SHOW YOUR WORK
documenting cultural considerations
Laurel Fox, MS, MBA, CHC, LMFT, LPCC
OBJECTIVES

• Describe the fundamental laws and policies which mandate cultural awareness in substance abuse and mental health treatment

• List three key strategies to demonstrate culturally influenced care

• Compose basic assessment information on the client’s cultural background
\[
\lim_{x \to 3} \frac{5x^2 - 8x - 13}{x^2 - 5} = 2
\]
BUT...

If you don’t show your work, you won’t get full credit.
BEHAVIORAL HEALTH DOCUMENTATION

• We have to show our work, too.

\[
\lim_{{x \to 3}} \frac{5x^2 - 8x - 13}{{x^2 - 5}} = \frac{5(3)^2 - 8(3) - 13}{{(3)^2 - 5}} = \frac{8}{4} = 2
\]

• With increasing legislation and focus on cultural competency, we have to learn how to document this work.
WHERE DID THE FOCUS ON CULTURE START?
According to The Economic Burden of Health Inequalities in the United States:

- The cost of direct medical care related to disparities is $229.4 billion.
- Combined costs of health inequalities and premature death is $1.24 trillion.
CENSUS: RIVERSIDE COUNTY

- Caucasian
- African American
- Asian
- Native Hawaiian and Pacific Islanders
- Hispanic
- Two or More Races
1986- Congress creates the Office of Minority Health
1987- Office of Minority Health launches Resource Center
1990- Americans with Disabilities Act
1990- Regional, State, and Territory offices of minority health are created
1995- Center for Linguistic and Cultural Competence in Health Care (collaborated with public and private entities to enhance health care systems access of limited English-speaking populations.
2000- Healthy People 2010- details a comprehensive, nationwide health promotion and disease prevention agenda, including the goal of eliminating health disparities
   - National CLAS Standards
   - Minority Health and Health Disparities Research and Education Act
   - Executive Order 13166- improve access for LEP. Requires Federal agencies to examine services, implement a system to provide meaningful access
   - National Center on Minority Health and Health Disparities- at the NIH, now its own Institute
   - LEP Guidance from Office of Civil Rights
NATIONAL CLAS STANDARDS

• Developed to address health care disparities
• Written for health care professionals and organizations
• Released in 2000 by the U.S. Department of Health & Human Services, updated 2013
• Defines culture in terms of racial, ethnic and linguistic groups, as well as geographic, religious, and spiritual, biological and sociological characteristics
PRINCIPAL STANDARD: PROVIDE EFFECTIVE, EQUITABLE, UNDERSTANDABLE, AND RESPECTFUL QUALITY CARE AND SERVICES THAT ARE RESPONSIVE TO DIVERSE CULTURAL HEALTH BELIEFS AND PRACTICES, PREFERRED LANGUAGES, HEALTH LITERACY, AND OTHER COMMUNICATION NEEDS

Standards 2-4: Governance, Leadership, and Workforce

Standards 5-8: Communication and Language Assistance

(Title VI of the Civil Rights Act of 1964)

Affordable Care Act (Partial)

Standards 9-15: Engagement, Continuous Improvement, and Accountability
Affordable Care Act
ACA LEGAL REQUIREMENTS

Section 1557
Non-Discrimination Requirement

Section 1001
Culturally and Linguistically Appropriate Requirement

Section 1331
Plain Language Requirement

The standards shall ensure that the summary is presented in a culturally and linguistically appropriate manner and utilizes terminology understandable by the average plan enrollee.
CALIFORNIA AND THE ACA

• Department of Health Care Services has re-affirmed that Medi-Cal and Medi-Care funded programs fall into the required entities.

• In addition to language requirements, programs must provide **Culturally relevant and competent services**
  
  • Culturally, developmentally, and linguistically appropriate and accessible services:
    • Personnel recruitment/retention, grievances related to cultural competence
    • Annual staff development plan and Board of Directors training
    • Equal access
    • Language assistance
    • **Assessment of cultural needs**
CHANGE
TREATMENT OF CHRONIC DISEASE

Identify and work with social determinants of health
• Educational attainment and employment
• Economic status
• Social support (family cohesiveness, sense of community)
• Social norms and attitudes
• Culture, language
• Literacy
• Race/ethnicity
Transforming the conditions in which people are BORN, GROW, LIVE, WORK and AGE for optimal health, mental health & well-being.

- Prevention
- Mental Health Services
- Culturally/Linguistically Appropriate and Competent Services
- Income Security
- Housing
- Neighborhood Safety/Collective Efficacy
- Environmental Quality

- Health Care
- Child Development, Education, and Literacy Rates
- Food Security/Nutrition
- Built Environments
- Discrimination/Minority Stressors

FIGURE 4: Achieving Health & Mental Health Equity At Every Level
Source: California Department of Public Health, Office of Health Equity, as inspired by World Health Organization, Robert Wood Johnson Foundation, and many others.
CULTURAL COMPETENCE PLAN

Required annually of all county mental health departments
Facilitate cultural competency at the county level
Reduce mental health service disparities identified in racial, ethnic, cultural, linguistic, and other underserved populations
Develop culturally and linguistically competent programs and services

In 2013, the criteria adopted the 13 National CLAS Standards
CCR Title 9 §1810.410
LA County Plan from 2011:
(b) (1) On and after July 1, 2006, all continuing medical education courses shall contain curriculum that includes cultural and linguistic competency in the practice of medicine.

