Cultural Competence: The Elements of Culture that Affect Treatment Outcomes

By Suzette E. Brann
CULTURAL CONSIDERATIONS FOR TREATING DIVERSE POPULATIONS

INTRODUCTION

As we worked on developing this curriculum, it became very evident that we would have been remiss if we did not take the time to address the cultural considerations that impact on a clinician’s ability to treat by effectuating meaningful change, different ethnic groups. Too often we have provided training to practitioners in the treatment arena to enhance counseling skills with the misguided assumption that every practitioner understands and appreciates the inextricable relationship between culture, addiction and the concomitant motivation to change. We will attempt not to make the same misguided assumption here. Instead, we will attempt to underscore the significance of various cultural “themes” that must be woven into any effort to improve the therapeutic outcomes for clients of different ethnic and racial groups. What follows is a brief description of those themes.

1. Communication

No other cultural theme holds as much importance as communication. For people of color especially, communication has a right brain orientation versus that of Euro-American cultures which tends to be left-brained. As such, the cultural value assigned to language for the left-brained Euro-American is demonstrated frequently in communication that values and utilizes the line, list, sequence, logic, order, fact, outline and takes things apart.\(^1\) Conversely, for people of color, the cultural context of language is to paint a picture using rhythm, volume, intonation, rates of speech, cadence, pauses, and gestures to create a more fluid, less structured interaction. When we commit to communicating in a more culturally competent way, we commit to using speech patterns that are richer in

---

symbolism, tonal rhythms, metaphors and personification and that avoid didactic, instructional formats. Thus the use of culturally competent communication techniques should always result in the type of therapeutic rapport that builds the relational resilience between clinician and client. In Latino cultures, such communications result in relationships defined by “personalismo” and “confianza”\(^2\), for Hawaiian clients, “laulima”\(^3\) or working together, for African-American clients, “understandin’ that is for real”, and for African Caribbean clients, “pragmatic acceptance without ‘airing we dirty laundry’”. No matter how it is described, communication styles in treatment that are culturally competent must at least demonstrate three things: an understanding of, an appreciation for and an ability to use appropriately, some of the functional vernacular of that ethnic or racial group.

2. **Values and Relationships**

The cultural meaning of values and relationships to people of color comes second only to communication. Some contend that for the “right-brained”, this theme is equally significant because from the cradle to the grave, people of color are connected to each other in interdependent, reciprocal relationships. For the African American, African Caribbean and Latino client, extended families, street corner and barbershop gatherings, for example, are the norm. In fact, for almost every person of color, the cultural value of relationships is metaphorically equal to a revitalization of the spirit because he/she never has to be alone (that is, without collateral support). It is not unlike a Latino client to say something like “I do not belong to the culture of 911 (there’s always a relative I can depend on to rescue me)”. This holds very poignant meaning for clinicians working with people of color because their perceptions of commonalities in values and relationships could make or break the therapeutic alliance. If


there is no feeling of “connectedness” with the clinician, clients will not engage the change process.

Of equal relevance, is the stark contrast in the Latino and African Caribbean client’s perspective of his/her locus of control. The former tends to have an external one and believes that little in life is under his/her direct control whereas the latter, firmly espouses a more self-determining and internally oriented locus of control. This, too, has important implications for clinicians attempting to motivate change in the therapeutic environment. For example, clinicians working with a client whose cultural value system is externally motivated will only succeed in effectuating change if that client is empowered to believe that it is not futile to attempt change life’s present circumstances, no matter how depressing those circumstances may be.

3. **Power**

“Internal power is manifest in the individual’s sense of mastery or competence... The power relationships between people determine whether their interactions are characterized by dominance-subordination or equality...”

For people of color, power has very different connotations than it does for their Euro-American counterparts. In the Euro-American milieu, the power discourse typically implies “power over” someone, themselves, their socio-cultural environment or their spirit. Whereas for the person of color, the power discourse focuses on the “power to” not the “power over”. No doubt, this interpretation of power, will have a critical impact on a clinician’s ability to motivate change if he/she does not make empowerment the focal point of most dialogues with Latinos, African Americans and Pacific Islanders. Sessions with such persons of color must therefore be solution-focused, pride-eliciting and esteem fortifying. It is important to note

---

here that in some cultures, such as Native American, there never was and never will be an inclination to have power over...Irrespective of where a client begins, culturally competent clinicians understand that powerlessness is the midpoint between the false sense of control so characteristic of the Pre-Contemplation and Contemplation phases and the empowerment that flows in the Action phase.

4. **Learning Styles**

For people of color, lessons about values, social mores and culturally appropriate behaviors are modeled more often in interactive, story telling ways than their left-brain counterparts. For the clinician attempting to enhance motivation in people of color this means that he/she must focus on incorporating the symbolic, image-laden, experiential, spiritual (sense of interconnectedness) and emotional dynamics of learning into the process of eliciting change. When clinicians accept that the predominant theme for learning that resonates with people of color is oral expression, they will allow Pacific Islanders, like Hawaiians, the verbal interaction called “talk story” (in which cooperative learning takes place as different persons contribute to the narrative). They will understand that for African Americans, Latinos and African Caribbeans, wisdom is commensurate with direct experience accumulated over a lifetime. So, for example, mentoring styles that utilize the experiences of those who have gone before and transcended tragedy, are effective ways to help those ethnic groups learn how to erode their own resistance to change. Note: They will also be keenly aware that Latinos and African Americans tend to balk at task-oriented therapeutic techniques such as homework assignments, contracts, behavioral experiments or communication exercises.

