of therapy seem to be missing the mark. They do not work well with Native Americans because they are procedure-oriented and mechanically applied. Native Americans have been traumatized for 500 years. Most of the treatments used today are a continuation of the traumatizing. The trauma needs to be relieved prior to the Native American listening to others.

Mr. Whalen concluded by stating, “I am sorry that I had only fifteen minutes, and thank you for giving me your time.”

PANEL ON CULTURAL PERSPECTIVES

Davis Ja, Ph.D.

Dr. Ja prefaced his presentation with a story about a friend, Alan Wong, who had passed on recently. He discussed Alan's experience as a former heroin user, as well as his accomplishments. During his period of recovery, Alan helped launch one of the first substance abuse treatment programs in the United States specifically for Asian Americans. Dr. Ja further stated that Alan's death leaves a legacy of both what can be and still needs to be accomplished.

Currently, Asian Americans represent the fastest growing population group in the United States. However, other cultures may have a difficult time understanding many unique and different aspects of the Asian cultures, as reflected through a wide spectrum of factors, including language, socio-economic status, cultural traditions, religion, and belief and value systems. Many elements can heavily influence these factors, including length of stay in the United States, immigration patterns of specific Asian groups, and relationships between immigrating Asians, local communities in the United States, and settled Asian groups. Intergenerational conflicts and issues between parents and children, and within families, also play a significant role. As immigrants become more settled in the United States, traditional norms regarding coping, teaching, disciplining, and communication shift and become less effective. To survive, Asians must learn to adapt their "norms" to be in sync with the present environment in the United States. This may mean survival within a society reflective of a different set of values, including the assumption of the family spokesperson role by children, materialism, and the common existence of latchkey children. In addition, Asians will need to learn how to handle high-risk environments commonly filled with ever increasing rates of school drop outs, truancy, delinquency, violence, gangs, and substance abuse. However, the common elements associated with successful coping and adjustment mechanisms used by Asians to survive in these high-risk environments have yet to be agreed upon and resolved.

On many levels, real knowledge of Asians remains nonexistent. The stereotypes associated with the "model minority" often encompass many people's perceptions of Asian Americans. These stereotypes are further perpetuated by a lack of prevalence data regarding substance abuse among Asians, such as the exclusion of Asians in many surveillance surveys and through inadequate research studies conducted with poor methodology. For example, in contradiction to the reality of increasing substance abuse rates among Asian groups, this problem appears to be nonexistent according to current research. In addition, the primary reliance on Western treatment approaches by many existing service programs does not address the cultural-specific needs of Asian clients, whether this failure results from a language barrier or a need for cultural-specific administrative support. Cultural specificity simply does not exist in many current treatment programs. To address the continued existence of stereotypes and misconceptions regarding Asians, NIAAA has recently allocated funding to collect more accurate information about Asian groups and to dispel the "model minority" stereotypes.

Despite the inherent dangers of a managed care service delivery system, the lack of a current infrastructure may actually lead to the creation of more service options for Asians. Those who have been residing in the United States for a longer period of time can utilize existing infrastructures which lend themselves to inclusion in managed care. However, the more recent Asian immigrants, especially Southeast Asians, have been one of the last Asian groups to immigrate to the United States. Due to the lack of financial resources, many of these immigrants are unable to finance much needed medical, mental health, and other treatment services. In many typical situations, one agency and three to four case workers attempt to meet all the needs of the latest wave of Asian immigrant clients and to address issues which can span both the mental health and substance abuse spectrums. However, the emergence of the managed care environment, coupled with few linkages to other existing services, may be detrimental to these type of agencies, as they will be unable to compete against established managed care providers. In addition, the recent implementation of welfare reforms and the rising tide of anti-immigration sentiment in the United States have also adversely affected many Asian immigrants.

One possible solution to meeting the needs of Asian clients may be the implementation of collaborative service models. Yet, more research is needed before conclusions can be drawn regarding effective and efficient treatment services. Despite current efforts attempting to design and define models

receptive to client needs, the primary focus during the process often shifts and succumbs to the certification processes and Western training strategies. One of the core factors in designing culturally-specific treatment programs for Asian clients involves building upon concepts which incorporate approaches from traditional and cultural perspectives. Culturally competent treatments utilizing an Eastern approach may emphasize acupuncture, healing, herbal medicine, and a family-based focus. Regardless of the combination of Eastern and Western treatment approaches and focuses, there is nothing to be lost by being creative in designing innovative service models which prioritize and maintain client needs as the primary concern.

PANEL ON CULTURAL PERSPECTIVES

Nicolas Parkhurst Carballeira, M.D., M.P.H.

Dr. Carballeira stated that he is convinced that substance abuse and addiction are self-medication for anxiety. High incidence of addiction among some groups is not surprising, if that group has a high level of anxiety in their daily lives, and few alternatives to self-medication.

By 2010, one out of every three net additions to the population will be Latino. Latinos are already a plural majority population in many states, and are growing at a faster rate than the dominant population. Very soon we will have a white minority government in America.

It is not surprising that we find this cluster of anti-immigrant initiatives in welfare, immigration, and health care reform. Each of these initiatives is designed expressly to prevent change in the existing power structures, or any change in the demographics in America

Substance abuse prevention and treatment, very often identified with minority populations, is also undergoing attack. Unfortunately, in substance abuse we have the same old programs where the service model does not change substantially with the populations of interest. Programs have to be designed for the population of interest. We need to start with culturally competent models of services. It is hard to say what that means for Latinos. You cannot have an "off the rack" culturally competent program designed for Latinos because of the many different populations, and differences within those populations.

However, Latino programs must include, at a minimum:

- recognition of the primacy of spirit
- an emphasis on family, meaning a group of people linked affectionately, socially, and spiritually
- intrinsic value of the person regardless of what they do for a living
- respect for age, function within the family unit, and community
- trust which is earned, personal, and non-transferable
- recognition of history, which means not regarding Latinos as immigrants when compared to the dominant culture of the United States.
- support systems following treatment, including the faith communities
- structures which are culturally acceptable, including the food that is served, surroundings, the family, and emphasis on family visitations
- language fluency for staff, and an ability to understand the culture behind the language, or the ability to utilize qualified interpreters

In conclusion, in order for services to be culturally competent for Latinos:

1. The model of service must not be one changed from someone else's model, but made explicitly for the population of interest.
2. A natural support system has to be included.
3. The places of service must be culturally accessible.
4. Support services must be in place.
5. Language must be adequate, if not from the provider, then from a qualified interpreter who has a working relationship with the provider.

DIALOGUE ON

ADVOCATING FOR SYSTEMS CHANGE

David Mactas

DIALOGUE ON ADVOCATING FOR SYSTEMS CHANGE

David Mactas
Director of the Center for Substance Abuse Treatment (CSAT)

Mr. Mactas began his presentation by quoting from a report, Managing Managed Care from the Institute of Medicine at the National Academy of Sciences. The report contains specific references to cultural competence and managed care. Among the findings were:

- Racial and ethnic minorities frequently lack access to culturally appropriate care.
- In the effort to create smaller and more efficient provider networks there is a risk of eliminating providers and groups who have special expertise with different cultures and different healing practices.
- Often the reason for exclusion of cultural practices is that accepted evidence of effectiveness does not exist. The Committee observed, however, that controlled trials assessing the outcomes of other medical treatments have not been done.

Recommendations that emerged from the study are:

- Health plans and programs should be responsible to the community demographics and to the cultural needs of the population they serve.
- Practitioners of alternative and innovative treatments with research-based proof of effectiveness should not be arbitrarily excluded from health plans. If these treatments are used, their effectiveness should continue to be studied so that standards of quality care can be enhanced.
- Health plans should have an explicit mechanism for evaluating new and innovative techniques and the qualifications of practitioners.

When we do outcome studies, we track somebody for six months or a year after treatment to showcase the effect of treatment by measuring how well clients are doing after discharge. If we find, six months or a year later, that the person is using drugs, is continuing with criminal behavior, is continuing to access the primary health care system, and is still on entitlement programs, we say treatment was not successful.

With medical treatment, it is fundamentally different. If a person fails to complete the regime, and a year later is tested and is not doing as well, the treatment is not blamed. For us, this failure indicates the failure of treatment. In the larger medical world, however, a doctor, his license or competency, would not be challenged if the person for whom he prescribed insulin robbed a bank.

Even when held to a standard against which no one else is held, how do we do? The National Treatment Improvement Evaluation Study indicated that of 4,500 people, one year after treatment, there was:

- a 78% decrease in violence and drug sales;
- over a 50% decrease in heroin, cocaine, and marijuana use;
- a statistically significant decrease in contraction and transmission rates of HIV;
- a statistically significant reduction in use of entitlements; and;
- a statistically significant increase in self-sufficiency, consisting of regained employment and productivity

CSAT has a number of programs, especially women and children's programs, that address culturally distinct populations in rural and remote areas. CSAT, historically, funds black colleges and universities to develop curricula that are culturally specific. CSAT funds faith communities through our target cities programs. We have a cultural competency monograph going through its final edit. At the same time, if you

ask how much is the federal government doing in relation to cultural competence in substance abuse treatment, the answer is, resoundingly, "Not enough."

The Substance Abuse and Mental Health Services Administration has a budget of $2.1 billion. CSAT has a budget of $1.5 billion. $1.3 billion of CSAT's dollars are tied to the block grant and are distributed via a congressional formula to all of the states and territories. In addition, CSAT has $156 million in discretionary programs, now known as, "knowledge development and application" activities.

Congress elected to cut SAMHSA's discretionary budget about 60 percent for FY 1996. Moreover, we were instructed to shift from services demonstrations to a more scientific, evaluation-oriented mode of inquiry.

Although there are an estimated 3.6 million chronic substance abusers nationwide, only 1.8 million are in treatment at a given time. Consequently, there continue to be wide gaps in service delivery--both geographically and programmatically. However, service delivery through discretionary demonstrations ended in FY 1995. The Block Grant is, at present, the only mechanism for services funding.

As part of the effort to become more scientific in our approach, CSAT has engaged a contractor to train community-based providers concerning evaluation principles and tasks.

Questions and Answers

What are your plans for the discretionary funds?

There is $156 million available in discretionary funds. Most of the money is being used to continue existing services. We are looking at brief interventions for marijuana dependence, and at the concept of "wraparound services."

The agenda is set for 1998 because we have had to submit our budget to Congress. In creating the budget, we met with program providers, and the National Institute on Drug Abuse, Alcoholism and Alcohol Abuse. We then integrated what we learned with all other key federal initiatives, goals, and objectives.

We are sending staff to association meetings, such as NASADAD, and American Methadone Treatment Association, in order to elicit from the field what we might want to put in our 1999 budget. At the same time, $156 million is not much money.

What kind of things should providers be doing to help?

Congress states that it hears from federal bureaucrats, but not the people who work in the field. The field has not spoken with one voice on any issue, including cultural competency, substance abuse, substance abuse treatment, and what we mean by those terms. The field has not done a good job educating in important areas, such as savings resulting from treatment, and where those savings occur, even though data are available. The field carries a stigma in Congress which affects the ability to educate. People in recovery need to organize, and bring the message forward.

To what extent will Native Americans, who live off reservations, or are not recognized, get services and dollars?

Allocations of resources to this group will be largely up to the states. The amount of money that goes to a state is determined by Congress through a very complex formula. Each state is required to complete a needs assessment leading to a plan. The states are responsible for distributing the money consistent with that plan. Although currently there are mandates and set asides, many will be disappearing. More and more discretion will be given to the states in this area.

What is the role of research?

Many providers do not engage in research because they fear that the results will indicate treatment does not work. We are not engaged enough in research. We need to do more research because it will tell us what works best for whom.

OPENING

PLENARY

Anita Pernell-Arnold, M.S.S.W.

MAY 15, 1997

I am going to undertake the daunting task of policy development in a culturally diverse society from a philosophical, ethical, and spiritual perspective because the obstacles to multicultural human services policy in a managed care environment are buried in the collective unconscious of the United States culture.

I would like to propose that we think of policy development as building a Temple on a hill in an area populated by many ethnic and cultural groups. The foundation is to be anchored deep in the rock of the hill. The hill must be large enough to accommodate additions and modification. The foundation is the philosophies that support the purpose of the Temple. Wise scholars and prophets (participants of this conference!) from the surrounding cultures give input into the philosophies to assure that the Temple will be able to accommodate many human differences. Constant attention must be given to the foundation by the sages to prevent seepage of assumptions that will occur as new groups arrive and old groups change. Above ground, the Temple will be constructed from ethical bricks that hold communal wisdom and scientific research. The ethical framework is cemented together by respect, yin and yang, balance, harmony, love, and caring for the people who seek comfort, relief, and healing there. The Temple will have many domes and spires that will soar into the sky in a never-ending thrust to maintain contact with the wisdom of the ancestors and spirits.