(c) (1) "cultural competency" means a set of integrated attitudes, knowledge, and skills that enables a health care professional or organization to care effectively for patients from diverse cultures, groups, and communities.
  (B) Utilizing cultural information to establish therapeutic relationships.
  (C) Eliciting and incorporating pertinent cultural data in diagnosis and treatment.
INTEGRATING FUNDAMENTAL ELEMENTS OF CULTURE INTO DOCUMENTATION
WHY DO WE DOCUMENT OUR WORK?

- To record professional work
- To serve as the basis for organization and continuity of care of the patient by practitioner
- To serve as a basis for continuity of care for future practitioners who need the clinically meaningful data
- To manage risks and protect against malpractice lawsuits and professional discipline complaints
- To comply with legal, regulatory, and institutional requirements
- To facilitate quality assurance and utilization review
- To facilitate coordination of treatment team communication and collaboration
**LAC DMH ADULT INITIAL ASSESSMENT**

MH 532  
Revised 10/01/17  

**ADULT FULL ASSESSMENT**

Date of first assessment contact: ________________

ASSESSING PRACTITIONER (NAME AND DISCIPLINE): ________________________________

Client/Others Interviewed: ____________________________________________________

<table>
<thead>
<tr>
<th>I. DEMOGRAPHIC DATA &amp; SPECIAL SERVICE NEEDS:</th>
</tr>
</thead>
<tbody>
<tr>
<td>DOB: _____  GENDER: _____  ETHNICITY: _______  Marital Status: ____________________</td>
</tr>
<tr>
<td>Referral Source: ____________________________</td>
</tr>
<tr>
<td>□ Non-English Speaking, specify language used for this interview: ____________________</td>
</tr>
<tr>
<td>Were Interpretive Services provided for this interview? □ Yes □ No</td>
</tr>
<tr>
<td>□ Cultural Considerations, specify: ______________________________________________</td>
</tr>
<tr>
<td>□ Physically challenged (wheelchair, hearing, visual, etc.) specify: ________________</td>
</tr>
<tr>
<td>□ Access issues (transportation, hours), specify: _________________________________</td>
</tr>
</tbody>
</table>
CULTURAL CONSIDERATIONS: AFRICAN AMERICAN
“CULTURAL CONSIDERATIONS: SPEAKS SPANISH”
CULTURAL CONSIDERATIONS: PARENT
CULTURAL CONSIDERATIONS: RIDES THE BUS
ASSESSMENTS THAT HAVE A SECTION FOR CULTURAL ISSUES
CULTURE IS SAID TO BE TOO BROAD A CONCEPT, TOO COMPLEX IN CONTENT, AND TOO HETEROGENEOUS IN NATURE... TO BE COVERED BY RELATIVELY SIMPLE CLINICAL INTERACTIONS.

ASPECTS OF CULTURE

- Language/mastery
- Religion/spirituality
- Gender/orientation
- Personal and group identity
- Migration
- Acculturation
- Roles
- Hierarchy
- Rules as understood by the client
When you review assessment questions or ideas, remember that this can help guide your documentation.
The National CLAS Standards are intended to advance health equity, improve quality, and help eliminate health care disparities by establishing a blueprint for health and health care organizations to:

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

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

5. Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.

6. Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.

7. Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.

8. Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.
• Engagement, Continuous Improvement, and Accountability

• 9. Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organization’s planning and operations.

• 10. Conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities.

• 11. Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery.

• 12. Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.

• 13. Partner with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness.

• 14. Create conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints.

• 15. Communicate the organization’s progress in implementing and sustaining CLAS to all stakeholders, constituents, and the general public.
DSM 5 TOOLS

• Cultural Formulation Interview
  • Cultural Definition of the Problem
  • Cultural Perceptions of Cause, Context, and Support
  • Cultural Factors Affecting Self-Coping and Past Help Seeking
  • Cultural Factors Affecting Current Help Seeking

• Cultural Concepts of Distress
  • Distinguish Between Three Concepts
  • Cultural Syndromes
  • Cultural Idioms of Distress
  • Cultural Explanations or Perceived Causes
Advice to Counselors and Clinical Supervisors: Initial Interview and Assessment Questions

When working with clients who are recent immigrants or have immigrated to United States during their lifetime, the APA (1990) recommends exploring:

- Number of generations in the United States.
- Number of years in the United States.
- Fluency in English (or literacy).
- Extent (or lack) of family support.
- Community resources.
- Level of education.
- Change in social status due to immigration.
- Extent of personal relationships with people from diverse cultural backgrounds.
- Stress due to migration and acculturation.
### How To Use a Multicultural Intake Checklist

