R E A C H

Recognizing and Eliminating disparities in Addiction
through Culturally informed Healthcare

How to Best Take Care of Racial and Ethnic Minoritized Patients with Opioid Use Disorders

REACH Scholars Shared Practical Skills for Better Outcomes

How to Best Take Care of Racial and Ethnic Minoritized Patients with Opioid Use Disorders

This guide and a companion video were created as a collaborative effort between two SAMHSA-funded grants: the *Opioid Response Network* and *Recognizing and Eliminating disparities in Addiction through Culturally informed Healthcare grant* (REACH) initiatives.

These resources were created to provide lessons learned and insights from the REACH scholars and faculty on what is important for health professionals to consider when providing prevention and treatment for substance use disorders for their patients who are ethnically and culturally minoritized.

Our hope is to also encourage other ethnically minoritized health professionals to become leaders in the addiction medicine and addiction psychiatry fields to increase and diversity the field.

www.REACHgrant.org   www.OpioidResponseNetwork.org

The Problem

Persons who use opioids and other substances that go on to develop opioid and other substance use disorders represent the full spectrum of human and cultural diversity. Thus, physicians, nurse practitioners, physician assistants, medical students, other medical service providers and service providers are responsible for preparing themselves to fully serve the needs of each individual and their unique histories.

For racially and ethnically minoritized service users, access to population health and medical interventions ranging from prevention to treatment services for those at risk of developing an opioid use disorder and other substance use disorders, and those with known disorders can be limited and when available, inadequate and not culturally informed.

This makes every contact with individuals from racial and ethnic minoritized populations an invaluable opportunity to offer the appropriate services at the right time and in a way that honors their needs to increase initiation, engagement, and retention in services for more positive health outcomes.

The Solution

In order to fully serve the needs of racially and ethnically minoritized service users, physicians, nurse practitioners, physician assistants, medical students, service providers and all members of the medical workforce are encouraged to embody the following six REACH principles:

• Commitment to understand historical and ongoing racial oppression and experiences of colonization

• Commitment to incorporation of a trauma informed approach that recognizes intergenerational trauma

• Commitment to individualize the treatment experience of each service user to honor their background, cultural values, and complex life stories

• Commitment to focus on rapport building using humility and demonstrating trustworthiness to build human connections with service users

• Commitment to center lived experiences and community expertise and will in developing and implementing relevant interventions

• Commitment to de-bias your approach to diagnosis, treatment and retention strategies

Understand | Incorporate | Individualize | Focus | Center | De-bias

The following how to guide components offer concrete strategies for embodying the six principles and include a reading list to support a sustained commitment to developing each principle.

Six REACH Principles Reflection Questions:

These questions will stimulate relevant reflections as you explore the how to resource guide. Take a moment to record your answers and refer back to them throughout your journey through the guide as you crystallize your action plans (see GROW Accountability Tool below).

If we collectively succeed in using the six REACH principles, how would things be different?

Are you aware of the types of inequities experienced by persons at risk of opioid misuse, those who actually misuse opioids and those with opioid use disorder (OUD) who are racially and ethnically minoritized?

What is the racial equity outcome you are most passionate about achieving?

What historical leaders, struggles and accomplishments in providing services to persons at risk of opioid misuse, those who misuse opioids and those with OUD who are racially and ethnically minoritized can teach or inspire you today?

What resources are needed to create more equitable outcomes amongst persons at risk of opioid misuse, those who misuse opioids and those with OUD who are racially and ethnically minoritized? How should they be distributed?

What policies and practices should be changed?

What new policies and practices would help promote equity, especially related to opioid treatment?

What assumptions, myths and stereotypes need to be debunked about persons at risk of opioid misuse, those who misuse opioids and those with OUD who are racially and ethnically minoritized?

What positive stories and images do you want to communicate to reduce the prevalence of these assumptions, myths and stereotypes?

Who is most affected by the current opioid and other drug involved overdose epidemic, and how are they involved in positive change?

