

SUPPORT Act Grant 101: 15 SUD & Cultural Humility

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Disclaimer

- The information contained in this material can change as we learn more about the brain and the ways it is impacted by the environment, trauma, medications, substances of misuse, and other things
- Always follow the guidelines of your agency, ethical and legal standards of your certifying Board, evidence-based practice methods; local, state and Federal laws as well as your judgement and commonsense when working with clients

Questions?

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If you have any questions, please do not hesitate
to contact me

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SUPPORT Act Courses

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1: ~~Tele-Behavioral Health in the Time of COVID-19~~ (No longer available—Incorporated into all courses!)

2: Client Engagement

3: Suicide

4: **Crisis & De-Escalation**

5: Withdrawal Syndromes & Withdrawal Management

6: Trauma-Informed Care

7: Overview of SUD

8: Opioids & Stimulants

9: SUD Treatment Basics

10: Screening & Assessment

11: Co-Occurring Disorders

12: Individual Therapy Skills

13: Group Therapy Skills

14: Addressing SUD Bias & Building Provider Empathy

15: SUD & Cultural Humility

16: SUD Treatment & the Family

Program Outline

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I. Introduction

II. Cultural Issues in SUD Treatment

III. Tele-Behavioral Health Basics

I. Introduction

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Language

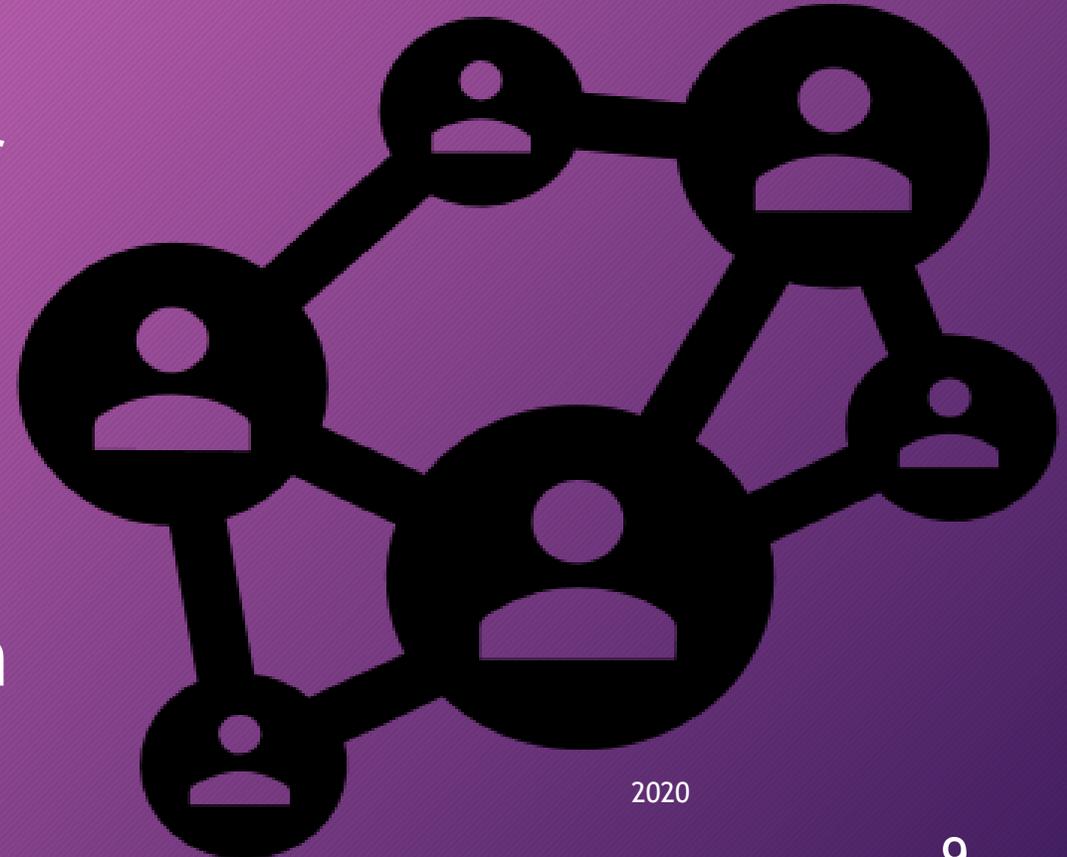
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- I believe in using “Person-Centered language” as much as possible, thus:
 - Not “Addict,” but Person who uses drugs or Person with a substance use/behavioral disorder
 - Not “Addiction,” but Substance Use Disorder (SUD)
 - Not “Clean,” but In Recovery or Testing Negative
 - Not “Dirty,” but Testing Positive
- At the same time, out of habit, I may inadvertently use some of these older words/terminology
- Also, be cognizant that some people may describe themselves as “alcoholics,” “junkies,” etc.