We must examine and contemplate some unconscious concepts in the open before strategies emerge that can help us tackle providing services to the myriad of differences that exist in the United States.

PERVASIVE PHILOSOPHICAL PRINCIPLES IN U.S. CULTURE. I have selected five philosophical concepts analyzed by Linda Myers, Elizabeth Minnich, Marimba Ani, and Howard Goldstein in order to develop weapons we can use to overcome the insidious effects of mind oppression. They are:

A. Dichotomous (either-or) versus diunital (also-and)
B. Linear logic versus global, relative and circular logic
C. Faulty generalization versus the study of humans in their own cultural context
D. Rhetorical ethic versus cultural relativity and inclusion
E. Deficit approach versus strengths approach

A. Dichotomy Versus Diunital. In the root "old world" view arising 350,000 years ago in the Rift Valley of East Africa, everything in the universe is connected. Man and woman are two parts of the human entity. Humans, nature, animals, spirits, ancestors, decedents and the Creator are connected and unified as the universe. In the philosophical shift that took place from Egypt to Greece to Rome and Europe, a split occurred in the perception of the universe. The creator, spirits, and ancestors were relegated to the sky, man became separated and superior to woman, non-members became strangers and outsiders, humans were elevated above nature and descendants became what their progenitors wanted them to be. The mind was elevated over the body, and the spirit or soul became largely irrelevant in daily life.

The body was related to animal functions to be ignored or overcome when they interfered with higher intellectual functions. Emotions were not to be trusted because they led to irrational non-objective thought. In short, human experience was dichotomized/separated into (if you will) cages. Many other cultures never accepted these separations. Dichotomies are represented as either/or, in or out, we or they, with or against, up or down, majority or minority, black or white. U.S. educational styles too often place inordinate emphasis on skills for "breaking things down into details," separating fact from fiction, the objective from the subjective. Dichotomous philosophies make connections and inclusion more difficult. This educational context or world view facilitates separation in general:

1. Separation of humans into more or less acceptable groups
2. Separation of spirituality from human services
3. Separation of substance abuse services from mental health, from developmental disabilities, from general health care
4. In science, statistical reality has supported the process of separating more from less and designating less as not significant

B. Linear Logic. American pragmatism has generally endorsed, for the most part, straight line thinking (A = B, B = C, therefore A must = C) or, direct cause and effect, if X and Y occur in the same time period, they must be related. (If you were in my office just before my purse disappeared, you must have stolen it.) Another example: 1. We need to reduce the deficit. 2. We spend a lot of money on welfare. 3. People on welfare are less worthy than... 4. Therefore, we will reduce the deficit by spending less on welfare. 5. We will give them jobs. Then... 1=5. We will reduce the deficit by giving people on welfare jobs.

Linear logic reduces people's ability to recognize complex systems of multiple, sometimes cyclical interrelated causes and effects. When the "jobs versus welfare" system is studied, it becomes relatively easier to understand that the same system of services that is needed to sustain people on welfare, are also needed off welfare. The major difference between the poor and the wealthy is not the services needed, but who pays for them.

C. Faulty Generalization. Faulty generalization is the process of establishing standards on the basis of a random sample of the assumed ideal--the dominant group. King Davis said, for example, that drug testing is done only on white men. After we have divided humans into neat packages, the poor, the addicted, black, white, male, or female, an assumption emerges,--everyone, regardless of their category, wants to be as much like the dominant group as possible. The assumption continues that dominant group characteristics afford the greatest access to the opportunity structure, economic success, and political power, therefore these characteristics are applied to all groups on the basis that they are universally true. However, treating everyone the same or as the dominant group wishes to be treated, reduces the human services system's ability to respond to the reality of difference. Using human services as a way to facilitate assimilation is a pitfall.

Counteracting faulty generalization requires abandonment of notions of cultural superiority. Problems are to be studied within which context they occur. As much attention must be given to the exceptions as to the statistically significant. Balance must be achieved, between communal experience (folklore) and abstract experimentation. For example: medication prescription must be based on empirical research, the person's experience, and input from indigenous healers or religion and spirituality. As Frances Brisbane stated yesterday, studies now indicate that prayer accelerates the healing process.

D. Rhetorical Ethic. "Rhetorical Ethic" is a term coined by Marimba Ani which explains the ethics/rules that the dominant group has for itself and does not apply to "outsiders." Separation once again. The dominant groups' rules of conduct provide admonishment, rejection, or punishment when used by non-dominant group members. Those of us who are poor, people of color, women, those with disabilities, and those who are gay, lesbian, or aging population quickly recognize this as the double-standard.

The examples David Mactas gave relative to the helper being stigmatized by the client are in part caused by the rhetorical ethic. The continuing thrust toward democracy and media exposure has currently placed this hypocrisy in public view. A submerged value many policy makers are trying to expose is multiple standards of care based on whether they are publicly or privately funded. The alternative views of inclusion and acceptance of difference place wider responsibility on public systems for cross-cultural understanding and accommodating to difference.

E. Deficits Versus Strengths. People who do not have dominant group characteristics are considered disadvantaged or deprived. This assumption has lead to the search for deficits, problems, or what is not working in "target groups." Difference is viewed as pathological; it is labeled and treated. If a person is involved in a closely knit extended family, this is viewed as a deficit in upward mobility, or in clinical jargon, "enmeshment" and/or "enabling." Early studies on the social networks of persons with schizophrenia showed that they had smaller networks than the general population. People with larger networks were less likely to suffer a relapse. Clearly, a closely knit extended family that has a strong concern for the client is a strength, a resource, and a source of solutions. Each and every cultural orientation, each family, each person, each community, has strengths--we should consider how growth could be accelerated by building on strengths. When these concepts are brought into daylight, we can see some of the policy foibles we have made:

1. A central point of entry to services, standardized treatments and medications
2. Five days of detox--regardless of varying circumstances
3. Drug free for ninety days before admission
4. Dual diagnosis-go to the other system first
5. No place for children or relatives in the treatment program

A. MULTICULTURAL WORLD VIEW. A multicultural world view assumes that there are many world views that connect and interconnect, and that the root world view was born with the dawning of humankind on the continent of Africa.

A. Four Principles Inherent in Multicultural World View

1. Subjective knowledge, ones own culture, must be in balance with objective knowledge that is a result of quantification.
2. Knowledge of others' cultures must be based on subjective knowledge (immersion), study, and the cataloging of experience. Each person, event, and situation be studied within the context of his/her world view from the general and the specific.
3. Harm results from interventions that are incompatible with the belief system that defines the client's world view. Therefore, a person, event, situation, or condition must be studied at least from the perspective of their respective world view; at best within the world view and in relation to accumulated quantitative experience. Exceptions can be explained by exploration of, or changing, the context.
4. Knowledge of difference requires attempts to accommodate.

B. Multicultural Ethics. In other world views, spirituality and health are one. An illness of any kind would not be treated without concern for the spirit. Navajo (Diné to be correct) songs are designed to establish harmony between the elements, spirits, and the human; Chinese healing methods are concerned with restoring the balance between yin and yang, hot and cold, or spirit and matter. This leads to the following:

The First Ethic. The whole person, mind/body/spirit, must be treated and cared for at the same time. The goals of human service are to increase integration, harmony and balance between internal functions--mind, body, spirit--and external functions--family, community.
The Second Ethic. The identity of a human being derives from his or her family and culture; therefore, the person, the family, and the social network are the client.
The Third Ethic. Knowledge is based on personal and communal experience as well as formal empirical and qualitative research.
The Fourth Ethic. Clients are offered a comprehensive range of services from which they make selections based on full disclosure of types of interventions, their duration, effects, and expected outcomes.
The Fifth Ethic. At the apex of a multicultural human service system is prevention. The general population should be educated from as early an age as possible (by at least eight years of age) on all of the issues related to addictions.
The Sixth Ethic. Since the apex is prevention, the centrifuge is represented by the "isms"--oppression in the form of racism, sexism, ableism, homophobia, and ageism. Separation, exclusion, and discrimination are phenomena that confuse, confound, and contaminate every U.S. system. They are central to U.S. social processes. They interfere with the:

a. implementation of multicultural humanistic ethical systems
b. provision of culturally appropriate, culturally responsive services
c. person's access to services and his/her ability to benefit from services
d. stable functioning of community
e. efforts to reduce the incidence of relapse

Discrimination causes major health, mental health, and substance abuse problems. We know this through the collective unconscious (i.e. our instinct, common sense, or gut feelings), through group communal experience, and through research. And yet its pervasive influence is frequently absent from policy deliberations and almost never represented in Federal, State, or local policy except as "Don't Discriminate!"

Discrimination--its impact, consequences and, resolution--is a central treatment issue for individuals and their families. People need psychological protection from discriminatory attacks and they need skills that will deflect these attacks. Policy development must place an emphasis on the provision of culturally based services, including the study and celebration of one's heritage, NTU psychotherapy, inoculation, rites of passage, vision quest, and expressive arts that reduce the psychological consequences of the accumulated effect of the "isms." These services should enable people to receive maximum benefits from behavioral health interventions.

When blacks were statistically the only significant group in the service system, their differences could be largely ignored or treated as differences that could be replaced by dominant-group, white-middle-class values and behaviors. The mid-century change in Asian immigration laws, the new Eastern European immigration, Caribbean and South American migrations, and recognition of the Mexican and American Indian presence created a major confrontation with the human service system.

MULTICULTURAL ISSUES IN ORGANIZATIONS

1. Establishment of policy. Our charge is to meet the above challenge by creating policy guidelines that are responsive to differences and promote cost containment. If it takes five phone calls and two trips to the emergency room to enable a person to accept detox, would not one of even two home visits be cheaper?

The tension we are experiencing in the field today between multicultural human services and managed care is caused by the need to proliferate approaches to accommodate differences and the need to hold down costs in a profit context. To prevent future dichotomies in policy, the following recommendations are driven by achieving the most effective response to human problems, e.g., substance abuse, which also results in cost effectiveness. Policy must require culturalogical diagnosis and assessment, including, but not limited to, the person, family, and community. Diagnosis and assessment that are not based on culturalogical considerations lead to inaccurate medication and prescription, and inappropriate treatment, which leads to relapse and increased costs.

Policy must sanction flexible approaches that can respond to differences in help-seeking behaviors, perception of illness, culturally influenced symptomatology and culturally appropriate modalities. Universal/unilateral treatments lead to avoidance of services until problems become severe, emergency or inpatient care is needed, and people are unable to work. Encounters with culturally incompetent services lead to increased drop-out rates, non-compliance with treatment regimens, and continued substance abuse. The following services are needed:

a. multiple points of access to services,--case management, mobile outreach with diagnostic capacities, intake located in neighborhood facilities and programs
b. multiple types of providers, folk healers, indigenous agencies, and collaborations between providers and systems
c. services provided by bilingual/bicultural providers or with trained interpreters

2. The Impact of Policy on Organizational Processes. Well-written policy establishes processes for (a) the amelioration of factors that lead to societal problems that affect everyone; and (b) the prevention of their existence or escalation. Statistical significance undermines the best policy by delaying action until there is a critical mass. How many people does it take to start an epidemic? How many people can one person infect with HIV? How many people can be infected by one contaminated needle? Policy must assure that:

a. interventions and programs are designed to impact specific factors
b. interventions are coordinated, integrated, culturally compatible and focused on the person, family, and community
c. emphasis is placed on unifying the mind, body, and spirit of the person

3. Cultural Accommodation. As Terry Cross asserts, the organization must encourage the presence of multiple human behavioral styles. Each culture has a system of values and behaviors that it incorporates

to facilitate group unity. An early step to organizational cultural competence is the creation of environments where various cultural styles can be expressed/accepted. Culturally competent programs typical address each of the following issues:

a. Communication styles: the expressive, stoic, verbal, and non-verbal languages
b. Ethnic/cultural identity development: the level of acculturation and the attitudes and values each member holds about his/her cultural group membership
c. Cognitive learning styles: the mode in which the person is most comfortable learning new information, e.g. observing, reading, listening, talking, thinking, working alone or working with others.
d. Leadership styles: the extent to which service consumers respond more positively to expert authority, non-directive support, and/or peer support
e. Inclusion of surface culture: the visible presence of music, art, literature, or food representative of different cultures throughout the program
f. Family involvement: the utilization of different strategies, consistent with the person's culture, which best engages family members from different ethnic groups, e.g. home visits, extended family therapy, network therapy
g. Help-seeking behavior: the awareness of ethnic group members' perceptions of the professional role, natural helpers, styles of interaction, interventions used, and compatibility with treatment norms such as self-disclosure.