5. **Symbols and Visual Cues**

You will find that the curriculum is littered with research and techniques that require visual not didactic interaction with the client.

---

African Americans, Native Americans, Latinos and African Caribbeans, tend to gravitate toward color, movement and spatial relationships in the symbols they use. As clinicians working with these populations, your ability to enhance their motivation and readiness to succeed in treatment, will depend on the creativity you exercise in engaging them on that level. We must be ever cognizant of the fact that people of color may model what they see, especially as they embark on the confusing journey of acculturation and acceptance, punctuated by a language whose nuances they have not yet fully grasped. This means that as a clinician, your body language, gesturing, style of reflective listening, and ways of teaching your clients about the reality of change, must be congruent with what you say.

As we bring this section to a close, read carefully the following statement:

“The first thing you do is to forget the fact that I am black. Second you must never forget that I am black…”

This statement best illustrates dilemma that clinicians often face when attempting to tailor their clinical interventions to the needs of African Americans or any other person of color, for that matter. As a result, it is critical that we add this caveat: we truly hope that this curriculum will help you to integrate the knowledge you have or have gained in a way that moves you closer to your personal goal of cultural competence not its opposite, cultural “encapsulation’. In other words, you must be clear that your quest to apply some general universal cultural themes to various ethnic groups does not equate to making stereotypical evaluations that rob clients of their individual histories and choices. Remember that our integration of culturally competent assumptions does not obviate our obligation to be cognizant of the fluidity of cultural transformations, new cultural blends and cultural inconsistencies.

---

It is our hope that as you proceed through this curriculum, the content, examples and exercises and/or scenarios included, will be help those of you who are clinicians or change agents and your respective organizations understand how these issues impact your ability to service these clients. We strongly believe that cultural competence, defined by some, as the ability of individuals or systems to provide services effectively to people of any race, gender, ethnic background and religion in a manner that recognizes, values, affirms and respects the worth of that individual and protects and preserves the dignity of each, is so akin to the universal principles of motivational enhancement that one should never be contemplated without an appreciation of the other.

What’s Cultural Competence Gotta Do With It?

Culture permeates every life domain. The saliency of culture is heightened in the lives of those living in a socio-cultural setting other than the one they come from. For so many of the clients we work with everyday, this is their reality. Think of the recently transplanted Cuban immigrant trying to negotiate life in English in a community starkly different than his own. Or the Jamaican immigrant who owns her own home in Jamaica and comes to the United States to work as a maid and nanny in someone else’s home in Boston. For these clients experiencing this kind of socio-cultural upheaval, it becomes abundantly clear to them that different cultures view the world in very different ways. Cultural knowledge and skill proficiency is, therefore, the most significant bridge that enhances our understanding of those differing world-views and provides some insight into the optimum approach to the problem-solving strategies to be used with those of differing cultural backgrounds.\footnote{Henderson, G., and Primeaux, M (Eds.) 1981. Transcultural Health Care. Menlo Park, CA: Addison-Wesley.}

If we are to engage and more importantly retain and successfully graduate/treat/supervise clients from diverse socio-cultural backgrounds, our service delivery systems must be culturally
responsive to the racial, ethnic, class, educational, vocational, sexual orientation, religious needs of majority of the clients we service. To do this, we must identify on a macro level, the barriers to recruitment and engagement and the gaps in service delivery that perpetuate lowered outcomes. On a micro (personal) level, we must continuously conduct self-assessments that aim to identify and challenge the personal biases that impact the delivery of substance abuse treatment services in a culturally competent way.

Cultural Considerations Re: the Core Functions of Treatment

After overcoming the “access” issue, people of color are then faced with issues of inaccurate “labeling”, deficit-focused treatment planning and counseling, and culturally irrelevant therapeutic interventions. For that matter, their entire treatment episode is focused inordinately on “fixing” the problem and not identifying and enhancing their strengths, gifts and talents. Unfortunately, since substance abuse treatment is such a multi-dimensional, interdependent and interdisciplinary process, there are so many places in which, even the most well-intentioned clinician can fall into the trap of believing that merely recognizing difference is all that is needed to treat “difference” in a culturally competent way.

The prevalence of the struggle many drug courts have to recruit, engage, retain and successfully graduate comparable numbers of people of color as their non-White counterparts, highlights how many places along the continuum of “healing” that culturally blind or incompetent practices continue to disenfranchise people of color.

Substance abuse treatment is characterized by twelve core functions and all of these are significantly impacted by cultural considerations.8 They are:

1. Screening
2. Intake

---

3. Orientation
4. Assessment
5. Treatment Planning
6. Counseling
7. Case Management
8. Crisis Intervention
9. Client Education
10. Referral
11. Report and Record Keeping
12. Consultation with Other Professionals re: client treatment