2020

Two Important Things You Must Do Before Working With Any Client

- I. **You must care!** You must like people in general regardless of their circumstances, behaviors or opinions of you
- II. **Find something to like** in the person you are working with—connect with them on a human level



2020

What Got You Here?

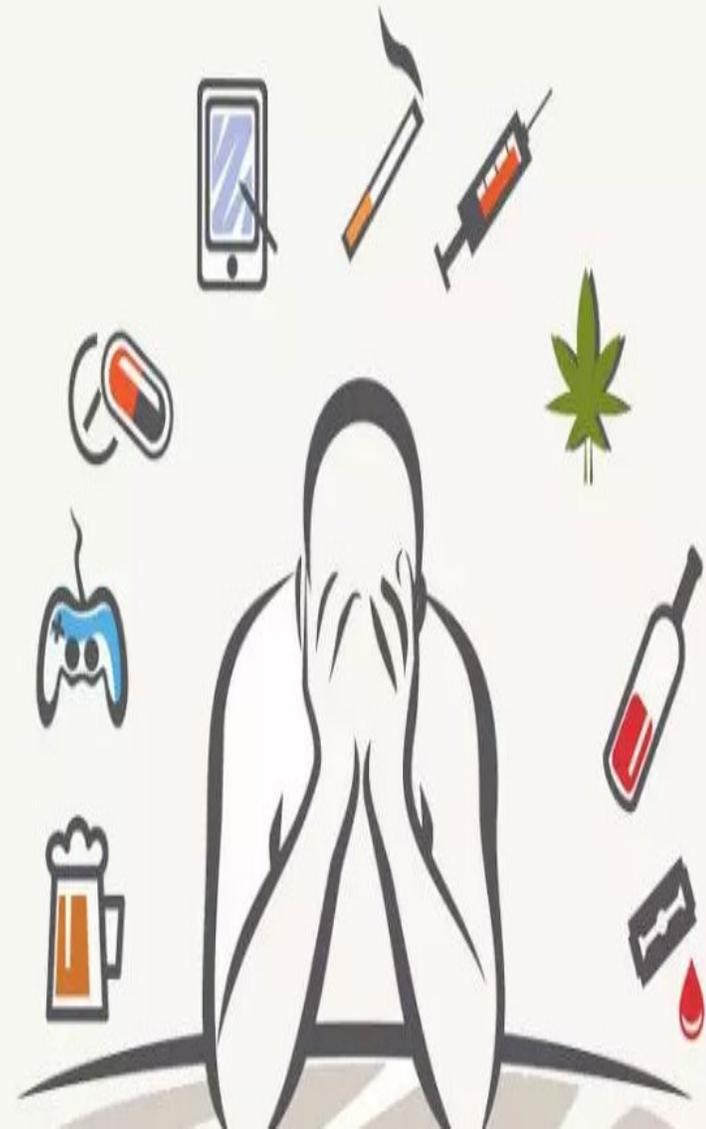
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NO ONE
sets out to
become
addicted to
chemicals or
behaviors

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Addiction Defined: ASAM

Addiction is a treatable, chronic medical disease involving complex interactions among brain circuits, genetics, the environment, and an individual's life experiences. People with addiction use substances or engage in behaviors that become compulsive and often continue despite harmful consequences.

Prevention efforts and treatment approaches for addiction are generally as successful as those for other chronic diseases.

Adopted by the ASAM Board of Directors September 15, 2019

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Addiction/SUD Defined: The 3 P's

(Filbey, 2019, P. 1)

Pervasive: SUD affects all aspects of a person's life

Persistent: SUD effects persevere despite efforts by the individual

Pathological: SUD effects are uncontrollable

Recovery Defined

“...A lived experience of improved life quality and a sense of empowerment; that the principles of recovery focus on the central ideas of hope, choice, freedom and aspiration that are experienced rather than diagnosed and occur in real life settings rather than in the rarefied atmosphere of clinical settings. Recovery is a process rather than an end state, with the goal of being in an ongoing quest for a better life.”