Who has high-level power over public narratives, rules and resources that affect persons at risk of opioid misuse, those who misuse opioids and those with OUD who are racially and ethnically minoritized and how do we engage their support?

Who has authority in day-to-day interactions with those persons at risk of opioid misuse, those who misuse opioids and those with OUD who are racially and ethnically minoritized?

What is our own sphere of influence?

Where do we have our own work to do to better support persons at risk of opioid misuse, those who misuse opioids and those with OUD who are racially and ethnically minoritized?

Suggestions for use

Each principle has elements that will support your efforts to increase the cultural responsiveness and quality of services provided to racial and ethnic minoritized service users. In order to improve your approach, and your organization's approach, to service provision for people with opioid use disorder, it will be important that you have an understanding of your goals, the current reality, your options and specific steps to be taken to embody each principle.

The GROW Accountability Tool* outlined below will keep you accountable throughout your journey.

G: Goal | R: Reality | O: Options | W: Will

Questions to consider:

Goal

What is your desired outcome?
What do you want?
What's the long term objective in mind?

Reality

What is happening now?
What have you done so far?
What are the hard, cold, brutal facts about
 the status quo?

Options

What could you do?
What options are available?
What Resources are available to you?

Will

Are you committed to action?
What will you do?
When will you do it?
What support do you need?

GROW Tool Tips for Success

Tip 1: Make it more specific as you go around and around

Tip 2: Make sure there are SMART goal-type aspects (including a timeline for what you will do) to your GROW page so that you can hold yourself accountable to what you *can* do and push aside what you *cannot* do at least at this time

Tip 3: Create multiple GROW pages for various goals to keep it neat

Tip 4: For any change, you must identify opportunities for quick wins that help you to sustain momentum; we often return to the status quo, it is a human thing.

Tip 5: SHARE your GROW with others you trust to support you in accountability

Tip 6: Record your progress along the GROW journey(s) so that you remember what you accomplished!

*This tool was created by leadershipcentre.org/uk and adapted by Vision for Equity LLC

Six REACH Principles

1) Commitment to Understand

The first principle is a commitment to understand historical and ongoing racial oppression and experiences of colonization. Oppression can be described as the systematic and pervasive mistreatment of individuals on the basis of their membership in a disadvantaged group. It involves an imbalance in power, and one group benefiting from the systemic exploitation of other groups. Historical and ongoing racial oppression can be described as burdening a specific racially minoritized group with unjust or cruel restraints or impositions. Social forms of racial oppression include exploitation and mistreatment that is socially supported.

Racialized health inequities are a consequence of racial oppression and can be connected to each level of oppression including individual, interpersonal, institutional and structural.

Colonization can be described as the action or process of settling among and establishing control over the indigenous people of an area. The United States is a settler-colony established in the late 17th century and by definition necessitated the genocide and enslavement of indigenous peoples. The contribution of indigenous leadership, knowledge and expertise into services provided for persons who use opioids and those with OUD was suppressed by colonization and continues to be suppressed. Decolonization of knowledge, expertise, leadership, prevention, diagnosis, and treatment starts with acknowledging and responding to how colonization shapes life exposures and experiences in ways that impact relationships with substances and risk of a substance use disorder.

Individual: a person's unconscious/conscious beliefs and actions can serve to perpetuate oppression

Example: A service provider believes service users who are poor and racially minoritized are less deserving of buprenorphine

Interpersonal: the interactions between people both within and across ethnoracial groups can serve to perpetuate oppression

Example: A service provider does not screen all service users at risk for opioid misuse or does not share all of the available and warranted treatment options during a clinical visit due to racial bias instead referring mostly Black service users to opioid treatment programs.