Let’s examine this statement in the context of each of the 12 core functions and the questions we must ask ourselves and our programs to ensure that they are aggressively seeking to include, and not exclude, people of color.
<table>
<thead>
<tr>
<th>Core Function</th>
<th>Question</th>
<th>Issues for Consideration</th>
<th>Recommendations for Drug Court Practitioners</th>
</tr>
</thead>
</table>
| Screening & Intake | Who is doing the clinical screening?  
What are the anticipated outcomes of the screening process? | ❖ Does this screener understand the cultural nuances and idiosyncrasies of this client population?  
❖ Is the screening process comprehensive enough to differentiate among use, abuse and dependence?  
❖ Is the goal to screen for eligibility or appropriateness or both?  
❖ How heavily does the client’s motivation, enthusiasm, readiness for treatment weigh in determining eligibility and appropriateness?  
❖ Will the identification of pre-existing psychiatric, developmental and medical conditions disqualify a client? | ❖ Make multi-cultural and cultural competency training mandatory for all assessors;  
❖ Modify screening instruments to take into consideration the cultural norms, values and strengths of the client population;  
❖ Create a system of review that will carefully evaluate those screened in and out and revisit the reasons why;  
❖ Train assessors to use techniques like Motivational Interviewing to assess where a client is in the Stages of Change Model so as to ensure that an apparent lack of motivation is not necessarily a prerequisite for program admission. Train staff to understand the cultural underpinnings of how motivation manifests itself in various ethnic and social groups.  
❖ Clarify eligibility criteria with changing demographics or service provider options. E.g., A program may decide to now admit clients who are homeless because a new MOU with a homeless shelter will provide adequate housing |
<table>
<thead>
<tr>
<th>Core Function</th>
<th>Question</th>
<th>Issues for Consideration</th>
<th>Recommendations for Drug Court Practitioners</th>
</tr>
</thead>
</table>
| Orientation   | What are the goals of orientation? | ✤ Is the orientation information presented in such a way as to empower, intimidate, or increase dissonance?  
✤ What are the barriers to engaging this population?  
✤ Again, who is presenting the orientation information? Does the orientation person have anything in common with the client?  
✤ Can they communicate all program rules, goals and obligations in a way that addresses the literacy and comprehension levels of the client population?  
✤ Are all of the forms, releases and client handbooks translated into the language of the client? | ✤ Ensure that staff is trained about the goals of orientation, that is, to begin the process of engagement. They must also be trained and use the Stages of Change Model and be able to quickly adapt a “canned” presentation to the specific needs of the client depending on where they are….  
✤ Know what the most common barriers to engagement are for this population and address them in orientation, e.g., transportation, child-care, homelessness, etc.  
✤ Balance the orientation process with information on the clients’ rights, incentives and the benefits, do not only focus on the program’s rules, sanctions and client obligations. Remember that first impressions are lasting ones. Can the orientation person relate to the client, linguistically, ethnically, etc,  
✤ Is the orientation staff person trained in cultural competence? Do they understand and use the themes described above, that is, communication and learning styles, etc. |
<table>
<thead>
<tr>
<th>Core Function</th>
<th>Question</th>
<th>Issues for Consideration</th>
<th>Recommendations for Drug Court Practitioners</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assessment</td>
<td>How does assessment data translate into a culturally sensitive and relevant, and measurable treatment plan goals?</td>
<td>All forms must be translated into the language of the dominant ethnic groups at the appropriate comprehension and literacy levels? Legalese and complicated treatment concepts should be simplified.</td>
<td>Ensure that all assessments are strength-based and can specifically identify and evaluate the talents, gifts and cultural strengths a client brings to the process. Ensure that all assessors look at assessment as a bio-psycho-social process that gathers more than just AOD histories. Ensure that all assessors are trained and have the ability to make the appropriate inferences from or ask for clarification when faced with incongruent body language or reported information? Ensure that assessors are trained and qualified to make diagnostic impressions. Clinical supervision must evaluate the kind and frequency of the diagnoses made, to ensure that certain ethnic or social groups are not inordinately misdiagnosed, under-diagnosed or over-diagnosed.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>dominant cultures?</td>
<td></td>
</tr>
<tr>
<td>Core Function</td>
<td>Question</td>
<td>Issues for Consideration</td>
<td>Recommendations for Drug Court Practitioners</td>
</tr>
<tr>
<td>---------------</td>
<td>----------</td>
<td>--------------------------</td>
<td>---------------------------------------------</td>
</tr>
<tr>
<td></td>
<td></td>
<td>trying find out “their business”</td>
<td>❖ Define significant others broadly and inclusively. Make the process safe enough so that for example, gay/lesbian clients feel safe to disclose who their partners are? This relates to the interviewing skill set of the assessor. Ensure that all assessors receive regular interviewing skills training.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>❖ Is assessment a one-time process?</td>
<td>❖ Ensure that the assessor explains the rationale for the use of the assessment instrument/tool to facilitate understanding, and allay client fears and suspicions about the process.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>❖ Ensure that the assessor explains the rationale for the use of the assessment instrument/tool to facilitate understanding, and allay client fears and suspicions about the process.</td>
<td>❖ Clearly define what events will trigger a re-assessment? Graduation, phase progression, etc.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>❖ Clearly define what events will trigger a re-assessment? Graduation, phase progression, etc.</td>
<td></td>
</tr>
<tr>
<td>Treatment Planning</td>
<td>How involved is the client in the treatment planning process?</td>
<td>❖ Is the identification and ranking of problems a collaborative process?</td>
<td>❖ Ensure that every client’s cultural views about what the problems are and how they should be prioritized are collaboratively selected and agreed upon. That the process is negotiated is non-negotiable, if the clinician truly understands that the client has the answers…</td>
</tr>
<tr>
<td></td>
<td></td>
<td>❖ Is the plan tailored uniquely to meet the needs of this specific client?</td>
<td>❖ Ensure that every client's cultural strengths and collateral supports are resources identified in the tailoring of the plan</td>
</tr>
<tr>
<td></td>
<td></td>
<td>❖ Does the client understand what he/she must accomplish to be seen as making progress in treatment?</td>
<td>❖ Ensure that cultural nuances vis-à-vis</td>
</tr>
<tr>
<td>Core Function</td>
<td>Question</td>
<td>Issues for Consideration</td>
<td>Recommendations for Drug Court Practitioners</td>
</tr>
<tr>
<td>---------------</td>
<td>----------</td>
<td>--------------------------</td>
<td>---------------------------------------------</td>
</tr>
</tbody>
</table>
| Counseling    | What are the goals of counseling? | ❖ Does the program’s clinicians understand the counseling techniques that work with this client population?  
❖ Can the counseling individualize counseling styles in accordance with cultural, gender and lifestyle differences?  
❖ Quality assurance? | ❖ Ensure that clinicians have a varied and eclectic repertoire of counseling techniques that address and respect the cultural backgrounds of the clients? Does the clinician know when to use Cognitive Behavioral vs Rational Emotive vs Reality vs client-centered therapies?  
❖ Ensure that there is a program commitment to using evidence-based counseling techniques that are effective with populations of different cultural backgrounds  
❖ Ensure that counseling is solution-focused and not merely educational  
❖ Ensure that regular clinical supervision is provided so that clinicians can articulate which counseling techniques they employ with certain clients and patterns of success or failure with the selection can proactively addressed or remediated. |