(Best & Laudet, 2010 as cited in Morgan, 2019, p. 191)



A large crowd of stylized human figures in various colors (brown, black, white) is shown. One white figure stands out in the center, surrounded by a circle of light. The background is a dark purple gradient.

Stigma Defined

“Stigma is a social phenomena whereby individuals who deviate from the accepted norm are perceived by society as less desirable and are judged or punished accordingly” (Avery & Avery, 2019, p. 94)

Why is This Important?

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Remember what we started with: People matter, regardless of what they are going through

Stigma is one of the main reasons that people with SUD do not seek treatment





II. Cultural Issues in SUD Treatment

Cultural Terms in SUD Treatment

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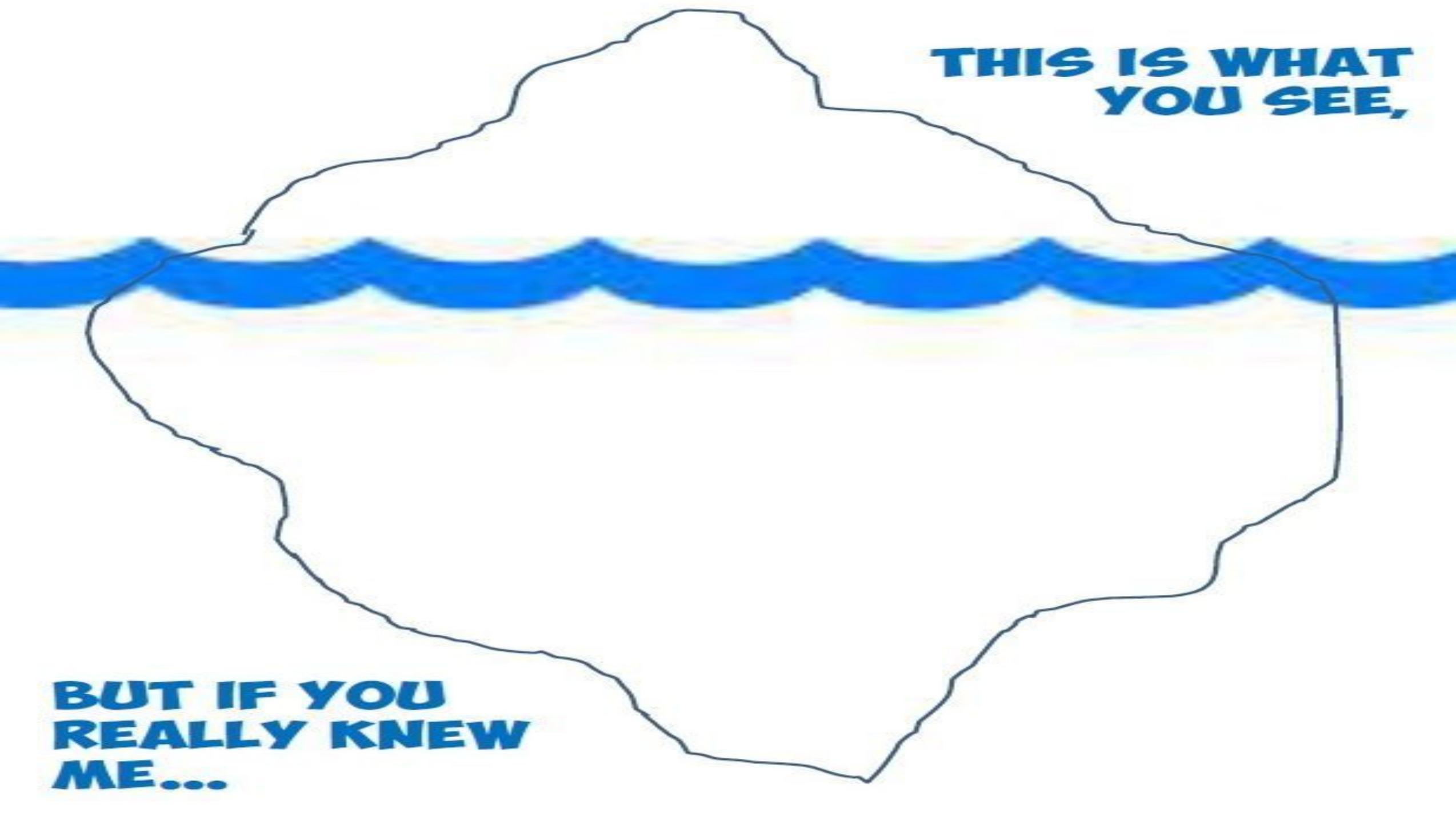
- **Culture:** A group's shared traditions, customs, languages, rituals, history and expectations
- **Ethnicity:** How people are classified based on shared ancestry and culture
- **Race:** A social construct, based on geographic location and physical characteristics
- **Identity:** Our self-conceptualization
- **Norms:** Behaviors within a culture that may be positive or negative; these norms can extend to the use of chemicals
- **Cultural Humility:** The ability to maintain an interpersonal stance to other people that respects their cultural identity and values; this is an ongoing process, not an end-state