4. Service Misfits. Organizations striving to be more accommodating to diversity acknowledge the current and historical context of discrimination toward specific groups so that stereotypes are not inadvertently reinforced. For example, there may be a service misfit when a woman with a history of being abused sexually is assigned to a counseling group of men with a male therapist (Ms. Pernell-Arnold went on to provide further examples).

PROGRAM REVIEW AND QUALITY IMPROVEMENT

1. Perception of Discrimination. Discrimination can operate so subtly that there must be continual review of programs and activities to determine whether anyone perceives discrimination. The following questions may help to identify and prevent discrimination:

a. Can the reception unit respond to different languages? Are clients discouraged from speaking their own language to each other?
b.Are some groups and focus of music (e.g. rap) discouraged?
c. Are some communication styles discouraged (such as emotionally charged, or silent)?
d.Are some residential programs only for African Americans, or people of color?
e.Are people with multiple heritages encouraged to describe and discuss them?
f. Are there specific activities designed to help people learn to cope with and solve problems related to cultural expectations, discrimination, and racial and cultural identity and affiliation?

2. Linkage to the Community. Each organization must be aware of the cultural, ethnic, and racial groups that are residents of the community it serves. The organization's boundaries must be permeable and accepting of open interaction with cultural, ethnic, and racial community leaders and representatives. Cultures generate varying institutional styles. Some have complex hierarchies, others emphasize peer relationships, some emphasize informality.

Some organizations exist to meet the need for recognition and respect. People from different cultures have different expectations for organizations that may result in misunderstandings and feelings of rejection. The hierarchy/organizational structure may interfere with effective community interaction and involvement. The organization must be representative of the community it serves, at all levels. Recruitment processes must be reasonably open, and the organization should have procedures that can be published and discussed with community representatives. The organization must also participate in the community's cultural life and activities and provide opportunities for the inclusion of the various groups' cultural and artistic expressions.

3. Problem Resolution. The organization must have established mechanisms that identify, examine, and resolve misunderstandings and disputes based on personal and cultural differences. Opportunities for open discussion and redress of actual or perceived discrimination and prejudice must regularly be available in order to prevent blatant or subtle forms of sexism, racism, ageism, etc., from becoming a part of the milieu or organizational culture. The organization needs to develop internal growth mechanisms that use differences as a basis for expanding strategies that are to be used for solving problems and providing rehabilitation experiences.

4. Training and Education. The organization must provide training and educational opportunities to maximize the cultural competency of board members, administrators, supervisors, and staff. There are at least five types of training activities which may occur in any agency setting in order to increase staff and organizational competence: (a) generic; (b) culture-specific; (c) skill development; (d) program development; and (e) organizational development.

Generic training activities target the enhancement of staff self-awareness regarding issues of diversity. Staff are exposed to the psychological dynamics of difference and learn information that is applicable across ethnic groups, e.g. learning styles, communication styles, ethnic identity development. Racism, oppression, and discrimination are explored experientially and cognitively in order to:

a. understand the similarities/differences between the expressions of prejudice
b. recognize the behaviors and responses of oppressors and victims
c. identify survival/coping skills people may use and/or need to transcend

Organizations interested in renovating their entire program so as to be more competent may select training and consultation in areas such as multicultural team building; designing a quality assurance program; supervision of culturally different staff; and revision of the organization's mission, policies, and procedures in order to insure compatibility with principles of a multicultural organization.

5. Specific Training Activities. Training may be provided in several arenas:

a. Training may occur within the organizational setting, conducted either by senior staff or invited outside speakers. There is an organizational commitment to incorporate all training activities, whether or not directly related to cultural diversity, with content applicable to staff working with persons from different ethnic groups. In this way, the organization avoids a major pitfall of providing "one shot" training devoted to cultural diversity.
b. Staff may be sent to courses, conferences, and workshops which provide opportunities to increase cultural competencies. The organization provides follow-up of such activities by incorporating new ideas and approaches into programs. Opportunities are also provided for staff to both inform and train others.
c. Connections may be developed to college-and university-based programs in which staff can obtain academic credentials with agency support through released compensatory time and/or financial contributions. Entry level staff, particularly those from different racial and ethnic groups, may be able to benefit from this training strategy in that their opportunities for advancement within the organization may be increased.

The number and type of cultural, ethnic and racial differences are so great that the process of learning to be culturally competent is a never-ending quest. The degree to which the organization accepts responsibility for assisting staff in this quest will directly affect its program outcomes with persons from various cultural groups.

6. Evaluation. There are several evaluation issues which must be addressed in order for programs to become more culturally competent.

First, there is a need to collect statistical data on the presence of different ethnic groups both within the agency and within the community at large. Maintaining statistical data according to Federal racial group designations, such as African American, Hispanic, White, Asian/Pacific Islander, and Native American, cannot facilitate an analysis of the operation and effectiveness of a multicultural program. The assumption is promulgated that each of these designations is monolithic and homogenous.

In reality, the race category does not define or illuminate culture or ethnicity. The African American group, for example, could be expected to include culturally diverse persons from various sections of the U.S. and people from the Caribbean, as well as those from the continent of Africa. The designated "white" group includes Swedes, English, Germans, Hungarians, Ukrainians, Italians, Irish, and numerous other ethnic groups.

Tremendous within-group variability may impact assessment outcomes, perception of illness, and help-seeking behaviors as well as required program modifications. African Americans from the rural South, for example, are more likely than second or third generation urban African Americans to believe in "roots," spirits, or a "lack of faith in God" as the cause of mental illness. Though Italians and Irish may primarily be Catholic, there are vast differences in their belief systems. Statistical documentation might be more beneficial if it were kept on the basis of self-report. Responses to two questions, e.g., "From where did your ancestors come?" and "With which group do you identify?" may provide the most useful information.

Second, the presence of each ethnic group within the service area and level of need for rehabilitative services requires documentation. Data on who is currently being served and those requiring services are compared. Comparisons are also made between numbers of individuals of diverse ethnicities with substance abuse problems served in relation to individuals from the dominant northern European cultural group.

Third, program modifications introduced to accommodate specific cultural differences must be reviewed in order to determine effects on program participation, units of services used, length of stay, ongoing progress, and goal attainment. Does an ethnotherapy group increase the participation of African American young men in a program and improve their service outcomes? Does program intake through home visits or the use of an orientation film increase the participation of Latinos in behavioral health programs?

Fourth, methods of determining consumer satisfaction with treatment interventions for addiction are required. A regular, structured feedback process through focus groups or questionnaires can be developed to determine quality of the program. Community groups need to receive information on whether this information has been incorporated into the program. A formal structure is required for incorporating the information received.

Our task is to integrate in policy cultural specifics, multicultural world views and ethics, qualitative and quantitative wisdom. To this end, remember a Zulu land proverb: Even an ant can harm an elephant."

Note: Ms Pernell-Arnold included in her conclusion a detailed example of a highly successful training program. The Advanced Certificate in Cultural Competence is a 120 hour course conducted by the Multicultural Training and Research Institute at Temple University. She also included Standards for Culturally Competent Agencies. These items, along with her extensive references and bibliography, are not included here because of space limitations.

PART II

OUTLINE

OF

CONSENSUS BUILDING FORUMS

MAY 14, 1997

SUBSTANCE ABUSE

TREATMENT CONSIDERATIONS

FOR

PERSONS OF AFRICAN ORIGIN

Fred Swam
Norma Baker
Frances Brisbane, Ph.D.

Substance Abuse Treatment Considerations for Persons of African Origin

This workshop opened with a look at the research findings related to African Americans concerning:

-cultural characteristics
-cultural cues
-survival styles
-cultural learning styles

The group posed and then answered the question as to why these distinctions are important to people providing substance abuse treatment to African Americans.

Mr. Swan spent a few minutes on the implications of managed care for treatment providers serving African Americans.

He offered some observations about the learning styles of African Americans, and offered a comparison between indirect and direct learning styles:

Learning Styles - (Developed by A. Hilliard, 1976)

African Americans Relational	European Americans Rational
Memory for Essence	Memory for Specific Facts
Variation	Standardization
Creativity	Conformity
Flexibility	Rigid Order
Improvise	Preconceive
Affective	Cognitive
Democratic	Hierarchical
Loyalty	Duty
Meaning Oriented	Sign Oriented
Indirect	Direct

Refer to some supporting materials presented to the group by Mr. Swan, as he discussed the cultural perspective common to African American people.

(copyrighted material from Linda J Myers)

(copyrighted material from Edwin J Nichols)

Mr. Swan then broke the group into three smaller groups, each focusing on one of the following issues:

-clinical issues
-program administration issues
-policy issues

Each group sought to reach conclusions and recommendations in their are, that would lead to more culturally responsive services.

General consensus across the groups emerged on two points. First, all believed that it was important to address cultural competency for substance abuse treatment workers as part of an overall development of professional competency. Thus, for example, cultural competency ought to be assessed as part of the counselor competency process concerning the 12 Core Functions.

Second, when we work with managed care companies, we need to encourage them to pay close attention to the caretaking patterns of the cultural group(s) being served. It is important, for example, to understand that in order to increase utilization of services and satisfaction in people of African origin, it is necessary that trusting relationships are established early on. All groups identified some barriers to the provision of culturally competent treatment. The composite list of barriers included:

Language, religion, and money
Location and child care
Way clinicians deal with drop out
Therapeutic relationship: clinician being color blind
Lack of liberal open-minded clinicians
Clinicians viewing culture as an exotic denial of patient's experience.
Clinician generalizing
Teaching literature does not reflect reality
Inability to develop a personal connection to foster a therapeutic relationship
Therapist does not have an idea where therapeutic process will go
Therapist can't foster safe environment and have an inability to address disclosure and deal with it
Quality assurance & evaluation
Need guidelines to help us establish cultural competence
Cultural; bias assessment instruments
Clients must be a part of cultural competence process
Treatment Process:
  Involve client in all aspects of treatment process
  Knowledge of client's rights and legal process

Clinical Issues

The Clinical Subgroup concluded that the following list of actions should be taken by clinicians in order to provide culturally competent care:

1. Develop cultural self-awareness through (1) training, (2) supervision, and (3) support

2. Challenge agency to be more culturally competent

3. Bring in an outside consultant

4. evelop viable coalitions for culturally competence trainings with other agencies

5. Require policy makers of agency to be culturally competent, using funding agencies to devise guidelines to facilitate implementation of policies requiring cultural competence training for entire agency, including administration.

6. Advocate for creation for cultural competency certification including community representation

7. Mandate client participation in the development and implementation of quality assurance.

8. Invite and encourages client to participate in their treatment planning

9. Develop programs specific to African origin

10. Provide sound treatment for the patient including culture as part of the treatment dynamic

11. Develop culturally appropriate client satisfaction surveys

12. Develop key concepts for training and prevention

Policy Issues

The Policy Makers Subgroup, in seeking to define policy-makers, identified the following list of people:

- State agencies
- Federal government
- Local government
- Community (voters)
- Advocates
- Governor and staff (advisory council)
- Program and agency director and boards
- Lobbyists
- Managed care and insurance companies

The group then turned to identification of the issues with which policy makers should concern themselves:

Core Issues

- Location
- Language
- Transportation
- Resources
- Hours of service
- Diversity of staff and board at all levels
- Environment of facility (welcoming?)
- Cost/insurance coverage
- Child care
- Procedures
- Availability (types, models, etc.)

Access Issues

Access to treatment was a special area of concern for the group. They identified several dimensions to access:

- Eligibility criteria
- Ease of movement between services
- Age
- Sex and sexual orientation
- Availability of insight support services

The group observed that "location" was a common factor in all access-related issues. Locating services where the people are and where the need is greatest is critical to ensuring that people utilize the services that are available.