Success and progress in treatment are considered and mutually agreed upon, e.g., is total abstinence or harm reduction the goal. Whatever it is, the client must know…
<table>
<thead>
<tr>
<th>Core Function</th>
<th>Question</th>
<th>Issues for Consideration</th>
<th>Recommendations for Drug Court Practitioners</th>
</tr>
</thead>
<tbody>
<tr>
<td>Case Management</td>
<td>What’s needed to broker the services and entitlements required to meet the needs identified in the assessment and the treatment planning processes?</td>
<td>- Can the clinician identify the service providers who can service this population in a culturally competent way?</td>
<td>- Clinicians/case managers should do comprehensive community mapping and know their eligibility criteria and program philosophies of all of the pertinent programs in their jurisdictions</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- How does the clinician/case manager reduce the barriers to follow-through?</td>
<td>- Ensure that clinicians understand the cultural dynamics of referring people of color and other social groups for services with agencies whom they may distrust</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Quality assurance?</td>
<td>- Ensure that there is a mechanism to assess the frequency, patterns and quality of case management interventions by staff and by the demographic profile of the clients on his/her caseload? E.g., Are African American clients referred more often to the vocational program with fewer training programs than their White counterparts?</td>
</tr>
<tr>
<td>Crisis Intervention</td>
<td>What is a crisis?</td>
<td>- How do people of different cultures define and respond to a crisis?</td>
<td>- A crisis is defined as a crucial event in the course of treatment that threatens to compromise or destroy treatment progress. People of color have very different ideas about what constitutes a “crisis” and staff needs to be trained on how to identify crises in various cultural contexts and how to respond appropriately.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Can staff identify the elements of a client crisis for people of different cultures?</td>
<td></td>
</tr>
<tr>
<td>Core Function</td>
<td>Question</td>
<td>Issues for Consideration</td>
<td>Recommendations for Drug Court Practitioners</td>
</tr>
<tr>
<td>---------------</td>
<td>--------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| Client Education | Is the goal of client education empowerment?                              | ❖ How should substance abuse education be presented to make it palatable?  
❖ What is the scope of the education intervention?  
❖ Who is the audience?  
❖ Who selects the education media and materials used for client education?                                                                                                       | ❖ Drug courts must consider learning styles, visual cues, communication and other cultural themes when presenting technical substance abuse and relapse prevention information? Can the client identify with the symbolism or subliminal messages in the written and audio-visual media and materials used to educate?  
❖ Focus also on expanding client’s knowledge base with evidence-based information that is presented at his/her literacy and comprehension level. Education should also focus on access to adjunct community services and holistic interventions that are culturally relevant to the client population  
❖ Drug courts should focus on educating the family and the community  
❖ Convene focus groups for people of color and other groups and ask their advice on the kinds of media that would engage them culturally and educationally                                                                 |
| Referral      | Who’s getting referred to which program and for what?                     | ❖ Are clients’ needs being matched with appropriate community resources?  
❖ What is the basis for the referral? A problem                                                                                                                             | ❖ How are clients’ cultural preferences, socio-economic status and ethnicity incorporated into the referral decision?  
❖ Ensure that clinicians have access to a multi-cultural directory of community resources that they are intimately                                                                 |
<table>
<thead>
<tr>
<th>Core Function</th>
<th>Question</th>
<th>Issues for Consideration</th>
<th>Recommendations for Drug Court Practitioners</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>the program cannot handle internally? A client the clinician does not want to “treat”?</td>
<td>familiar with? They must be able to competently address client fears and concerns about the referral.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Who reviews the types, frequency and patterns in which clients tend to be referred to certain resources?</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Ensure that any resource to which clients will be referred has the cultural proficiency and expertise to service them.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Are all clients uniformly protected against breaches of confidentiality and do they all understand their rights re: confidentiality?</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Content</td>
<td>What is a documentable event or incident? Reporting must be balanced that is, focused on incremental progress and the client’s cultural strengths.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Quality assurance?</td>
<td>Who reviews the types, frequency and quality of the documentation with which each client’s progress, or lack thereof, is charted?</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Discharge planning</td>
<td>What kinds of sanctions and incentives did this client receive? Is there a nexus between what works and the cultural values of the clients?</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Ensure that clinicians incorporate and document how a client’s cultural strengths that will have greatest impact</td>
</tr>
<tr>
<td>Core Function</td>
<td>Question</td>
<td>Issues for Consideration</td>
<td>Recommendations for Drug Court Practitioners</td>
</tr>
<tr>
<td>---------------</td>
<td>---------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Professional Consultation</td>
<td>When does the clinician consult with other professionals about a case?</td>
<td>❖ Frequency and precipitating consultation event?</td>
<td>❖ Does the clinician know how to recognize the cultural and other issues that are beyond his/her knowledge base and skill? How often does he/she consult with others and for what reasons?</td>
</tr>
<tr>
<td></td>
<td></td>
<td>❖ Is the rationale for consultation clearly explained to the client?</td>
<td>❖ Does the clinician understand the cultural dynamics of introducing another professional into the client’s treatment episode, especially if he must have that professional intervene in person, e.g., a referral to a psychiatrist?</td>
</tr>
</tbody>
</table>
CASE STUDIES/VIGNETTES
FOR PARTICIPANT DISCUSSION