Additional Aspects of People We Need to Be Aware Of

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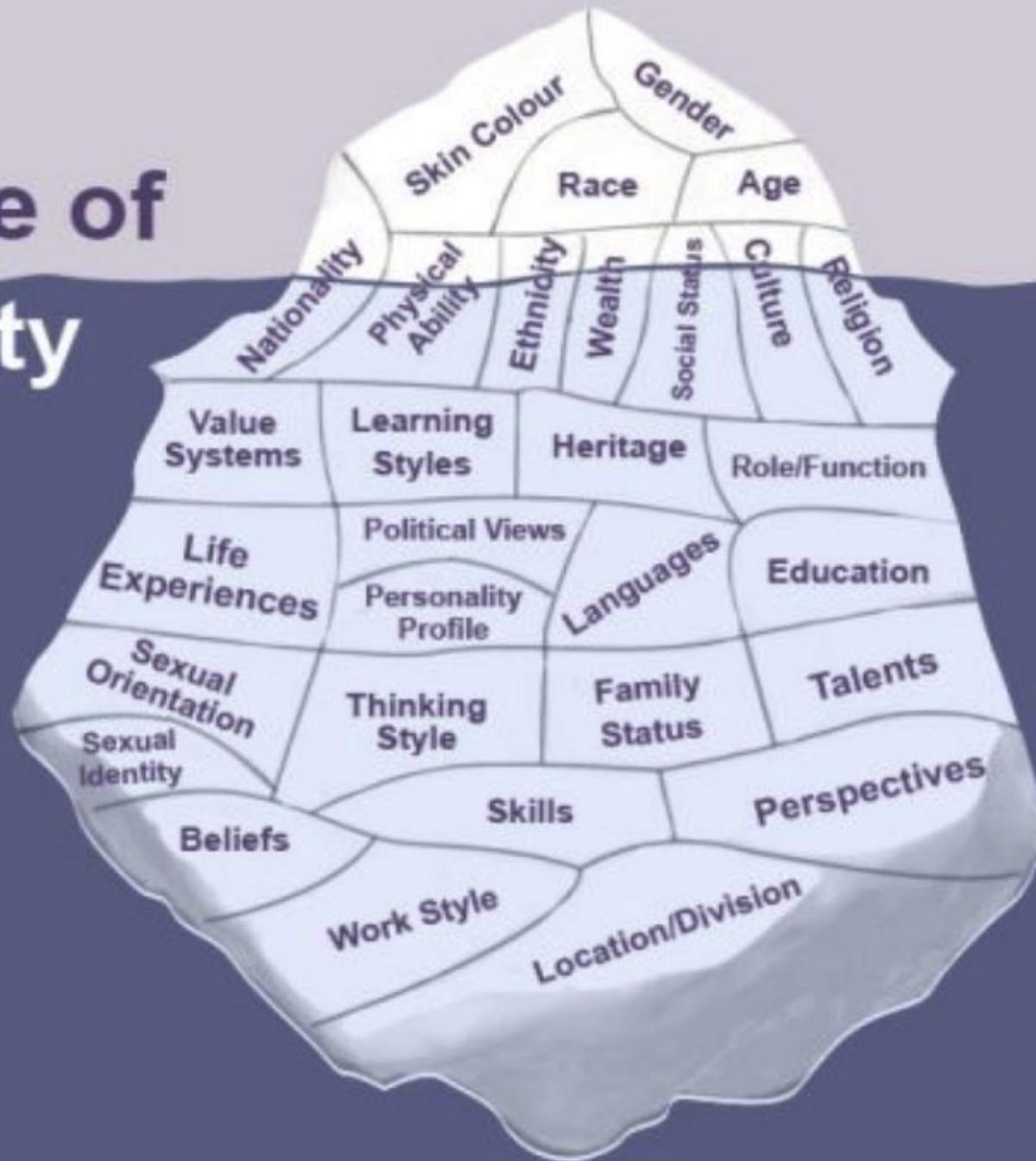
- Sex
- Gender Identity
- Gender Expression
- Sexual Orientation
- Age
- Socio-Economic Status
- Nation of Origin
- Spirituality, Faith, Religion
- Political Beliefs
- Physical Disabilities
- Intellectual Disabilities