Ways to Increase Cultural Competency via Policy

The group discussed ways that policy can be used to increase cultural competency. These included:

- Planning grants
- Linkages
- Contracting requirements in areas with minorities to provide appropriate services
- Better description of how outreach, treatment, etc. is carried out
- Held accountable for treatment
- A shift in time/funding
- Technical assistance
- More emphasis on process and outcomes rather than admission number
- Career development training
- Recognition of experience in field
- Outcome studies
- Requirement for competency-based training
- Basing rates not on degrees, but on outcomes and quality

Outcomes

The group identified several client outcomes that will be likely to result from the development and delivery of culturally competent services:

- Higher employment
- Continuing education
- Improvement in family situation
- Lack of legal involvement
- Better self-advocacy
- Better record of keeping appointments
- Increased utilization of services

Actions with Regards to Policy Makers

Finally, the group identified specific actions that today's policy makers should take, starting immediately:

- Provide more planning grants
- Offer incentives for main line organizations to establish mutually beneficial linkages (with minority-based organizations or organizations servicing minorities)
- Make programs accountable, through contracting requirements in areas with minorities, for providing culturally competent services
- Require that programs/applicants provide measurable description of activities of outreach, treatment, etc.
- Offer flexible treatment option with unbroken service continuum including the development of interim services in and out of treatment and increased resources, e.g., technical assistance, funding, training and information
- Set standards by which agencies are held accountable to a significant % of minority representation on policy-making boards that have power
- Shift funds toward agencies with proven (measurable by objectives) record of providing culturally competent services
- (Government and state agencies) invest in capacity building of minority, community-based agencies
- Use authority to leverage funds from other federal or state funding sources to build comprehensive services
- (HMO managed care) Mandate reimbursement for case management, prevention, and aftercare

- Improve MIS and national data systems to better identify needs and evaluate service
- Take in to account acuity level when entering treatment
- Define how we measure activities with cultural competence
- Fund research proposals with minority involvement
- Demonstrate that cultural competency makes a difference
- Develop a national licensing standard that incorporates cultural competence as a factor in credentialing
- Require that single state agencies develop strategic plans that incorporate cultural-competency goals and objectives to be evaluated annually.
- Charge the State with developing a mechanism for receiving input from community providers
- Make an effort to get input from minority providers

Administration Issues

The group discussed and identified issues of special concern to program administrators. They established the marketing of the program as a key focus. In considering marketing, administrators need to ask questions about the following: capacity; resources; public awareness; availability; helping; healing alternatives; knowledge of community; and marketing "promises"

Other important topics of concern to administrators include:

- Early identification
- Community assess for residents
- Support-id of leadership
- Who, what, where, when, how
- Data collection/analysis
- Economic status indicators
- Outreach and program access
- Stakeholder cooperation/interdependence/synergy
- Trust
- Community standards
- Geography/location/public transportation
- Violence
- Inhibitors/stigma
- Acceptable outcomes - measures
- Resource development/HRD/OD
- Support/existing services
- Whose standards/relationship to outcomes
- Fiscal concerns
- How quickly do you project and measure success/save money?
- Mission
- Uniqueness
- Service capacity
- Why cultural competence? (understanding)
- Provider competence
- Continuum of care (seamless integration)
- Client demographics
- Population of interest
- Agency profile/policies
- Client flow pattern
- Aftercare/other program components

Specifications for Increasing Cultural Competence in Program Administration

The following are some specific recommendations and areas of focus for program administrators who wish to provide culturally competent services:

1. Represent commitment to cultural competency as part of mission statement/mandate/ policy/processes/practices

2. Provide human resource development and outreach development training to insure cultural competence as evidenced by clinical outcomes and client satisfaction

3. Consider culture competence as a necessary and sufficient condition part of the equation of the therapeutic relationship (i.e. trust, respect, etc.)

4. Leverage outcomes/gain buying to gain financial support from various stakeholders to promote and improve quality of life for all members of the community

5. Acknowledge that a program must succeed in four areas--accessibility, availability, affordability, and suitability before achieving cultural competence in substance abuse treatment services

6. Represent commitment to cultural competency as part of the standard for academic education, licensure, and accreditation

7. Promote joint planning and program design processes which involve substance abuse services, the faith community, and general community

8. Utilize existing knowledge and information about people of African American origin in the culture as a basis for program design and deliver

SUBSTANCE ABUSE TREATMENT CONSIDERATIONS FOR LATINO PEOPLE

Haner Hernandez
Fernando Miranda
Rolando Martinez

SUBSTANCE ABUSE TREATMENT CONSIDERATIONS

FOR LATINO PEOPLE

The Latino Discussion Group was facilitated by Haner Hernandez, Fernando Miranda, and Rolando Martinez. The group decided to meet as a whole and comment on cultural competency issues according to the three categories of program administration, clinical issues, and policy issues. Each category was discussed by the group as a whole and a consensus reached on key points. Much of the discussion occurred within the framework established by Dr. Carballeira. He spoke of the importance in the Latino culture of family, respect, and culture.

Administration Issues

After lengthy discussion concerning program administration the following issues were identified:

- Develop materials appropriate for clients
- Build teams that validate experience of para-professionals and professional credentials
- Involve people in recovery in program planning and evaluation
- Assure internal quality for treatment plans, objectives, goals, etc., specific to Latinos
- Incorporate into the program, the areas of care identified by clients (in addition to substance abuse education, jobs, housing, child care, etc.)
- Teach survival and learning skills and offer alternatives
- Hire staff into positions of power who are committed to community at all levels of organization
- Set minimum standards for cultural competence
- Assure that board of directors, administration, staff represent the population of concern
- Ensure that gatekeepers (receptionists, telephone operators) speaks Spanish and are sensitive to culture
- Decorate the environment in culturally appropriate ways
- Share data with staff to increase understanding of Latinos
- Solicit input by staff to refine program
- Educate Latinos about alcohol as a drug
- Train board members and administrators as well as counselors on cultural competence regarding Latinos (Latino values of *personalismo*, *respeto*, *familia*, *espiritualismo*, *confianza, historia*).
- Offer Latino clinical supervisors for counselors.
- Provide support to Latino staff
- Allow Spanish to be spoken
- Develop staff to assume leadership
- Recruit-aggressively-Latino workers
- Make special efforts to support and retain Latino staff
- Design client-centered programs with the help of staff and clients, de-emphasizing focus on administration and finances
- Conduct outreach
- Educate community about services
- Send Spanish-reading monitors to review documentation (CHARTS)
- Remunerate support services
- Provide financial acknowledgment of competencies
- Develop mechanism for conducting studies that support Latino needs
- Establish certification process for cultural competence
- Suggest equitable caseloads
- Implement support/supervision/clinical and administrative structures
- Invest in training
- Hire competent support for clinicians

Clinical Issues

Turning to the clinical area, group consensus was gained on the following identified issues/approaches:

- Conduct specific needs assessment to identify those particular services identified by Latinos
- Conduct evaluation of program models managed by Latino agencies to demonstrate their effectiveness
- Develop dedicated funding standards (hard data) of care to define caseload maximum for Latinos clients/clinicians
- Be flexible on requirements for Latino clinicians
- Create career opportunities through internal and external training or in-service (funding allocation)
- Test prototypes, modalities, staffing combination of case manager, counselor, outreach worker
- Address two additional clinical needs: 1) oppression trauma; and 2) sexual and physical abuse
- Explore how to retain clients (Against Medical Advice rate very high), how to lengthen stay, and how to ensure completion of detox. Explore what needs to change
- Accept consumer, family, and community in input shaping the program
- Develop standards for appropriate placement
- Be aware that a program fully staffed by Latino people had increased success in completion of treatment
- Provide pre-treatment for women, stabilizing their lives to support their detox completion
- Engage client's partner in treatment
- Offer alternative therapies
- Review our own ideology
- Ask the client for his/her definition of treatment success and structure program accordingly
- Incorporate a variety of activities that work for Latinos
- Advocate for policy change to cover those activities that are not reimbursed
- Conduct specialized programs for Latinos with children or with AIDS
- Conduct evaluation (success rates) at all levels of treatment spectrum
- Conduct wide-range assessment including spirituality and religion, and make appropriate referrals based on identified needs
- Foster love, respect, personalism.
- Employ art therapy.
- Look at models that have been successful:
    - Teen challenge-Pentecostal and 12 step
    - Hogar Crea
    - Youth challenge - Pentecostal
    - Religious programs: Encourage state or managed care organizations to recognize the success of these programs and fund them

Correctional Institutions:

Although limited time was available to discuss the needs of Latinos within and being released from correctional institutions, the discussion forum noted that this is a group which requires special attention. The following were identified:

1. Latinos released without proper ID's

2. Employment--provide income critical to recovery

3. Housing--work closely with parole or probation officer

4. 90 days to 6 months of treatment-- allow graduates/clients to visit and contribute to program

The Under-documented:

The under-documented also received attention as a special group of Latino people. Two barriers to utilization of substance abuse treatment services were cited:

- Limited services (very few are available and accessible)
- Fear of being reported by service providers

Key Elements in Working with Latino People:

The following elements are critical for providers seeking to offer culturally responsive services:

- Involving the family and other supports in treatment
- Training staff on cultural issues
- Avoiding eye contact as a sign of respect
- Eliminating (client) shame
- Eliminating staff prejudice
- Reinforcing the positive, highlighting personal successes of clients
- Emphasizing harm reduction (improvement, reduction in use)

Policy Issues

It was the consensus of the group that the Latino community on the whole, needs to mobilize and do a lot more in order to gain political strength and impact on policy issues. Policy recommendations of the group are as follows:

- Advocate for flexible HMO credentialing requirements
- Increase funding for research and development of "Latinocentric" programs
- Develop strategies to persuade policy-makers, funders and providers to be more responsive to the Latino community
- Explore validating volunteer services as resources for Latinos
- Seek remuneration for support services
- Define and develop standards for culturally competent agencies and programs
- Assure resources for Latino Culturally Competent agency and staff development
- Develop certification credential for culturally competent practitioners.
- Reduce the high rate of Against Medical Advice discharges among Latino Heroin users (LOS 3 to 4 days)
- Protect specialized, spiritually focused, non-medical community-based treatment programs
- Encourage programs to intensively involve families in treatment
- Establish a formal grievance procedure for employees and clients who have not been treated appropriately and respectfully
- Assure that the State has the capacity to treat everyone regardless of language and cultural service requirements
- Learn from other movements (for example, the AIDS mobilization)
- Increase research in substance abuse for all populations, especially Latinos and communities of color
- Use other resources, such as out-of-state activities to plan and mobilize

SUBSTANCE ABUSE

TREATMENT CONSIDERATIONS

FOR NATIVE AMERICANS

Richard Gott
Gerald Fougere
Michael Torch
Erving Pulchis
Edward Perley
Vincent Nicholas

SUBSTANCE ABUSE TREATMENT CONSIDERATIONS

FOR NATIVE AMERICANS

In preparation for the workshop Mike Torch gave a presentation on anthropological culture, its meaning, and its current influences. Richard Gott gave a presentation on the Medicine Wheel and spirituality. The Medicine Wheel is used to give the client a perception of the journey taken by humans on this planet. The Four Directions were spoken about and included a discussion on the four cultures of the human race as an effort to eliminate racism and prejudice. The Wheel also speaks to the self-dignity of human, animal, plant, and water beings. The discussion of the Medicine Wheel included a discussion of Native values while walking the Red Road of being sober and clean.