These vignettes are taken from actual clinical cases in an operational drug court. The names have been altered to protect anonymity. It is hoped that these cases can be discussed vis-à-vis the development, re-examination and/or refinement of practices that negatively impact these clients’ ability to be recruited for, be admitted to, become engaged in and successfully graduated from specialty courts.

It is recommended that participants of different disciplines be placed in small groups to brainstorm about what their programs need to do, to address the specific cultural needs of these clients to ensure that they become success outcomes. Participants should also discuss how staff’s own cultural biases and misperceptions would influence each or any of the twelve core functions and ultimately, their treatment system’s ability to service these clients.

Paulo L.

Paulo is a 19-year old, Caucasian and African American male. He is on probation for a Possession with Intent to Distribute: Cocaine charge. At 14, Paulo was convicted of Assault with Intent to Kill. Of course, his juvenile records are sealed. He was referred to the Free Life outpatient treatment program 6 months ago because he was assessed to be alcohol and marijuana dependent. Paulo reported smoking “weed” and drinking at 9 because his older brother introduced him to what he now refers to as the “wonderful world of drugs”. Paulo’s participation in court-ordered treatment has been poor and he has been sanctioned on four different occasions for drug positives and non-compliance with program rules. Paulo reports that Free Living is simply not “hip” to his needs as a young “brother”. Although Paulo was able to stay clean long enough to be eligible for and moved to the second phase of treatment, his inability to remain drug free, continued denial, sporadic program attendance and angry,
violent outbursts have made him disruptive in group. Even after his referral to an in-custody program for 28 days, Paulo showed no improvement in his commitment to becoming and remaining sober. Family counseling interventions have failed because Paulo’s father (who is Caucasian) does not want to be involved and his mother is an “enabler”. Mentoring referrals have also been unsuccessful because Paulo does not follow through with recommended activities. The multi-disciplinary treatment team and his case manager at Free Life “staffed” Paulo’s case last week and will recommend to the judge at the next status hearing that he be terminated from the program for failure to make significant progress in treatment.

**Jesus T.**

Jesus is a 40-year old, Latino male. He is in a domestic violence program run by the District Attorney’s office for his second Assault charge but first conviction. Jesus reports that when he drinks, his “machismo” gets in the way but his intention is never to hurt anyone and his wife understands. He reports that he is a good father, husband and provider. Jesus had 4 children, aged, 9, 7, 5 and 2 and is proud of the fact that his wife does not have to work because he earns enough money as a carpenter. Jesus understands English better than he speaks it and admits that he does not read or write very well.

**Rosa T.**

Rosa is a 30-year old Latino woman with 5 children, all under age 10 who is now one month pregnant. She was referred to Free Life Treatment Center, 6 months ago, for treatment of her heroin and alcohol addictions. Rosa has been drinking since she was 10 and began injecting heroin at 17. She now snorts heroin. Everyone in her family drank heavily. Rosa was in an abusive relationship with Tito, the father of her children and husband of 12 years. She reports that she loves her husband and her religion will not allow her to be on birth control. Rosa does not want this child. She worries incessantly about the children because she has to work 3 jobs to pay the mortgage, send the children to a private Catholic school and take care
of her aging mother. Tito was recently laid off and is currently unemployed.

Rosa has not been able to maintain firm patterns of sobriety with the longest period of time for which she has been sober being 27 days. Her attendance compliance and group participation are both inconsistent and tend to show improvement whenever Rosa was drug and alcohol free. She has been on Methadone but says it does not help and reports using while on it. The treatment team at Free Life has “staffed” Rosa and has convinced her to go to a 90-day residential program. She has tentatively agreed to go as long as the program is one that will allow her to bring her two youngest children, aged 3 and 18 months. Free Life has scheduled an intake appointment at Demeter House, a women with children program with whom they contract.