Institutional: the policies and practices at an organization can serve to perpetuate oppression

Example: The no show policy for a clinic that offers medications for opioid use disorder
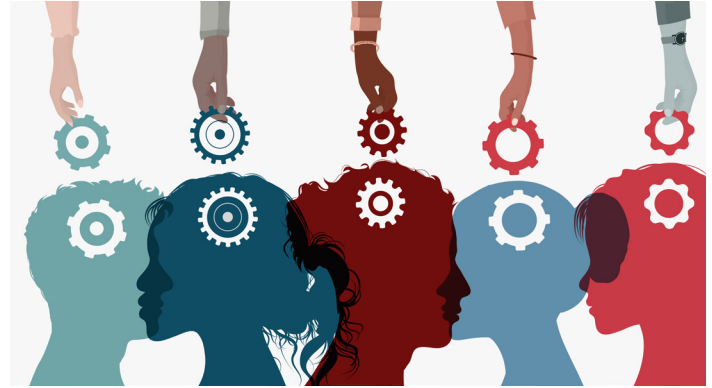
Strategy A

One strategy to embody this principle can be the adoption of an anti-oppressive practice orientation to service development and delivery. Anti-oppressive practice (AOP) places service users, their families, networks and history into context. The AOP approach pays particular attention to how social identities (such as race, ethnicity, class, gender, disability and more) impact individuals as well as organizations. This requires an AOP oriented service provider to proactively reveal and grapple with the use (and potential abuse) of power and how it can be corrupted by oppressive beliefs and behaviors.

Example: A service provider has the power to selectively apply a clinic policy or norm of practice such as offering a dual diagnosis inpatient admission based on race or class status or co-prescribing benzodiazepines with buprenorphine at higher rates to White service users

At a societal level, these same social identities carry with them a history and present day circumstance that shapes how persons at risk of opioid misuse, those who misuse opioids and those with OUD who are racially and ethnically minoritized experience various systems inclusive of the healthcare system. Thus, service providers must evaluate the positionality of those seeking and making use of services in order to properly respond to their group level and individual life stories in ways that honor their social, political and economic complexities.

Example B: The criminalization and racialization of crack cocaine use in the 1980s and 1990s supported by the War on Drugs resulted in a vulnerability to a higher ACE score for a particular Black service user who experienced loss of a parent to prison, parental divorce, witnessed intimate partner violence, a depressed parent and unmet basic needs in childhood. This ACE score has contributed to multiple medical comorbidities as well as comorbid PTSD.

However, while this service user resides in an area rife with the consequences of the opioid epidemic, they are not screened for opioid misuse despite having risk factors revealed during service visits.

Strategy B

An additional strategy is the adoption of structural humility and competency as a professional competency essential for working with racially and ethnically minoritized service users. This can be supported by becoming familiar with the concept as well as by use of the structural vulnerability tool during intakes and treatment planning. The tool assesses an individual's or a population groups' condition of being at risk for negative health outcomes, such as morbidity and mortality from opioid misuse, through their interface with socioeconomic, political and. cultural/normative hierarchies.

The tool includes an examination of the service user's potential exposure to discrimination and past experiences of discrimination in health care contexts. Additional areas of focus include financial security, residence, risk environments, food access, social network, legal status and education.

Reflection Questions

How might you incorporate an awareness of manifestations of racial oppression into your clinical formulations and treatment plans?

Have you identified the racial or ethnic disparities that you have produced and perpetuated in your workplace by disaggregating available clinical and administrative data on service users at risk of opioid misuse, those who misuse opioids and those with OUD who are racially and ethnically minoritized?

How has ingrained cultural and social conditioning impacted your decisions and attitudes towards service users at risk of opioid misuse, those who misuse opioids and those with OUD who are racially and ethnically minoritized?

For the following, consider a recent service user who is a racially or ethnically minoritized individual with OUD seeking treatment and identify a particular treatment need you hoped to address (access to medications for OUD, access to psychotherapy, food insecurity, underemployment, etc).

If you are unsure of a particular inequity that has shaped a recent service user's experience, you can view the references for this principle first before this exercise.

For this service user, what is the situation you want to analyze or the racial inequity you want to address?