Following the presentations, the group identified through the "brainstorm" process a list of important aspects of Native American culture that need to be considered in Native American treatment. The following list, using clinical, program, and policy categories, is the result of the process :

Clinical Issues

- Family (wide boundaries)--oftentimes all members of the Tribe are considered and treated as family
- Ceremonies (spiritual, grounding)
- The majority of Natives believe that all races are brothers and sisters
- Build trust; relationships paramount
- Clinicians need to acknowledge that they don't know Native American culture and must be willing to listen and learn

Clinical Observations:

- Culture is passed person-to-person (relationships)
- Tools and training developed that can help document cultural needs different with each individual (Important to establish if individual was raised or off the reservation, and if s/he believes in living traditional ways. So an assessment tool for this would be beneficial)
- Realize that everyone's perception of the world is limited by their social context, which affects their goals and priorities
- Avoid stereotyping
- Clients need to culturally identify with all facets of recovery plan and program
- AA alone doesn't do it--AA, and its 12 steps, could be perceived by some as further attempts to assimilate.
- Residential treatment facility must provide a sense of family
- Address loneliness and isolation within treatment facilities
- Client needs to revisit ancestral ways in treatment, then integrate AA (if appropriate) as another way to recovery--culture comes first!
- Spiritual aspect comes first, then cultural way
- Walk together in harmony
- Use wheel of culture as a tool to determine cultural needs in treatment plan (ceremonies out of first 5 steps in AA)
- Recognize time and space issues--here and now, not concerned with later or future
- Design culturally appropriate aftercare
- If a program meets client needs, it will work
- Screening to determine needs of client may require creativity
  Rule #1: Listen
  Rule #2: Listen
  Rule #3: Listen
- Ask Native American client what he/she needs and how together you can reach his/her goals-respectively engage him or her in the process
- If you "touch the client's heart" he/she will listen to you
- Oppression is the reason why many Native Americans deny their heritage

- Native American transition says "it's not what we have that makes us what we are, it's what we give (We need to build on this value in recovery. This is an important cultural value to most Native Americans, but nearly impossible to maintain in today's society)
- To force eye contact with a Native American is an invasion of their privacy and "insulting"

Clinical Recommendations:

- Develop common language
- Meet clients where they're at, where they want to end up, not where we want them to go
- Rehab should be client-paced, but structure is important, especially in the primary stages of treatment

Program:

- Native American ceremonies (pipe ceremony, medicine wheel, drumming, sweat lodge, and vision quest) should be an integral part of the recovery program.
- Native American culture is passed on person to person. Therefore, incorporation of larger extended family and elders in treatment is supportive and yields better outcomes.
- Native American culture is also activity-based. Therefore, treatment plans should be action-oriented, and include native arts and crafts.
- Covert unintentional prejudice is a real issue. Both Native American clients and staff from other cultures need to "speak" about this and make it overt, so that the prejudice is addressed. Otherwise, clients do not recover.
- A Native American may work 3 days if that is all that he/she needs that week and to take care of the family. An employer may not understand his/her not coming to work the other 2 days. This should be considered and addressed in treatment, and in preparation for future employment.
- The entire disclosure culture of AA can go against the privacy value of the American Indian. There is shame and guilt connected with being an addict and standing up and admitting it publicly is not always the best approach. Even deciding how much would be shared by the American Indian representatives to this conference was the subject of a lengthy meeting last night. This Native American value needs to be respected.
- People are not answering questions now as freely as they did in the pre-managed-care era as mistrust of the system and funder has increased.

During his presentation, Mike Torch had suggested that the group utilize the 12 Core Functions to identify problem areas. Utilizing the 12 Core Function format the group identified the following:

Screening:

- It is critically important that the right person does the screening.
- It is also essential to be able to determine the degree of acculturation.
- Screening instruments need more demographic categories to adequately reflect the diverse populations.
- "Eligibility" should include "met with elder and agreed to come to this culturally appropriate service." This becomes a front end indicator of success.
- Offer client a "Self-assessment" tool that is understandable to him/her.
- Ask about substance use, i.e. are you in trouble with alcohol and drugs? Why are you here? What is the crisis that brought you here today? (the technical term for this kind of back-door questioning is "cultural surrogate markers"). Also, use a "flexible" vs. a "cut and dried" approach to questions. Another strategy is to say "Tell me the story that got you here."

Intake:

- Ask, "How did you find out about our services?"
- Ensure that tribal members perform intake.
- Determine if client is medically able to take advantage of services by asking these questions:

  1. Who do you see when you get sick?

2. When was the last time you saw them?
3. Did you need anything at that time and, if so, what?

At this point, you will probably know if the client uses traditional or alopathic medicine, or a combination, and if the client has liver problems. Intake procedure should also recognize that family is of paramount importance in Native American culture and should be part of intake questionnaire (this will allow you to determine whether the client has the support of or is alienated from his/her family). Additionally, you should determine the client's other support systems.

Treatment Planning:

- Tailor to individual but include:
  1. Consultation with and involvement of family
  2. Consultation with and involvement of elders
  3. AA/Community Healing
  4. Behavior Change
  5. Traditional Arts & Crafts
  6. Spiritual needs
  7. Sexuality
- Negotiate the entire treatment plan with client

Rationale: Show funding source that you have increased possibility of better outcomes if you work with the individual's priorities and within the individual's culture and tradition.

OFF-RESERVATION NATIVE AMERICAN ISSUES

Key Differences:

- Off reservation Native Americans required decentralized but inclusive service delivery systems
- Off-reservation Native Americans do not receive IHS medical coverage, unlike on-reservation Native Americans.
- Community and kinship structures are different, and often include families of choice comprised of intertribal members

Clinicians:

- Need to act as a liaison between and among clients, family members, ancillary social service providers
- Need to be good interpreters for their clients, ready to explain how their treatment is funded, how external authorities may impact on their course of treatment
- Need to be comfortable with providing a level of cultural services appropriate to the needs of each individual client
- Need to involve all family members
- Need to be prepared to address legal issues, such as runaways, racism in the schools, discrimination in employment
- Need to be familiar with client families who may live on the reservation
- Need to be strongly familiar with the need for extensive social supports, which may include traditional cultural teaching and ceremonies, and must be able to make connections with spiritual leaders, artists (birch bark basket makers, etc.), and language instructors
- Need to maintain continuous contact with community members and attend social gatherings
- Need to work with the client to identify an appropriate self-help support for recovery, whether AA, NA, or Red Road meetings

Clinical Setting Needs to reflect:

- The values of the culture, i.e., comfortable seating, flexibility in scheduling, client preference to be outside

Administration Issues

- Policies and procedures must reflect the values of the Board and clients
- Negotiations with external funding sources need to be consistently supportive of cultural competency
- Clients' information and consent must be clearly delineated and culturally appropriate while reflecting respect for client comfort with levels of disclosure
- Changes in policies must be discussed by all program staff prior to final decisions
- Data collection needs to be quarterly, if possible, in order to supply timely reports for managed care payers to demonstrate client success rates
- Measures of success in treatment must include client participation in conventional counseling as well as all other additional support opportunities
- Primary source credentialing must include credentialing Native clinicians on the basis of cultural competence as well as achievement of conventional credentials
- Utilization review must include only pertinent client data to be released with client permission
- Off-reservation Native clinicians must be prepared to make contingency plans in the absence of reimbursement by external funders

Policy Issues

- Look for the commonalties across tribes and other cultures and build policy accordingly
- Respond to differences by leaving enough flexibility in policy to accommodate them/highlight them as appropriate
- Determine what the 3rd party payer really needs to know and no more
- Inform clients should what information will be used for

State policy-makers

- Would benefit from training in culturally competent service delivery for Native American communities
- Should consider funding formulas that are flexible and responsive to changing demographics and data regarding substance abuse treatment services for Indian people
- Need to have reliable community-based sources of demographic information in order to decrease the impact of problems such as racial misclassification of Indian people
- Should consider cultural competency certification and mandates for all clinicians
- Should be aware that off-reservation Indians make up 78% of the Indian population in New England

SUBSTANCE ABUSE
TREATMENT CONSIDERATIONS
FOR PEOPLE OF ASIAN DESCENT

Joy Connell
Carolyn D'Avanzo, D.N.Sc

"With the grateful assistance of Davis Y. Ja, Ph.D., Maryann Amodeo, Ph.D., Sonith Peou, Saly Pin-Riebe, An Ton That, Hanh Tran, and other members of the Southeast Asian Substance Abuse Treatment Working Group."

SUBSTANCE ABUSE TREATMENT CONSIDERATIONS

FOR PEOPLE OF ASIAN DESCENT

The workshop opened with introductions of each participant, thus revealing that many were members of a group called the Southeast Asian Substance Abuse Treatment Working Group (Refer to description at end of this section). Outreach to this group was conducted specifically in preparation for the conference because of earlier at decisions to focus on New England as a geographic area, on Southeast Asians as a specific segment of the larger Asian community, and on the extreme dearth of culturally-specific treatment services available anywhere in the country. Because of the imminent beginning of the first culturally-specific treatment program for Cambodians under the direction of the Working Group, it was felt that a description of the Group's development and its plans for the new program would be a potential model for others in the workshop. Although the Working Group focuses on Cambodians and Vietnamese, it was felt that particular issues would be relevant to other Asians as well.

The workshop was also highlighted by the presence of one of the conference's plenary panelists, Dr. Davis Ja. Since Dr. Ja has pioneered the field of substance abuse treatment services for Asians in California, as well as consulted to other groups throughout the country, much of the workshop's focus was to learn as much as possible about his experiences in California and elsewhere.

With these two main areas of focus, the following arose as issues identified by participants that have implications for clinical, program, and policy considerations:

General Principals:

- In the discussion of "Asian" substance abuse services, there must first be a recognition of the heterogeneity of Asians. The tremendous diversity among Asians encompasses distinct linguistic, cultural, and historical traditions. These, and other characteristics, must be considered in the development of services to communities and in treatment with individuals.
- Substance abuse treatment services for first-generation Asians must address cultural issues, spiritual beliefs and health care practices, as well as linguistic barriers, in order to be effective.

Note: While the following have been placed in specific categories --clinical, program, or policy--for conference presentation, many are also perceived as belonging to a second, or all three, arenas. Given the paucity of available treatment services for Asians, it is hoped that anyone interested in the development of such services takes into consideration all three of the categories and their interplay with one another.

Clinical Issues

- Understanding culturally-defined reasons for use of substances, which responds to the view of many community members that substances may hold medicinal value, and which give insight into traditional health practices which include the partaking of potentially harmful substances
- Distinguishing between substance-abusing behavior as a chemical abuse issue and as a symptom of post-traumatic stress disorder and the stress of the acculturation process.
- Centering treatment on a family approach that includes ancestors and descendants, rather than focusing on the individual
- Utilizing a social support model which includes the natural support systems of the client (such as family, extended family, temple, church, work, etc.)
- Being flexible in the number and length of sessions
- Basing screening questions on culturally-appropriate norms--unique approaches must be developed when necessary.
- Acknowledging the importance of "face-saving" opportunities
- Limiting confrontation; using indirect information-gathering methods

- Organizing groups in a gender-specific fashion and clustering group members based on optimum and appropriate combination of subcultures (e.g., Cambodian female elders, young adult Vietnamese men, etc.)
- Developing engagement and ongoing activities that might include work-related/vocational training, ESL, or other types of concrete activities
- Developing cultural identity for Asians struggling with intergenerational conflict, personal identity, racism, and other issues
- Identifying and addressing sexual trauma issues, if necessary

Program Issues

- Utilizing staffing pattern that reflects the cultural and linguistic characteristics of the Asian community; staff must be both bilingual and bicultural
- Using trained professional interpreters to conduct face-to-face sessions when staff is not bilingual
- Training English-only providers who work with Asians on how to work effectively with such interpreters
- Viewing interpreter services as a critical component of service delivery and, therefore, as a third-party reimbursable service.
- Documenting and collecting data to accurately capture who is being served and what specific services offered are most effective and their cost
- Creating a support network for bilingual/bicultural workers
- Conducting training efforts customized for workers from a particular community
- Maximizing existing resources and using them appropriately
- Developing a full continuum of services
- Developing appropriate assessment tools to produce outcome data

Policy Issues

- Including Asians in planning, evaluation, and monitoring of programs
- Furthering leadership role of federal and state governments and availability of seed money to start pilots
- Examining definition of "Medical Necessity" according to Managed Care entities
- Examining Purchase of Service policies and procedures
- Outlining advantages regarding long-term outcomes/risk management/cost control
- Directing funds to community-based organizations who understand the target population--these groups have already been doing community work and need to receive training on substance abuse issues to further their work--funds should not be wasted on training mainstream organizations to become culturally competent to work with Asians
- Addressing inequity in resources
- Continuing advocacy and strategy development

The Southeast Asian Substance Abuse Treatment Working Group:

Established in 1992 by an ad hoc group of providers and advocates joining together, the mission of the Working Group is to promote the development of culturally-specific substance abuse treatment services for Cambodians and Vietnamese in the metropolitan Boston area. The Working Group currently has thirteen members representing a variety of organizations involved in services to Southeast Asians. Among them are the state Departments of Public Health and Mental Health, the Alcohol and Drug Institute at Boston University School of Social Work, mutual assistance associations (MAAs), and local health and mental health agencies. Each member is active in a number of other provider and community organizations, thus broadening the perspectives and resources of the Working Group. Many members are Southeast Asians themselves.

As a result of the Working Group's efforts, a pilot treatment program has been developed called "Project Sangkhim" (sangkhim is the word for hope in Khmer, the language spoken by Cambodians). It is designed to develop community capacity to provide culturally-competent outpatient substance abuse treatment services to Cambodian adults living in the Boston area.