Some clients do not see their presenting physical, psychological, and/or behavioral difficulties as problems. Instead, they may view their presenting difficulties as the result of stress or another issue, thus defining or labeling the presenting problem as something other than a physical or mental disorder. In such cases, word questions about the following topics using the client’s terminology, rather than using the word “problem.” Asking questions about the following topics can help you explore how a client may view his or her behavioral health concerns:

- □ Immigration history
- □ Relocations (current migration patterns)
- □ Losses associated with immigration and relocation history
- □ English language fluency
- □ Bilingual or multilingual fluency
- □ Individualistic/collectivistic orientation
- □ Racial, ethnic, and cultural identities
- □ Tribal affiliation, if appropriate
- □ Geographic location
- □ Family and extended family concerns (including nonblood kinships)
- □ Acculturation level (e.g., traditional, bicultural)
- □ Acculturation stress
- □ History of discrimination/racism
- □ Trauma history
- □ Historical trauma
- □ Intergenerational family history and concerns
- □ Gender roles and expectations
- □ Birth order roles and expectations
- □ Relationship and dating concerns
- □ Sexual and gender orientation
- □ Health concerns
- □ Traditional healing practices
- □ Help-seeking patterns
- □ Beliefs about wellness
- □ Beliefs about mental illness and mental health treatment
- □ Beliefs about substance use, abuse, and dependence
- □ Beliefs about substance abuse treatment
- □ Family views on substance use and substance abuse treatment
- □ Treatment concerns related to cultural differences
- □ Cultural approaches to healing or treatment of substance use and mental disorders
- □ Education history and concerns
- □ Work history and concerns
- □ SES and financial concerns
- □ Cultural group affiliation
- □ Current network of support
- □ Community concerns
- □ Review of confidentiality parameters and concerns
- □ Cultural concepts of distress (DSM-5*)
- □ DSM-5 culturally related V-codes


Sources: Comas-Diaz 2012; Constantine and Sue 2005; Sussman 2004.
# ADDRESSING THE DRUG CULTURE

<table>
<thead>
<tr>
<th>Drug Culture</th>
<th>Establishing Trust and Credibility</th>
<th>Socialization</th>
<th>Values</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Status</strong></td>
<td>In what ways can you obtain status or be seen as a success?</td>
<td>How were you introduced to the culture?</td>
<td>What values are upheld or devalued in the group?</td>
</tr>
<tr>
<td><strong>Concepts of Sanction, Punishment, and Conflict Mediation</strong></td>
<td>How does the group deal with in-group conflicts?</td>
<td>Are there symbols that represent a particular association with a group or substance?</td>
<td>Gender Roles and Relationships</td>
</tr>
<tr>
<td><strong>View of Past, Present, and Future</strong></td>
<td>Are there specific beliefs about the past, present, and/or future?</td>
<td>Language &amp; Communication</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Are there special verbal or nonverbal ways to communicate about substance-related activities?</td>
<td></td>
</tr>
</tbody>
</table>

SAMHSA Tip 59: [https://store.samhsa.gov/shin/content/SMA14-4849/SMA14-4849.pdf](https://store.samhsa.gov/shin/content/SMA14-4849/SMA14-4849.pdf)
How To Use the LEARN Mnemonic for Intake Interviews

Listen to each client from his or her cultural perspective. Avoid interrupting or posing questions before the client finishes talking; instead, find creative ways to redirect dialog (or explain session limitations if time is short). Take time to learn the client’s perception of his or her problems, concerns about presenting problems and treatment, and preferences for treatment and healing practices.

Explain the overall purpose of the interview and intake process. Walk through the general agenda for the initial session and discuss the reasons for asking about personal information. Remember that the client’s needs come before the set agenda for the interview; don’t cover every intake question at the expense of taking time (usually brief) to address questions and concerns expressed by the client.

Acknowledge client concerns and discuss the probable differences between you and your clients. Take time to understand each client’s explanatory model of illness and health. Recognize, when appropriate, the client’s healing beliefs and practices and explore ways to incorporate these into the treatment plan.

Recommend a course of action through collaboration with the client. The client must know the importance of his or her participation in the treatment planning process. With client assistance, client beliefs and traditions can serve as a framework for healing in treatment. However, not all clients have the same expectations of treatment involvement; some see the counselor as the expert, desire a directive approach, and have little desire to participate in developing the treatment plan themselves.

Negotiate a treatment plan that weaves the client’s cultural norms and lifeways into treatment goals, objectives, and steps. Once the treatment plan and modality are established and implemented, encourage regular dialog to gain feedback and assess treatment satisfaction. Respecting the client’s culture and encouraging communication throughout the process increases client willing to engage in treatment and to adhere to the treatment plan and continuing care recommendations.

Sources: Berlin and Fowkes 1983; Dreachslin et al. 2013; Ring 2008.