For this service user, how is what you see today in their recent life history a reflection or continuation of historical events and patterns?

For this service user, how are resources distributed along lines of race? Who is controlling the resources? Whose needs do the allocation of these resources typically meet?

For this service user, what policies and practices may be contributing to the racial inequity at the organizational, local, state and federal level?

For this service user, what are the coded images, myths and assumptions that are used to rationalize this inequity?

What beliefs and behaviors are contributing to this specific inequity?

Who has the formal and informal power to make change to reduce this specific inequity?

What is your own sphere of influence to mitigate the impact of this specific inequity?

Resources:

Sara Matsuzaka & Margaret Knapp (2019): Anti-racism and substance use treatment: Addiction does not discriminate, but do we?, Journal of Ethnicity in Substance Abuse, DOI: 10.1080/15332640.2018.1548323
How is Structural Racism Operating, The Open Source Framework https://buildthefoundation.org/wp-content/uploads/2018/11/RE-Analysis-Strategy-Worksheet.pdf

CDC Vital Signs: Drug Overdose Deaths Rise, Disparities Widen Differences Grew by Race, Ethnicity, and Other Factors   https://www.cdc.gov/vitalsigns/overdose-death-disparities/index.html#equity

Burke, B., Harrison, P. (1998). Anti-oppressive practice. In: Adams, R., Dominelli, L., Payne, M., Campling, J. (eds) Social Work. Palgrave, London. https://doi.org/10.1007/978-1-349-14400-6_19

Clifford D. & Burke B. (2009). Anti-oppressive ethics and values in social work. Palgrave Macmillan.

Brown, J. D. (2019). Anti-oppressive counseling and psychotherapy: Action for personal and social change. Routledge/Taylor & Francis Group. https://doi.org/10.4324/9781315110097

Metzl JM, Hansen H. Structural competency: theorizing a new medical engagement with stigma and inequality. Soc Sci Med. 2014;103:126-133.

Castillo, E. G., Isom, J., DeBonis, K. L., Jordan, A., Braslow, J. T., & Rohrbaugh, R. (2020). Reconsidering Systems-Based Practice: Advancing Structural Competency, Health Equity, and Social Responsibility in Graduate Medical Education. Academic medicine : journal of the Association of American Medical Colleges, 95(12), 1817–1822. https://doi.org/10.1097/ACM.0000000000003559

Bourgois, P., Holmes, S. M., Sue, K., & Quesada, J. (2017). Structural Vulnerability: Operationalizing the Concept to Address Health Disparities in Clinical Care. Academic medicine : journal of the Association of American Medical Colleges, 92(3), 299–307. https://doi.org/10.1097/ACM.0000000000001294
https://nationalpress.org/topic/race-and-the-criminalization-of-drugs/

2) Commitment to Incorporation

The second principle is to commit to incorporation of a trauma informed approach that recognizes intergenerational trauma. Historical trauma, connected to intergenerational trauma, is experienced by a specific cultural group that has a history of being systematically oppressed. Transgenerational trauma, or intergenerational trauma, is the psychological effects that the collective trauma experienced by a group of people has on subsequent generations in that group. For example, those persons with OUD who are descendents of enslaved African and indigenous persons, these concepts are a part of their lived reality. Thus, an anti oppressive as well as decolonial approach to working with these individuals is one that is trauma-informed.

Additional forms of trauma include vicarious trauma which occurs when an individual who was not an immediate witness to the trauma absorbs and integrates disturbing aspects of the traumatic experience into their own functioning. The consumption of narratives of police violence in the media, for example, has been shown to have a negative impact on the psychological and emotional experiences of Black adults in the United States. Racial trauma describes the mental and emotional injury caused by encounters with racial bias and ethnic discrimination, racism, and hate crimes.