PART III

OUTLINE

OF

CONSENSUS BUILDING FORUMS

MAY 15, 1997

POLICY ISSUES IN FOSTERING DIVERSITY AMONG SUBSTANCE ABUSE TREATMENT PROGRAMS

Suman R. Timsina, M.A., C.A.C
Michael J. Finnegan, M.Ed., C.A.C

POLICY ISSUES IN
FOSTERING DIVERSITY AMONG
SUBSTANCE ABUSE TREATMENT PROGRAMS

The afternoon session began with a review of Wednesday's breakout sessions. The group was representative of all breakout sessions. It was represented by all minorities with the exception of Native Americans. Each member gave a brief update on what his/her session covered. Obviously there were a number of overlapping topics and cross fertilization of ideas was strongly encouraged. This brainstorming and sharing session was to provide the basis of subgroup recommendations to be submitted later.

As co-facilitators we were both frustrated and exhausted by the ambiguity of the task at hand. However, this frustration gave way to exhilaration and a sense of unity as the group tested and tried various ways of looking at policy. The morning session began with a brief introduction of managed care, differences between traditional services and HMOs, and changes in managed care policies. We further discussed a decision-making model of policy formulation. This model which was adopted throughout the workshop, advocated a client-centered approach to policy. It was characterized by:

1. Freedom to choose
2. Fairness in services, and
3. Equality.

The morning session's presentation served up the model of Community Behavioral Health (CBH) as one example of the many responses to managed behavioral care. Our enthusiasm for this model and the fact that the New Hampshire delegates learned that their bill had been passed (during our session) served as reminders as to what our efforts might look like. We all felt strongly about some type of certification or accreditation process for culturally competent service providers.

Outcome measures, consumer-oriented boards of trustees, and participation in ongoing dialogue of what works were also emphasized. All participants were in agreement that providers need to "prove" their cultural competence. Mere demographic and minority profiling wouldn't be sufficient for recognition as "a culturally competent caregiver." Participants hoped that the overseeing (policy-making) body that awards contracts would recognize the need for culturally competent care and accept the recommendations and suggestions of the communities they serve.

Governance

- Managed care should form a culturally diverse advisory committee
- Ethnically and culturally diverse consumers, providers, government and community leaders and representatives should be included
- Advisory committee should have impact on grievance process
- Advisory committee should have representation on board
- Advisory committee should be empowered to advise in areas concerning personnel, treatment-decision making, informed consent, and consumer relations
- Contract renewal should be performance based
- Recognize that the previously stated efforts will:
  - Lead to "good community will"
  - Assist in achieving cultural competence

Benefits Design

- Educate clients on selection of managed care companies, e.g., client education package about benefits
- Train culturally competent staff to provide "Hot Line" services managed care selection/services
- Create incentives for providers and managed care companies to educate consumers and providers, leading to less restrictive outcomes for clients
- Identify following models of treatment as needed:

Non-traditional
Hospitals
Residential
Outpatient
Halfway Houses

- Recognize alternative healers
- Ask/require that there is coordinator of benefits with residential vendors and payers
- Encourage managed care companies to look at outcomes and design community prevention plans which include culturally competent framework
- Acknowledge importance of contracting with culturally and ethnically diverse treatment providers
- Increase incentives for managed care companies to embrace prevention strategies
- Review periodically the following benefits for substance abuse:

Dollar limits
Treatment days

- Avoided repeated use of a DSMIV/ICD-9 diagnosis unless an assessment is done within six months

Quality Monitoring and Improvement

- Solicit input from the advisory committee
- Study varying impacts on ethnically and culturally diverse population
- Employ consumer surveys and utilization review in outcome study
- Revise utilization review to include items addressing cultural sensitivity
- Provide culturally sensitive drug and alcohol training to staff
- Recognize all providers to be trained in cultural sensitivity
- Encourage managed care companies to identify culturally diverse providers
- Identify and contract with competency-based providers, including those who use non-traditional methods of demonstrating competency.

Management Information Systems

- Managed care system should be instrumental in establishing uniform definitions and methodology
- Accurate data should be collected to establish correlation between diagnosis, assessment, treatment modalities, outcome, and ethnic and culturally diverse groups
- Health and psychosocial information should be collected

Staff Training and Development

- Staff should be trained to be culturally sensitive and aware of the population(s) served
- Performance Review/Evaluation (staff assessment) should include cultural competence
- Advisory committee should have input into training and development

PROGRAM ADMINISTRATION ISSUES IN TREATING DIVERSE POPULATIONS

Arthur Evans, Ph.D.
Del Oladeinde
Edith Sanchez

PROGRAM ADMINISTRATIVE ISSUES IN TREATING DIVERSE POPULATIONS

The workshop began with Ms. Sanchez making a presentation regarding her experiences in developing a program for Latino clients in Bridgeport, CT. Ms. Sanchez described how she started the program and the many challenges she faced in beginning a program specifically for Latinos. She described how she worked with funding and regulatory agencies because they did not have a clear understanding of what she was doing and how her specific program functioned.

Ms. Sanchez also described the things that program administrators should do to develop programs which are more responsive to people with diverse backgrounds. Ms. Sanchez described surveying her staff as to their satisfaction with working at CASA/MAAS in a cultural context with their clients. What she discovered was that most of her staff expressed a high degree of satisfaction with the work they were doing within the agency. They felt good about being able to respond to the needs of their clients within the context of the clients' cultural values.

Attending the workshop were highly experienced administrators who represented all four groups, Native American, Asian American, Latino, and African origin. Participants were also representative of all six New England states. Participants broke into small groups to discuss what program administrators need to do to develop programs that are more responsive to the groups that were the focus of the Conference. Each group identified issues in the areas of Access and Entry, Process-Treatment, Quality Assurance and Evaluation, Governance and Policy, and Staff Development. The following resulted from the workshop:

Access & Entry Issues

- Conduct aggressive outreach to ensure early intervention (coming into treatment at earlier stage in the disease process)
- Recognize the impact of culture in outreach and engagement rather than denying importance of culture
- Use screening/intake to motivate client
- Respect client's need/desire to have family involved in screening/intake (family, friends, blood relatives, client's system of support)
- Welcome clients from diverse backgrounds to physical plant; programs should pay attention to food served, decorations, music
- Establish a relationship at first point of contact which will provide follow-through (a critical factor); focus on the establishment of a good therapeutic relationship (First point of contact needs to be receptive, hopeful, respectful, and uphold possibility of recovery)
- Understand the culturally defined reasons/contexts for alcohol/drug use within the various communities that are served (environmental secondary factors, racism and oppression, etc.)
- Understand that accessibility, affordability, availability and suitability equal cultural competence
- Create printed goods that are readable at "street level," be open to constant education--learn from clients
- Increase client population with marketing outreach and proper approach (offer appropriate services)

Treatment Process/Program Development

- Design screening/assessment tools that are based on culturally appropriate norms--develop valid instruments for the groups served
- Recognize heterogeneity of the communities of interest (native-born vs. foreign-born, countries, language, religion, migration history)
- Respect and value the heritage and the uniqueness of each community of interest (COI)
- Include natural supports such as family, church, temple, work, extended family, etc.
- Decrease the criminal justice system as the first intervention by creating effective prevention/outreach/intervention with multicultural impact on communities of interest
- Capitalize on presence of formal and informal community-based support networks to sustain recovery

- Identify and respect the community of concern, which may have different therapeutic relationship boundaries
- Uphold actions and behaviors that reflect respect, equality, uniqueness, and dignity
- Affirm cultural competence as a necessary and vital part of the equation of the therapeutic relationship (i.e. trust, respect)
- Promote joint planning and program design processes which involve substance abuse services, faith community, and general community as well
- Utilize existing knowledge and information about communities of interest in culture as a basis for program design and delivery (For example, providers should be aware that African American women abstain from alcohol and other drugs at a higher rate than any other group)
- Uphold client rights and make appeal process accessible and understandable
- Develop process for involving clients in selection of treatment options (educate on the effectiveness of each)
- Engage COI with respect in the process of goal identification and attainment (CS)
- Incorporate culturally specific activities--symbolic/ritualistic healing, music, dance games, sports, arts, etc.
- Validate the indigenous experience of paraprofessionals in a bona fide service agency through collaboration with indigenous community organizations
- Investigate how alcoholism is incorporated into the cultural framework
- Training providers who work with interpreters
- Develop a multi-linguistic service-(face to face); are the providers familiar with addiction issues? HIV/AIDS? etc.; are they culturally competent and S/A qualified? Need a cadre of these for each culture-(linguistically, eventually culturally competent)
- Build a program that has the capacity to learn to meet people’s needs--understand that we don't know it all
- Develop mechanisms for information gathering to better serve the client
- “Walk in the shoes" of clients- visit their environment, be aware of their issues and feelings, and educate staff about other groups
- Read newspapers and attend religious services
- Refuse to passively accept mandates that clearly don’t work for culturally diverse groups
- Be willing to take the risk of doing things differently
- Consider using volunteers; form partnership with community-based and academic-based programs (schmooz, barter--show them they need you)
- Integrate family-based approach into program and get reimbursed for it
- Define the role of family in the client’s culture
- Use referrals to defray expenses
- Know resources in the area and get them involved with your program
- Recognize the heterogeneity of different groups--generational issues, geographic issues, ethnic differences, etc.
- Acknowledge and be inclusive of faith communities in service delivery
- Consider the possibility of religious-based programs-- be open to potential pastoral contributions
- Respect, value, and promote the value and diversity of spiritual experiences
- Incorporate spirituality into program design, i.e. provide volunteer clergy
- Develop programs that recognize that Native Americans generally want to improve well-being of the tribe.
- Develop culturally appropriate materials for clients that they can understand
- Involve people from diverse cultural backgrounds in recovery, in developing the program, in surveys, etc.

Quality Assurance and Evaluation:

- Identify culturally specific measures of improvement
- Provide training to ensure cultural competency as evidenced by clinical outcomes and client satisfaction
- Assure internal quality assurance of treatment plans, objectives, goals, etc. specific to populations of interest in a language of their understanding
- Develop culturally appropriate satisfaction surveys and make results available for community inspection

- Conduct needs assessment with client involvement to identify particular services that are needed to sustain involvement in treatment and recovery
- Use evaluators who are culturally competent (certification in cultural competency would be most desirable)
- Locate similar agencies across country and compare outcomes, modalities, measurements, cost-effectiveness; find ways to collect data and demonstrate need to managed care organizations and potential funders
- Collect data on how well the program is serving different cultural groups and distribute data to staff
- Collect data in a way that verifies to what extent each ethnic group is being served and that interventions are making a difference
- Conduct a culturally appropriate post-client survey--if necessary, invent a new survey format
- Set incremental objectives in a definitive way
- Get technical assistance to effect change in structure of the agency seeking to be culturally competent--get help by providing data to research group

Staff Development and Training

- Promote the development of staff from communities of interest
- Support ongoing, culturally relevant ATODA training for all staff, including the executive director and Board of Directors (Note: administrators must give time to staff)
- Support development of culturally relevant support networks--foster empowerment of staff
- Support staff in their own growth, development, recovery, and renewal in a cultural context
- Include multicultural considerations in the “Science of Ethics"
- Train culturally competent community-based organizations (CBO) to become competent managed care providers
- Ensure that those providing clinical supervision adopt and "buy into" the mission, goals, methods, techniques of the agency as they relate to cultural competency
- Provide culturally appropriate supervision with culturally appropriate training
- Avoid overloading the cultural staff person with all of the cultural clients and issues within the agency
- Use the information superhighway that increases overall staff resources
- Provide all necessary support to the staff to meet credential requirements
- Employ culturally appropriate family counselors

Policy and Governance

- Assure that communities of interest are employed at all levels of the substance abuse treatment system
- Assure that Board of Directors, administration, and staff represent the population of concern
- Include commitment to cultural competence as a part of agency's mission statement/mandate/ policy /processes/practices
- Incorporate cultural competencies into the standards for academic education, licensure, and accreditation
- Reflect the client populations served in governance management and staffing
- Promote and support state standards for cultural competency that treatment and managed care agencies should adhere to
- Make special efforts to support and retain culturally appropriate staff
- Begin to value equally the knowledge and experience of culturally diverse treatment providers and compensate accordingly
- Offer equality of pay for all levels of work for culturally competent staff
- Enter into contractual relationships with staff regarding training, staying with agency
- Advocate that State and Federal funding sources begin to value equally the services of culturally relevant programs (providers must be more aggressive in finding out "going rate" and in advocating for equal reimbursement)
- Be clear in mission in regard to cultural specificity
- Define and be cognizant of "medical necessity" in each culture--program administrators must know differences and be aware how they manifest themselves in groups
- Understand cultural differences in defining "alcoholism"

- Rewrite policy to embrace holistic approach to treatment and counter elitist attitude (administration needs to have a policy of inclusion of religious/spiritual activity on a voluntary basis)
- Represent Cultural group needs at all levels of organization
- Commit to maintaining credential standards for all staff (even if it means importing culturally appropriate trainees and supervisor)
- Advocate for culturally competent state inspectors
- Reward cultural competency with salary increases

CLINICAL SERVICE ISSUES
IN TREATING DIVERSE POPULATIONS

Alicia Munroe, M.D.
Catherine Dubé, Ed.D.
Roberta Goldman, Ph.D.