**Dahlia N.**

Dahlia is a 20 year old, African American female with two children: Kaela, 2 and Jasmine, 7 months. Dahlia’s instant offenses are Prostitution and Possession of Crack with Intent to Distribute (PWID). With the exception of an Assault charge that was dropped, Dahlia has no other criminal history. She has been placed in pretrial supervision while awaiting the disposition of her case. Nevertheless, upon arrest, she tested positive for cocaine and marijuana but reports that her drug of choice is crack cocaine. Dahlia reports using crack daily for the past 2 years because it keeps her weight “down” and keeps her “up” for long hours at night. As a result of the drug test results and self-reported drug use, her conditions of release included participation in an outpatient treatment program, and weekly drug testing.

Dahlia considers herself a single mother but her mother has unofficial custody of the girls. She still receives WIC and TANF and gives most of that money to her mother for the care of her children. She also works as a shampooer at a beauty salon close to her apartment.
because “she loves making others pretty”. She lives with her boyfriend, Franco, in his subsidized efficiency apartment in Southeast DC. Franco is unemployed (because of a serious back injury that has left him on disability) and is in recovery. According to Dahlia, Franco does not know that she uses crack as often as she does and she believes he would kill her if he did. Franco has been, and continues to be, physically and emotionally abusive but Dahlia reports that she loves him and has nowhere else to go.
DEVELOPING AN ORGANIZATIONAL AND THERAPEUTIC CULTURE THAT VALUES DIVERSITY

Creating a therapeutic environment that does more than pay “lip service” to the need to ensure that their staff becomes culturally competent requires a commitment to conducting regular organizational assessments. These assessments must facilitate an introspective look not only at where each individual in that organization is in their growth but what the organization has been able to do to facilitate, engender, codify, emulate, reward and punish a culture that espouses diversity appreciation and is continually looking for proficient ways to address diversity (i.e., in its marketing, policy development, recruitment of staff, training, promotions, the demographic profile of its management, etc).

What follows will be a selection of exercises that can be used by staff, individual staff questionnaires, organizational assessments that can be discussed to highlight pertinent issues and engender meaningful dialogue about solutions, strategies or organizational changes needed.
Exercise I
Organizational Dynamics Exercise

Objectives: To heighten staff’s awareness of how people (especially women, men of color, people with physical disabilities, GLBT clients and others) get labeled in organizations and how it impacts the individual labeled and the organization itself.

Time: 30 minutes

Material: Labels
Markers

Instructions: 1. The facilitator prepares for the exercise by labeling eight name tags with the following labels:

   a. Insignificant: Ignore me
   b. Expert: Ask my advice
   c. Important: Defer to me
   d. ESL: Ignore me
   e. GLBT: Be uncomfortable around me
   f. Comedian: Laugh at me
   g. Leave this tag blank

2. Facilitator places eight chairs in the middle of the room
3. Facilitator asks for seven volunteers to participate in the exercise and ask them to take a seat in the circle

---

4. Facilitator places a name tag on each of the seven people in the circle, and instructs them not to look at their own tag.

5. Facilitator gives the seven people in the circle a topic, any topic (health care reform, crime, racism, discrimination, etc) to discuss, instructing them to respond to each other as indicated on their name tags.

6. Allow the conversation to take place for about 10 minutes.

7. Ask each of the volunteers how they felt doing the exercise with their assigned identity. (Chart some of the response on newsprint)

8. Ask the observing participants what dynamics they observed in the circle (eg, did anyone get angry, withdrawn? Did anyone rebel against his/her label? How?)

9. Allow the volunteers to look at their own name tag.

Learning points:

1. The dynamics that emerged in the circle are similar to those that occur in treatment among staff and in client-staff relationships.

2. Labeling often happens quickly and is rarely ever corroborated with more than an “impression” of a person.

3. Often, the particular label a person is given is in response (either entirely or partially) to the person’s race, gender, sex, sexual orientation, class, language skills or physical impairment.

4. In treatment, clients who are labeled often respond with anger, withdrawal,
“resistance”, poor compliance, disengagement, rebellion...
Exercise 2
The Need for Inclusion...The Impact of Exclusion

Objectives: To heighten staff’s awareness of the importance of the basic human need for belonging
To increase staff’s understanding of the negative consequences that may result from individuals who feel alienated and minimized.

Time: 20 minutes

Materials: Color star stickers

Instructions:
1. Facilitator places one self-adhesive colored star (or dot or other shape) on each staff persons’ back, making sure it sticks. Facilitator instructs staff not to look at the sticker on their back. Depending on the size of the group, at least two colors should be used (the more staff, the more colors it is helpful to use). The size of each color group can vary (i.e., two greens, four blues, etc.)
2. Facilitator selects one to three staff who will get a sticker that is a different shape from anyone else’s in the room.
3. Facilitator instructs staff to get into groups with people who have the same color star (or other shape) in any way they can, without talking (note to trainer: they can gesture, put people with the

---

same color star together, etc., but it is best to let them figure this out)

4. After all of the groups have formed (and the few individuals with the unique stickers have been left out, or been adopted by one of the other groups, or formed their own group or done something else), reconvene the entire group for discussion.