It is essential for those providing services to understand historical, intergeneration, vicarious and identity-based trauma in order to offer trauma-informed services. Co-occurring trauma disorders as well as a vulnerability to traumatic exposures is common for persons at risk of opioid misuse, those who misuse opioids and those with OUD who are racially and ethnically minoritized . For example, one retrospective study of intake data from persons receiving medications for OUD found that lifetime history of sexual, physical and emotional abuse ranged from one-quarter to nearly two-thirds of service users.

Strategy A

One strategy to embody this principle can be through adoption of a trauma informed care approach as outlined by SAMHSA which emphasizes the following:

SAMHSA Principle	Description
Safety	Throughout the organization, staff and the people they serve feel physically and psychologically safe.
Trustworthiness and Transparency	Organizational operations and decisions are conducted with transparency and the goal of building and maintaining trust among staff, clients, and family members of those receiving services.
Peer Support	These are integral to the organizational and service delivery approach and are understood as a key vehicle for building trust, establishing safety, and empowerment.
Collaboration and Mutuality	There is recognition that healing happens in relationships and in the meaningful sharing of power and decision-making. The organization recognizes that everyone has a role to play in a trauma-informed approach. One does not have to be a therapist to be therapeutic.
Empowerment, Voice and Choice	Organization aims to strengthen the staff, client, and family members' experience of choice and recognizes that every person's experience is unique and requires an individualized approach. This builds on what clients, staff, and communities have to offer, rather than responding to perceived deficits.
Cultural, Historical, and Gender Issues	The organization actively moves past cultural stereotypes and biases , offers culturally responsive services, leverages the healing value of traditional cultural connections, and recognizes and addresses historical trauma.

Strategy B

Another strategy is to screen for trauma and trauma related disorders with an intention to intervene making use of available resources (including referrals to services that incorporate trauma focused therapy). Screening for and offering treatment for trauma related symptoms is a competency warranted by the prevalence of co-occurring trauma disorders amongst service users. An important concept to understand is the risk of re-traumatization which describes any event or external stimuli that causes thoughts and feelings of trauma to re-emerge within an individual. Service provider strategies for mitigating the risk of re-traumatization, especially during the screening process, can include the following:

- Build a rapport with a service user
- Explain the impact of trauma
- Maintain an open communication
- Consider and respond to service user remarks
- Positive reinforcement

Interventions for service providers in a variety of treatment settings can include:

- Normalize their distress by affirming that what they are experiencing is normal
- Offering psychoeducation on trauma and related symptoms and help them be aware of possible symptoms that may require additional assistance.
- Exploring with service users their interest in treatment options (psychotherapy, spiritual support, acupuncture, yoga, massage, etc)
- Providing a positive experience that will increase their chances of seeking help if they need it in the future
- Sharing strategies for acute management of symptoms (relaxation training, biofeedback, and breathing retraining strategies)

It is important that service providers approach service users, their trauma narratives and symptoms with humility. Cultural and racial ignorance can increase the likelihood that service users experience invalidation and minimization of their trauma exposures and its impact. This can affect the engagement and retention of service users. Active efforts to seek out cultural and racial knowledge that is unfamiliar to service providers is a professional responsibility.

Strategy C

Another strategy is to prepare for and respond to racial harm occurring in the treatment relationship and/or during an experience of accessing organizational and outside services. Racial harms can occur in the form of intention or unintentional macroaggressions and microaggressions. Racial stress and racial battle fatigue may also be discussed as a major stressor shaping a service user's relationship with opioids. Additionally, racial harms can occur when a service provider dismisses or invalidates a narrative of racism through adoption of race evasiveness, also known as colorblind racial ideology.

Unintentional macroaggressions: Carrying out supposedly race-neutral policies that result in disparate outcomes for Blacks and Latinos (e.g. sentencing disparities between cocaine users and crack users)

Intentional macroaggressions: These were legal historically and included the implementation of Jim Crow Laws

Unintentional microaggressions: A service provider mistakenly assumes a service user lacks formal education and possesses low health literacy

Intentional microaggressions: A service user is dismissed when raising concerns about potential racial discrimination in the clinic

Racial battle fatigue: The cumulative psychological, social, physiological, and emotional impacts of racial micro and macro aggressions and racist abuse on racially marginalized groups – particularly Black individuals. Attempting to cope with these persistent hostile, violent, demeaning, dismissive, and toxic race-based stressors completely depletes one's physical, emotional, and mental energy.