CLINICAL SERVICE ISSUES
IN
TREATING DIVERSE POPULATIONS

After discussing the option of meeting in small groups, the participants decided to meet as a large group so that all could benefit form the discussion.

The group was facilitated by Dr. Munroe with he assistance of Dr. Goldman, and Dr. Dubé. The group was asked the following:

What advice or guidance would you give to managed care organizations regarding cultural competency in the areas of outreach and prevention, access, the treatment process, and quality assurance and evaluation, as they apply to clinical services for culturally diverse populations?

As the group discussed each of the above areas the recommendations were summarized and recorded. Not all of the recommendations listed necessarily reflect group consensus. However, whenever objections were voiced, the recommendation was discussed, and amended in an attempt to resolve any conflict.

The discussion resulted in lists of recommendations generated by the group. The group noted that the lists may be incomplete, and that each point could be expanded upon and further defined. They also noted that the resulting recommendations were in no particular order of priority or importance. Final listings reflect the order in which topics were suggested and/or discussed in the group process.

The following resulted from the group discussion:

Quality Assurance and Evaluation Issues

- Define success in terms that are relevant to the client
- Don't feel confined by evaluation
- Don't miss opportunities to collect data through strategies that are easily implemented for proof of success and feedback to HMO's--demonstrate your effectiveness integrated with treatment
- Deliver treatment plans and treatment in client's language
- Translation needs:
  - -Confidentiality
  - -Trained, bilingual/bicultural interpreters if no bilingual/bicultural clinicians available
  - -Increased availability of bilingual/bicultural clinicians
  - -Network of trained translators to share among agencies
  - -Aggressive strategies in place to recruit bilingual/bicultural clinicians and
  - -Strategies to invest in training clinicians in their area
- Bicultural important and does not always entail bilingual also bicultural and/or bilingual/bicultural
- Monitor HMO's to minimize barriers for clients
  - -How do administrative policies cause barriers?
  - -Be flexible about credentialing of clinicians
- Develop strategies for working with homeless
  - -No fixed addresses
- Discuss issues with HMO personnel directly
  - -Providers must be willing to advocate for clients directly with HMO
  - -Providers need to be willing to go beyond boundaries and resources of their office to include community and spiritual resources as appropriate for client (especially for Native Americans--but may be applicable to many groups)
  - -Providers should gain direct understanding of HMO policies in their area
  - -HMOs must develop strategies to accommodate client diversity in a culturally responsive way
  - -HMOs must take responsibility-responsibility should not fall entirely on treatment clinicians outside HMO
  - -HMO must employ competent intermediaries
  - -HMOs need to simplify systematic issues to allow energy to be focused on treatment

-Continuing education/staff development funding for cultural issues should be made available
-Information about differences in HMO policies/benefits should be made available to agencies, employers, community groups, via the internet and other means
-HMO must have advocacy office of multicultural issues--not just symbolic but real advocacy
-Providers must be willing to lobby legislature for needed changes
-Clinicians should become familiar with "sympathetic" legislators and contact them
-Professional organizations should get involved in talking to legislators
-Providers should educate and empower clients to vote
-HMOs must better inform clients about their benefits:

- clear, understandable English
- variety of languages
- translator available to explain

-HMOs should make information available about provider's bilingual/bicultural abilities and what kind of translators are available

<-Both have value->

VS.

Credentialing	Experience
Important for reimbursement	Reaches more diverse populations of providers
Important for research	May be stronger in cultural connections
Generates revenue	May be more competent culturally
Documents skills	Taps talents of valuable personnel
Protects people in the profession	Lack of rules
May be a goal for non-licensed personnel	Reimbursement problems - not billable
Need resources to develop these people	
May lead to rigid rules	
Excludes valuable people	

Access Issues

- Money-funding for those without insurance-or if agency doesn't take third-party payments, agency funding.
- Off-reservation Indians
  -access problems distinct from reservation Indians (poverty and illegal immigrant status may directly affect access)
- Issue-legal status
- Geographic location--transportation--rural issues
- Need creative strategies to allow clients to access services when they aren't nearby, (also an outreach issue)
- Family role in seeking care and coverage--no assumptions about "family" since structures vary
  -Who is partner
  -Access to health coverage, (also a serious treatment issue-support network)
- Local availability of services
- Distance strategies (outreach)
- Language (non-English-speaking)
- Need for services in the client's language
- Multiple language with translators (minimize this practice; complicates organizational issues and treatment confidentiality)
- Minimization of need for the therapist to translate the plan of therapy from patient's language back to English
- Use of translators-minimize or abolish use of translators if possible
  -Highest Good: Bilingual and/or bicultural (Incentive for recruitment of providers and translators
  -Second Highest Good: Trained translators to work with providers and providers trained to work with translators
- Need agency resources for translation and training for above

- Staff competence to work biculturally
  -Recruitment (new staff)
  -Staff development (existing staff)
- HMO-cost savings
  Short-Term and Long-Term Goals
  -Emphasis on cost-saving reduces interferes with access to care-system designed to provide less care
  -Need monitoring to reduce these barriers
    - Legislators--influence the law
    - HMO's--direct lobbying by providers
- Allow flexibility on for clinicians
  -Some clients are homeless and have no address
  -Clients need to have the values of their cultural group understood (recommendation: include community resources and people from community as resources in treatment)
  -HMO disclosure of process to get mental health services
- Providers should gain an understanding of HMOs and their administrative policies and maintain relationships with HMO administrators
- HMOs need to provide support and liaison with treatment programs and develop their own culturally competent staff and other intermediaries for outreach
- HMO's need to take care of substance abusers in culturally diverse populations
- HMO's need greater flexibility to work with a wider range of treatment professionals and better strategies for lessening the burden of providers trying to work with them
- Money and support for professional development and training for people willing to work in this field (cultural competency and treatment)
  -Preservice
  -Inservice
- Counter-advertising--making public (e.g. web page) the problems HMO's are creating will allow consumers to make an informed choice
- Organize providers to fight back against HMO's
- Each HMO should have an office for multicultural services for clients and to help providers
- Clinicians should understand the state and federal role in changing laws related to coverage and care
- Clinician's professional organizations should work to change the laws and should encourage voter registration
- HMO's should be clear with clients as to what their benefits are
  -In 8th grade language level or lower (clients don't know what their benefits are; written form should be clear and staff must be available to explain)
- HMO provider guide should indicate cultural and linguistic specialties of provider

General Recommendation on Access Issues:

- Develop creative strategies for outreach to overcome geographic, cultural, and financial barriers

Treatment Process Issues

- Engage in scientific research to document quality of treatment
  -Qualitative/quantitative strategy
  -Data for proof of treatment effectiveness
- Collect self-report cultural information from all clients in a way that is meaningful for the clients
- Construct intake procedures that minimize the trauma of intake and facilitate the collection of accurate data collection, e.g. use culturally appropriate methods, revise intake forms to make them culturally competent, accommodating for variations in client gender, culture, lifestyle, sexual orientation
- Improve cultural compliance, stress all treatment professionals have this responsibility
  -Appropriate support needs to be available for clinicians
  -Supervisors need to know their staff and their limitations (e.g., prejudice) and be able to appropriately match patients and/or intervene
  -Supervisors and clinicians may come from different cultures

-Strategies in agencies to deal with clinicians biases and other cultural self awareness issues that can impact style and quality of care
- Need opportunities for collaboration among all levels of staff on cultural awareness issues
- Emphasize training to enhance self-awareness of clinicians (improve their understanding of transference and counter-transference cross-culturally)
- Foster cultural competency through collaboration with other agencies who bring cultural insights and information (bi-directional collaboration)
  -Goals for clients should be client-driven
- Consider gender issues (as well as gay/lesbian issues) when matching clients with clinicians
- Accommodate characteristics of the client:
  -Gender/ culture/ language
  -Lifestyle/ previous experience
  -Socio-historical experience
  -Where the client is and wants to go is an important consideration when developing treatment plans
  -Treatment providers from various constituencies need to be valued for their strength, not marginalized
- Accept that all treatment professionals must improve their cultural competence skills--not just refer clients of different ethnicity
- Use "spiritual life" as a more accurate method of determining a client's spiritual orientation than "religion"
- Understand the spiritual orientation of clients and incorporate into aspects of spirituality important to clients and consistent with their beliefs (involve clergy if appropriate)
- Get meaningful cultural information from clients in a sensitive way, using self-identification
- Gather more than government-category information--include broader, more appropriate categories that are more reflective of cultural competence and needs of clients,- remain advocates for changing government shortcomings, and continue to give feedback to government agencies on changing their "categories"
- Allow cultural information to inform treatment plans
- Construct intake procedures that minimize the trauma of intake, minimize dropout, and facilitate the collection of accurate data (e.g. using groups, culturally appropriate methods, home intake, or the best you can do)
- Include consumers in policy development and the development of treatment plans (e.g. client counsel or representatives)
- Pair clients of similar backgrounds to help each other
- Revise Intake Forms to make them culturally competent
- Present recommendations to managed care in a manner that address their own interests (e.g. profits)
- Train clients to be advocates for culturally competent services
- Train indigenous people to work in the substance abuse field
  -Empower people
  -Recruit/mentor in high schools and colleges
  -Increase lower-level clinician skills
- Reexamine and challenge traditional, long-held assumptions about what quality treatment is
  -Increase level of research to demonstrate what treatment modalities work
  -Anecdotal stories are useful but not enough
- Assess alternative treatments, e.g., art therapy, music therapy, dance therapy, and biblio-therapy--incorporate when appropriate
- Recognize utility of alternate, complementary therapies that can help elicit information and promote healing when talk therapy cannot
  -Utilize only certified therapist in these fields
- Inform HMOs which agencies have cultural services so referrals are appropriate
- Provide gender appropriate care
- Consider sexual orientation, as well as gender and ethnicity in arranging treatment
- Understand the skills and special abilities as well as the biases that clinicians bring to their work
- Create a community of collaboration that also acknowledges people's contributions even if they are not of that cultural group

- Promote wide-spread cultural responsiveness (If a clinician is gay or comfortable treating gays, it is not OK to send all gay/lesbian clients to that clinician, thus allowing all others to avoid responsibility of becoming more culturally responsive)
- Use inclusive language--reconsider utility, for example, of asking for race or sex on a form (Note: Native American concept of two-spirit person)
- Foster environment of honesty and respect in which discussion can be open and clarifying
- Counter cultural insensitivity in everyday, small ways, e.g., if you collect information on race, also collect from an inclusive list of ethnicity
- Ensure collection of accurate data on demographics--ethnicity must be self-reported to be accurate
- Do intake in groups, avoiding the power differential of 1 worker/1 client (serves as a form of peer initiation)
  -Other methods may work in specific settings, but thought must be given to what is the most culturally responsive method
- Develop flexible strategies for staff to raise skill and credential level (funding; time from work to seek higher training; no docked pay; no forced use of vacation days)
  -We are **NOT** saying to lower credentials to accommodate cultural appropriate care
  -Those with credentials and those with personal experience can learn from each other
  -Understand that credentialing is a separate issue--credentials are necessary, but uncredentialed experienced people should be valued
  -Staff with qualifications but lower-level degrees should be supported in their efforts to obtain higher credentials (especially where needed to satisfy HMO reimbursing rules)