5. Facilitator processes the discussion by asking the following questions:
   a. How did you manage to find your group?
   b. How did you feel when you found your group?
   c. How did you feel when you were rejected by a group?
   d. How did those of you wearing a unique shape feel about being excluded?
   e. Why did you form your own group? (If they didn’t, ask why not?)
   f. Did anyone consider asking one of the individuals with the unique shape to join your group?
   g. Are there people who group together in your treatment program?
   h. Take a minute to think about these groups of persons. Are they usually racially homogeneous or diverse? Gender, age, or class homogeneous or diverse?
   i. Are some of the persons at work seen as more favorable than others?
j. Who tends to be a part of which group? Who is outside?
k. How would feel to be excluded form the favorable groups?

Learning Points:

1. Most people have a need for membership in a group with which they can identify and in which they feel welcomed and proud of their membership.
2. When people are excluded from a group, they may feel alienation and experience a lack of self-esteem and self-confidence.
3. The feelings of alienation and lowered self-esteem and self-confidence may result in a deeper sense of loss of hope for a successful future with the organization and thus loss of motivation and organizational loyalty.
4. Apply the above to a gay client who does not feel that he/she fits into treatment program.
However you define cultural competence, it is clear that becoming proficient in another’s culture is a deliberate, conscious act. It is learned...
Personal Diversity Awareness/Cultural Competence Inventories

How an individual feels about diversity can be directly correlated with where he/she is on the cultural competence continuum. This in turn, will affect the individual ability to treat diverse clients in a culturally competent manner.

*Diversity Awareness Continuum*¹¹

*Put an “X” that represents where you fit along the dotted line for each continuum below.*

<table>
<thead>
<tr>
<th>I am not knowledgeable about the cultural norms of different groups I treat/supervise.</th>
<th>I am knowledgeable about the cultural norms of different groups that I treat/supervise.</th>
</tr>
</thead>
<tbody>
<tr>
<td>I do not hold stereotypes about other groups.</td>
<td>I admit my stereotypes about other groups.</td>
</tr>
<tr>
<td>I feel partial to, and more comfortable with, some groups rather than others.</td>
<td>I feel equally comfortable with all groups.</td>
</tr>
<tr>
<td>I gravitate toward others who are like me.</td>
<td>I gravitate toward others who are different.</td>
</tr>
<tr>
<td>I find it more satisfying to manage a homogeneous caseload.</td>
<td>I find it more satisfying to manage a multi-cultural caseload.</td>
</tr>
<tr>
<td>I feel that everyone is the same with similar values and preferences</td>
<td>I feel that everyone is unique, with differing values and preferences.</td>
</tr>
<tr>
<td>I am perplexed by the culturally different behaviors I see among clients.</td>
<td>I understand the cultural influences that are at the root of some of the behaviors I see.</td>
</tr>
<tr>
<td>I react with irritation when confronted with a client or co-worker who does not speak English fluently.</td>
<td>I show patience and understanding with limited English speakers</td>
</tr>
<tr>
<td>I am task-oriented and don’t like to waste time chatting.</td>
<td>I find that more gets done when I spend the time to develop relationships first.</td>
</tr>
<tr>
<td>I feel that immigrants to this country should adapt to our rules.</td>
<td>I feel that both immigrants and the organizations that service them need to change to fit together.</td>
</tr>
</tbody>
</table>

Draw your profile by connecting your Xs. The closer your line is to the right-hand column, the greater your awareness of diversity. The closer to the left-hand column, the less aware you may be about diversity-related issues.
**Diversity Self Assessment**

*(How well do you value diversity and how culturally competent are you?)*

Rate yourself on how you respond to the statements listed below. Use a scale of 5 to 1, on how strongly you agree with the statements (5 is strong agreement and 1 is weak agreement).

<table>
<thead>
<tr>
<th>Statement</th>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>I make a conscious effort not to think stereotypically.</td>
<td>5 4 3 2 1</td>
</tr>
<tr>
<td>I listen with interest to the ideas of people who don't think like me</td>
<td>5 4 3 2 1</td>
</tr>
<tr>
<td>I respect other people’s opinions, even though I may disagree</td>
<td>5 4 3 2 1</td>
</tr>
<tr>
<td>If I were at a social event with people who differed ethnically from me, I would make every effort to talk to them</td>
<td>5 4 3 2 1</td>
</tr>
<tr>
<td>I have a number of friends who are not my age, race, gender or the same economic status and education</td>
<td>5 4 3 2 1</td>
</tr>
<tr>
<td>I recognize the influence that my upbringing has had on my values and beliefs</td>
<td>5 4 3 2 1</td>
</tr>
<tr>
<td>I adapt well to change and new situations</td>
<td>5 4 3 2 1</td>
</tr>
<tr>
<td>I enjoy people watching and trying to understand the human dynamics of interactions</td>
<td>5 4 3 2 1</td>
</tr>
<tr>
<td>When I don’t understand what someone is telling me, I ask questions</td>
<td>5 4 3 2 1</td>
</tr>
<tr>
<td>I watch for people’s reactions whenever I am speaking to them</td>
<td>5 4 3 2 1</td>
</tr>
<tr>
<td>I am aware of what my fears are about persons of other cultural groups</td>
<td>5 4 3 2 1</td>
</tr>
<tr>
<td>I understand how the “isms” impact the daily life of the clients I treat/supervise</td>
<td>5 4 3 2 1</td>
</tr>
<tr>
<td>I understand what unearned privileges are (gender, sexual orientation, race)</td>
<td>5 4 3 2 1</td>
</tr>
<tr>
<td>I am knowledgeable about institutional racism, sexism, etc.</td>
<td>5 4 3 2 1</td>
</tr>
<tr>
<td>I get uptight when people challenge my ability to understand them</td>
<td>5 4 3 2 1</td>
</tr>
<tr>
<td>I vary my communication patterns when talking to persons of another culture</td>
<td>5 4 3 2 1</td>
</tr>
<tr>
<td>I feel guilty and angry when in a discussion with a person of another culture about racism</td>
<td>5 4 3 2 1</td>
</tr>
<tr>
<td>I feel comfortable or neutral when in a discussion with a person of another culture about racism</td>
<td>5 4 3 2 1</td>
</tr>
</tbody>
</table>