**THIS IS WHAT
YOU SEE,**



**BUT IF YOU
REALLY KNEW
ME...**

Waterline of Visibility



Iceberg Exercise

You & Me

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- How do we appropriately address racial, age, cultural, sex, gender and socio-economic identities while still seeing the person we are working with as a unique individual?
- How do you practice *genuine-ness*?

Please keep these concepts in mind as we examine some specific groups in class today

Why is This Important?

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- Most SUD treatment has historically been based on older, white, middle-upper class, heterosexual males
- Only recently have we begun to examine how SUD impacts women, adolescents, ethnic groups, and sexual minorities
- Even when we examine substance use disorder in the context of these differences, we need to remember that rarely does “one-size-fit-all”
 - (e.g., a person’s community and/or socio-economic level may play a larger role in their lives than their ethnic identity)
- We also need to be aware of cultural trends and our country’s history in working with others
- All of this influences treatment delivery

It is Important to Note



We cannot fully discuss SUD and SUD treatment without recognizing that racism and classism have been an integral part of determining which substances are acceptable and which are made illegal: The difference often lies in underlying societal attitudes, prejudice or stigma rather than science

Please be aware that the following slides present broad views of complex and varied groups: Treatment should always be individualized

African Americans

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- Generally have less access to quality treatment
- Institutional and economic discrimination remain significant barriers in many communities
- Representation among “harder drugs” may be disproportionately higher because of a higher incarceration rate
 - Which leads to a higher proportion of health problems
- Alcohol use starts slower, then tends to catch up to Caucasians as people age (especially in men)
 - Lower incidents of drunk driving compared to Caucasians
- Higher incidence of medical problems (e.g., hypertension) brought on by SUD and lack of access to medical treatment
- Greater spiritual and religious participation, relationships and emotional expression, and these should be incorporated into treatment

Race, Stigma & SUD

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- In addition to racial inequalities in terms of economics and institutional barriers, there are differences in the types of treatment available
 - “Buprenorphine patients who were enrolled in primary care differed demographically and clinically from those enrolled in OTPs [Methadone clinics]. Compared with the patients in the substance abuse OTP, primary care patients [OBOT, or buprenorphine] were more likely to be white, employed, stably housed, to hold at least a bachelor’s degree, and to be new to addiction treatment” (Avery & Avery, 2019, p. 139)
 - “Medicalization of addiction and the increased accessibility of treatment for OUD offered by OBOTs were predicted to decrease stigmatization, but access to this treatment is not evenly distributed or experienced the same way across race, ethnicity, and social class” (Avery & Avery, p. 145)

Latino/Latina Americans

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- A diverse group (Mexican-American, Cuban-American, Puerto Rican, etc.)
- In the U.S., males are more likely to develop alcohol use disorder, possibly due to a more permissive cultural norm that is tied to acculturation, but women are increasing their levels of drinking
- Drinking increases as education and income levels increase
- This is another underserved community with a lack of culturally relevant treatment personnel
 - Language barriers and cultural barriers to treatment in many places
- Family roles are important, as is interdependence, and the extended family and these themes can be incorporated into treatment