Outreach and Prevention Issues

- Promote education of entire community (religious leaders, cultural centers, etc.) to reduce stigma
- Focus particular groups, e.g., funders, cultural groups, gay/lesbian, elderly, homeless, and develop services to address the needs of those underserved populations
- Use cultural immersion as a method to connect with the community and extend outreach
  -Festivals and activities can integrate information about substance abuse
  -Identify opportunities for contact with individuals in the community
- Develop strategies to reach high-risk populations (for example, go to gathering places such as bars and clubs)
- Connect with grass roots organizations
  -Train police and fire departments about stress and substance abuse
  -Train community action advocacy groups who are already involved in outreach work
  -Work with emergency services in the community
- Create outreach strategies-outreach at times hindered by lack of space for more clients
  -Need to assess which groups in community are not seeking treatment at your agency and outreach to them (including elderly, gay/lesbian)
  -Outreach and access hand-in-hand--can't outreach without appropriate services
  -Outreach to new immigrant communities when they don't know about services or when a stigma is associated with treatment
  -Utilize community leaders to help
  -Find ways to reach underserved groups--i.e., homeless--go to shelters, soup kitchens
  -Outreach to adults to help prevent future problems with their children (prevention)
  -Develop student assistance programs and mentoring programs in schools-(prevention)
  -Outreach to single mothers (parenting support, stress management, even to mothers who aren't using, to aid prevention in kids) Outreach=prevention for their kids
- Educate on concept of addiction and mental illness as diseases-rather than as states of moral delinquency
  -Education-helps with prevention and relapse prevention
  -You enter treatment not because you have done “a bad thing”-addiction is a disease
  -Develop partnerships with clergy, traditional healers, cultural centers
  -Do something in community that is fun--host a carnival to show human side of agency
  -Show off perks of being a client of the agency (e.g., good subsidies, section VIII, etc.)
  -Also educate how illness is a result of other factors affecting the family
  -School system is an essential point of access

-Connect with culturally specific festivals and community events (e.g., have a float in the Puerto Rican parade with some salsa music, hand out flyers)
-Find a culturally appropriate medium to get into school system--then integrate information about substance abuse prevention
-Consider reaching parents through your work with the kids
-Integrate discussion of alcohol and drugs into other broader parenting programs so participants aren't targeted, stigmatized for attending
-Go where the kids are--boys club, gyms, basketball games
-Policy: develop a strategy for building knowledge and empowerment in the community through groups not necessarily working solely in substance abuse
-Outreach for mothers and treatment settings conducive to mothers needs

PART IV

NEXT STEPS: STEERING COMMITTEE PLANNING

FOLLOW-UP ACTIVITIES TO THE CONFERENCE

The planning committee which developed the conference has identified a series of follow-up activities which it is pursuing, now that the initial educational event has been completed. Following are the overall goals and expected next steps:

Goal: Further development and dissemination of emerging knowledge concerning culturally competent substance abuse treatment

The conference in May produced a wealth of practical information about how to develop and deliver culturally competent substance abuse treatment. In order to begin advocating for specific actions, it is important to balance this practical information with what has been proved in a sound, research oriented environment and documented in the literature.

Toward this goal, the Addiction Technology Transfer Center of New England is conducting a search of the literature for articles which address the following questions:

- What are the key elements of substance abuse treatment approaches which enhance the cultural competency of the service?
- For specific cultural groups, what are the aspects of culture which must be acknowledged and addressed in the therapeutic environment?
- What culturally sensitive tools and techniques have been developed and tested in the therapeutic setting? What have been the results of their use?
- What culturally sensitive tools and techniques have been developed and tested in administration of substance abuse treatment program? What have been the results of their use?
- What culturally sensitive tools and techniques have been developed for policy-makers who are managing and developing treatment systems? What have been the results of their use?

The results of this literature search will be published and disseminated during Fall, 1997 to participants at the conference among other interested parties.

The literature search will help target and guide further activities of this planning group.

Goal: Development of specific tools for clinicians, administrators and policy-makers to enhance the cultural competency of the treatment system across New England.

The planning group wants to see an immediate impact from its work on the current substance abuse treatment system. Toward this end, it would like to partner with the State Alcohol and Drug Agencies across New England that have identified increased cultural competency as a goal for the state's treatment system.

In August, members of the planning committee will meet with selected State Agency Directors at a Board meeting of the New England Institute of Addiction Studies. During this meeting and follow-up meetings with selected state agency staff, the planning committee will:

- Identify states actively working on cultural competency initiatives
- Identify the staff assigned these tasks
- Identify specific tools which are needed to enhance local services (refer to following section)
- Determine whether needed tools currently exist or need to be developed
- Work with state agency staff to begin to access and use these tools (refer to following section)

Specific Tools

"Tools" to enhance the cultural competency of the treatment system can include a number of items. For example, clinical tools would include screening and assessment questionnaires or instruments designed to take into account important cultural factors. Administrative tools would include check lists to be used by agency directors or board members to determine things that the agency is or is not doing to provide culturally centered services. Policy tools would include suggested performance standards to be used in the contracting process with provider agencies, to measure and encourage increased cultural competency.

Accessing and Using the Tools

There appear to be a variety of assessment instruments, check lists, indicators, and guidelines that have been developed for treatment systems. The planning committee would like to promote awareness of those that seem promising and identify gaps in available tools where they exist.

The committee will consider a range of activities to promote the use of existing tools. They will include: copying and disseminating tools, arranging for technical assistance in the use of selected tools, and supporting or conducting formal training sessions, where this would be useful.

Resources for this kind of support will be limited and the committee will need to prioritize the potential activities. However, members f the committee look forward to this implementation phase of its work.

CULTURAL COMPETENCY IN THE AGE OF MANAGED CARE

May 14 & 15, 1997
Holiday Inn
Worcester, MA

ABOUT THE EVENT: The Addiction Technology Transfer Center of New England, in cooperation with a number of other groups, developed a two-day conference, "Cultural Competency in the Age of Managed Care," in order to consider ways of making substance abuse treatment services more responsive to and effective for people from diverse racial and ethnic backgrounds.

The conference was designed to:

1. Focus on the special treatment needs of four groups:
   - -People of African Origin
   - -Latino People
   - -Asian People
   - -Native Americans

2. Present current knowledge about making treatment services responsive to people from these groups

3. Create a forum within which participants could discuss the issues and build consensus about guidelines for the delivery of treatment services at three levels:
   - -Clinicians treating people from these groups
   - -Program administrators who manage or develop treatment services for people from these groups
   - -Policy developers at the state level who support, regulate or purchase these programs

The conference participants included people who were members of the ethnic or racial groups being considered, plus those who work with or develop services for clients from diverse ethnic or racial backgrounds. Program content was designed to be useful to clinicians, program administrators, policy makers, scholars, and public and private funders of treatment services.

The event was planned by a group of professionals representing the designated ethnic and racial groups, the Addiction Training Center of New England, a large list of co-sponsors, and the State Alcohol and Drug Agencies from across New England.

CONFERENCE PROCEEDINGS: The plenary sessions and workshop session were taped in order to facilitate the development of Conference proceedings. The tape led to the production of this document, which will be shared with the participants and selected additional groups. The proceedings are intended to serve as the basis for the development of standards or guidelines for practice at the practitioner, program, and policy levels.

CULTURAL COMPETENCY IN THE AGE OF MANAGED CARE

May 14 & 15, 1997
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Worcester, MA

SPONSORS

The Addiction Technology Transfer Center of New England (ATTC-NE)
and
The Center for Substance Abuse Treatment

This event was developed and supported by the ATTC-NE through a grant from The Center for Substance Abuse Treatment. The ATTC-NE is a project of Brown University's Center for Alcohol and Addiction Studies, Providence, RI

CO-SPONSORS

A number of organizations throughout New England agreed to co-sponsor this event. They are organizations which have a special interest in promoting cultural competency across the substance abuse treatment system. They agreed to help promote awareness of this event, and supported its development in a variety of ways.

CONNECTICUT

- Connecticut Department of Mental Health and Addiction Services
- Connecticut Hispanic Alcoholism Commission
- Connecticut Association of Substance Abuse Agencies
- CT Chapter, Black Nurses Association
- Oxford Health Plans
- ProBehavioral Health

MASSACHUSETTS

- Massachusetts Bureau of Substance Abuse Services
- AdCare Educational Institute, Inc.
- Massachusetts Chapter of the Black Alcoholism and Addiction Council
- Western Massachusetts Substance Abuse Providers Association
- Brandies/Harvard Research Center on Managed Care and Drug Abuse Treatment
- Boston University School of Social Work, Alcohol and Drug Institute

MAINE

- New England Institute of Addiction Studies
- Maine Office of Substance Abuse

NEW HAMPSHIRE

- New Hampshire Bureau of Substance Abuse Services
- New Hampshire Minority Health Coalition
- New Hampshire Alcohol and Drug Counselor Certification Board
- New Hampshire Alliance for the Progress of Hispanic Americans

RHODE ISLAND

- Brown University’s Center for Alcohol and Addiction Studies
- Rhode Island Division of Substance Abuse Services
- Rhode Island Minority Health Council
- Drug and Alcohol Treatment Association of Rhode Island

VERMONT

Vermont Office of Alcohol and Drug Abuse Programs
ALANA Community Organization

REGIONAL

Office of Minority Health, U.S. Dept. of Health and Human Services

NATIONAL

Multicultural Training and Research Institute, Temple University

FINANCIAL PARTNERS

Among our co-sponsors were several organizations which agreed to partner financially with The Addiction Technology Transfer Center of New England and Brown University's Center for Alcohol and Addiction Studies. The funds they were essential in making this event possible.

State Agencies

Connecticut Department of Mental Health and Addiction Services
Massachusetts Bureau of Substance Abuse Services
New Hampshire Bureau of Substance Abuse Services
Rhode Island Division of Substance Abuse Services
Vermont Office of Alcohol and Drug Abuse Programs

Federal Agencies

Office of Minority Health, U.S. Dept. of Health and Human Services

Managed Care Companies:

Pro Behavioral Health, Hamden, CT
Oxford Health Plans, Norwalk, CT

ORGANIZATIONS PROVIDING ADMINISTRATIVE SUPPORT

AdCare Educational Institute, Inc.
Brown University's Center for Alcohol and Addiction Studies
The New England Institute of Addiction Studies

ABOUT OUR PRESENTERS

This was a unique event. We gathered the most knowledgeable people about cultural competency and substance abuse treatment from across New England and beyond. This expertise was reflected in the keynote speakers, the workshop presenters, the planners of the event, the resource people invited to participate, and the people who chose to attend the event and share their perspective and skills.

Following is some information about several of these groups of people.

The Keynote Presenters:

King Davis, Ph.D. is Professor of Social Policy at Virginia Commonwealth University, School of Social Work. He is the former commissioner of the Department of Mental Health and Mental Retardation in Virginia. He was responsible for the management of a statewide behavioral health care system.

Frances Brisbane, Ph.D. is Professor and Dean of the School of Social Welfare at the State University of New York. She is Dean of the Black Alcoholism and Addictions Institute. She is cofounder of the "Counseling and Treating People of Colour: An International Perspective." She is an author and editor.

Nicholas Parkhurst Carballeira, N.D. is Director and CEO of the Latino Health Institute in Boston. He is the past director of educational and community outreach for the Multicultural AIDS Coalition in Boston. He was Assistant Dean of Academic Affairs at the University of Puerto Rico Medical Sciences Campus.

Davis Ja, Ph.D. is a Research and Program Evaluation Consultant with the California School of Professional Psychology at Alameida/Berkeley, CA. He provides clinical and consulting services through the Asian American Recovery Services in San Francisco, CA, and has a special interest in increasing the cultural competency of behavioral health services.

Jeff Whelan is the Addiction Counselor Supervisor for the Akwesasne Addiction and Counseling Program on the St. Regis Mohawk Indian Reservation in Ontario, Canada. He has developed and implemented seven substance abuse treatment programs for Native Americans in Canada and the United States, including the first U.S. federal program for adolescent Native Americans.

David Mactas is Director of the Center for Substance Abuse Treatment, the lead agency in the national effort to provide treatment to all Americans with addictive disorders. Prior to joining CSAT, he was President of Marathon, Inc., an eminent treatment agency and a significant research and demonstration site for a number of federal initiatives.

Anita Pernell-Arnold, M.S.S.W. is a clinical associate of the Department of Psychiatry at the University of Pennsylvania. She is associated with the schools of social work at both Hunter College and Temple University. She is immediate past chairperson of the Multicultural Research and Training Institute Advisory Board at Temple University.

The Consensus Building Forum Presenters and Leaders

This group of people agreed to lead us to consensus on the tasks that clinicians, program administrators, and policy makers must accomplish in order to assure the cultural competency of our substance abuse treatment system.

The Planning Committee

A diverse group of people helped in the planning and development of this event. They cheerfully volunteered their time and expertise to help translate a good idea into a reality.

Several members of this group also volunteered to provide logistical support throughout the conference. Special thanks to Denise Adams, Sallie Brown, Jim Gorske, Della Hennelly, Lisa Lund, and Susan Storti from the planning committee for their invaluable assistance in this area.

the

conference

planning

committee

would