---

12 Adapted by Suzette Brann from the instrument used by the Training and Development department of Wal-Mart Stores, Inc.
Scoring

Total your answers. If your score is 80 or above, you probably value diversity and can easily adapt to working with diverse populations in a culturally competent manner. Nevertheless, continue to look for areas of improvement as you move toward cultural competence.

If your score is below 50, you probably do not understand the need to value diversity and could benefit from further information and training.
QUALITY ASSURANCE AND OTHER SYSTEM/PROGRAM CHECKS FOR THE DEVELOPMENT OF A CULTURALLY COMPETENT STAFF

1. Peer Reviews

Developing a therapeutic environment in which staff feels safe to discuss how the performance of their team members affects them personally or as a team is an invaluable tool for ensuring quality service delivery. It is critical that peer reviews are done in a team that trusts each other and have bonded. If not, this exercise could degenerate into a “bitch/snitch” session about colleagues that are not popular, hip, “in with certain cliques” etc.

See Sample Peer Review Form at the end of this section

2. Retreats

Getting away from the routine to discuss policy and work on issues such as team building and specialized training on pertinent cultural issues. Retreats do not have to be formal or held at fancy facilities, they could be held at a park, other office building, etc but they should focus on taking time away from the regular routine of work.

3. Clinical Supervision

A structured process in which a licensed clinical professional reviews the assessment findings, the treatment plans that are based on those assessments, progress notes and the types and frequency of any outside interventions/referrals made. Clinicians must
be able to articulate the rationale for selecting one intervention, referral, or counseling technique over the other. They must be able to discuss why they think each would be effective for the client...
**PEER REVIEW PROCESS & FORM**

**Instructions:** Have all staff including (clinical supervisors) randomly select one or more names of staff to review depending on the size of your staff and the amount of time you have to allocate to the peer review process. Each person then fills out the form below about the person they selected and should be willing to discuss the issues raised/identified on the form at the peer review session.

The form needs to completed with concrete examples and real incidences and should contain recommended solutions, ways to address the problem, etc.

---

**SAMPLE PEER REVIEW FORM**

Date of Review: ____________ Period of Review: __________________________

Person Reviewed: __________________________

**Personal Interactions:**

When you did _______ I really felt ________.

**Professional Interactions with clients and others:**

I notice that you do/say/handle _______ (certain situations, clients, other professionals) _______ and I really _______ (like, admire, feel insulted/offended by, etc) how you do/handle the incident described above.

**Solutions/Recommendations:**

Perhaps the next time you are faced with, have to do, are assigned to _________, you could consider doing/saying ____________

---
ORGANIZATIONAL CULTURAL NEEDS ASSESSMENT QUESTIONNAIRE

This questionnaire has several sections that focus on areas such as evaluation, training, staffing patterns, and prior performance patterns. Please answer as many questions about your agency, system, or organization as you know the answers to without collaborating with others.

Evaluation:

1. Has the agency/organization/program conducted a formal needs assessment during the last three years pertaining to the populations it serves? If so, answer the following questions.

2. Was the data collected compared with similar data from the community/jurisdiction’s population at large?

3. Was the data used for agency/program/organizational self-evaluation?

4. Was the data used for future development of new initiatives to attract, recruit, engage, retain diverse populations in your community?

Training

1. Has the program/agency/organization required any training on multi-culturism or cultural competence for its management and support staff during the last three years?

2. Have all staff persons providing direct clinical/supervision services been required to be trained in multi-culturism or cultural competence during the last three years?

Staffing Patterns

1. What percent of the program/agency/organization’s staff reflects the composition of the population(s) served?
2. What percent of the staff is bilingual or multilingual?
3. What percent of minorities or persons representative of the dominant cultures in your community are on the program’s/organization’s board of directors/advisory committees?
4. What percent of minorities or persons representative of the dominant cultures in your community hold administrative or management positions in the program/organization/agency?

Prior Performance Patterns

1. What linkages have been made with minority organizations, churches, NGO’s, and other institutions in the community that serve the same groups?
2. Have contracts been awarded to diverse cultural service providers who specialize in issues or needs of minority populations? If not, do you know why?
3. Does the agency/program/system adjust holidays to accommodate the cultural/religious diversity of its staff and clientele?
4. Do the clients have input into or give feedback to the program/agency’s management team about design issues and effectiveness?
5. Is the program located in the community it serves or is it accessible to its target population?
6. Are needs assessments and issue identification strength-based and culturally specific?
7. Does the program/agency environment/offices reflect an appreciation of the culture of the target populations?
8. Does the program/agency have its materials translated into the dominant languages of the target populations?
9. Has an independent evaluator/researcher ever analyzed the program/agency’s outcomes by race, gender, ethnicity, sexual orientation, education, etc.?
10. Does the program/agency seek to identify and liaise with other organizations in the community that work with these populations?
REFERENCES