Asian & Pacific Island- Americans

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- Another diverse group; the fastest-growing in the U.S.
 - (Chinese, Japanese, Korean, Indian, Middle-Eastern, Vietnamese, Hmong, etc.)
- Diversity in religion and spiritual expressions with varying views about chemicals of misuse
- The “flushing” reaction when alcohol is used may lead to lower ETOH use among people of East-Asian descent
- Family embarrassment and shame may lead to increased instances of hiding drug use
- Privacy is important
- The family is often more important than the individual
- Gender roles are important; same-sex treatment groups may be more effective

Native Americans/First Nationers

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- Diverse: There are over 200 Native tribal groups in North American
- Alcohol abuse is recognized as a significant problem in many tribes, but patterns vary widely among tribes
- Hallucinogens are responsibly used in some Native American rituals
- Belief in the unity and sacredness of all nature
- Self-determination is also very important
- Growing use of alternative methods and models of recovery
 - Tribal Drug Treatment Courts have existed for decades

What Do Clinicians Need to Do?

Recognize

Recognize, confront and adjust our own biases

Do not make

Do not make assumptions about a client based on their ethnicity

Conduct

Conduct a thorough assessment

Avoid

Avoid stereotyping, and develop individualized treatment plans for each client

Ask

If you have a question

Own it

If you make a mistake: Apologize

III. Tele-Behavioral Health Basics

Tele-Behavioral Health

We first need to admit that most of us do not enjoy “connecting” with clients this way; “I didn’t go to school for this!”

We also need to acknowledge that not all clients have access to technology to participate in tele-behavioral health and so we have to improvise

Therefore practitioners and clients are using phones, Skype and FaceTime to conduct sessions; and getting creative in other ways

Clinicians do not have to use HIPAA-compliant video conferencing technology during the current National Emergency; Health & Human Services will waive any penalties for HIPAA violations related to the platform used during this emergency

Tele-Behavioral Health: Clinician

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- Have a space set up where you can connect with your client without being disturbed
- Your work-space should provide some privacy for your client
- Internet connectivity and/or phone signal strength should be tested prior to engaging in tele-behavioral health
- If conducting a group therapy session, educate clients on muting themselves unless they are speaking
- I recommend against using your personal phone, but sometimes this cannot be avoided

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- If using a personal device, I would set firm boundaries with clients regarding when they can and cannot contact you



You'll likely notice that the flow of clinical sessions will be slower than in-person



Be aware that you will likely need to speak slower than in person



Try to express empathy with your voice, especially when not connecting via video

Tele- Behavioral Health: Clinician

Tele-Behavioral Health: Client

- Try to have a private space where you can connect with your counselor that is also free from interruptions and distractions
- Test out your communications system (connectivity) prior to meeting with your counselor
- Most of us (counselors especially) don't like meeting this way, so remember this is temporary and we (like you) look forward to meeting face-to-face again

Informed Consent to Tele-Behavioral Health Treatment—Essential Elements

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- A statement explaining what tele-behavioral health will look like for you and the client (methods to be utilized: FaceTime, phone, etc.)
- A statement discussing the risks of tele-behavioral health (technology limitations and failures; possible/unintentional breaches of confidentiality)
- A statement agreeing that the sessions will not be recorded by either party
- A statement emphasizing that the content of the session is confidential and that a written release is required from the client to release information
- A statement noting the limits of confidentiality, including having to report suspected child abuse, vulnerable adult abuse, danger to self or others

Informed Consent to Tele-Behavioral Health Treatment—Essential Elements

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- A statement explaining what steps must be taken should the clinician believe that the client is a danger to themselves, a danger to others or is unable to care for themselves
 - This could include a statement that participation in tele-behavioral health may not be appropriate and a higher level of care could be required
- A statement describing how you will handle technical problems should they arise
- A statement explaining that the client must disclose their physical location during the session and an individual the clinician can contact in case of an emergency
- A statement that you are continuing to maintain treatment records during this time

Documentation

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- **If you don't write it down, it never happened**
- Record, in detail, all aspects of client interactions, including any known precipitating events, interventions, outcomes, staff members involved and all contacts with outside agencies
- Record where the client says they are contacting you from
- Do this as quickly as possible following the session
- **Stick to the facts**; do not presuppose or assume anything
- See documentation as a necessary means to protect yourself, the people you serve, and your organization

References

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References

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