Race evasiveness: a form of racial ideology that denies the societal experience of race and the existence of racism

Race evasiveness maneuver	Description	Example
Cultural racism	Attributing racial differences to cultural practices	A service provider believes that methadone is more appropriate for non-White service users rooted in a belief that these service users typically benefit from more monitoring and structure
Abstract Liberalism	Explaining racial matters in an abstract, decontextualized manner	A service provider attributes lack of ethnoracial diversity in the suboxone clinic to 'freedom of choice' where non-White service users are choosing other treatment options using their own free will
Naturalization	Naturalizing racialized outcomes such as neighborhood segregation	A service provider viewing a map of suboxone availability attributes the geographic correlation with White race and wealth to chance
Minimization of racism	Suggests discrimination is no longer a central factor affecting minorities' life chances	A service provider disbelieves a service user's connecting of structural racism to their troubled relationship with opioids

In order to prepare for racial harms that will occur, a service provider can adopt the following approach to providing services that focuses on building a maintaining a strong therapeutic alliance (FOCAL):

- Foster a stance of racial and cultural curiosity
- Offer validation of the emotional, psychological and cognitive impact of racial stress and trauma
- Commit to learning from mistakes
- Apologize when needed
- Leverage racial humility with a growth mindset

Reflection Questions

In your approach to a clinical formulation of a person misusing opioids or with an opioid use disorder who is racially or ethnically minoritized, how often have you considered the psychological and biological impact of racial oppression, settler colonization, and intergenerational trauma?

What strategies, policies or practices are currently in place at your institution or in your own practice that center collaboration, empowerment and strengths-based

approaches to service users at risk of opioid misuse, those who misuse opioids and those with OUD who are racially and ethnically minoritized?

What other strategies, policies or practices could be put in place to meet the SAMHSA approach criteria?

What action is needed as a next step to implementing or strengthening trauma-informed practice in your own clinical work and also that of your organization?

Resources:

Substance Abuse and Mental Health Service Administration (2014). SAMHSA's concept of trauma and guidance for a trauma-informed approach. HHS Publication No. (SMA) 14-4884. Rockville, MD: Substance Abuse and Mental Health Services Administration.

Center for Substance Abuse Treatment (US). Trauma-Informed Care in Behavioral Health Services. Rockville (MD): Substance Abuse and Mental Health Services Administration (US); 2014. (Treatment Improvement Protocol (TIP) Series, No. 57.) Chapter 6, Trauma-Specific Services. Available from: https://www.ncbi.nlm.nih.gov/books/NBK207184/

Dass-Brailsford, P. (2007). A practical approach to trauma: Empowering interventions. Thousand Oaks, CA: Sage Publications.

Curran, L. A. (2013). 101 trauma-informed interventions: Activities, exercises and assignments to move the client and therapy forward. Eau Claire, WI: PESI Publishing and Media.

Najavits, L. M. (2002). Seeking safety: A treatment manual for PTSD and substance abuse. New York, NY: The Guilford Press

Comas-Díaz, L., Hall, G. N., & Neville, H. A. (2019). Racial trauma: Theory, research, and healing: Introduction to the special issue. American Psychologist, 74(1), 1-5. http://dx.doi.org/10.1037/amp0000442

Skewes, M. C., & Blume, A. W. (2019). Understanding the link between racial trauma and substance use among American Indians. American Psychologist, 74, 88–100. https://doi.org/10.1037/amp0000331

Levchak C.C. (2018) Microaggressions, Macroaggressions, and Modern Racism. In: Microaggressions and Modern Racism. Palgrave Macmillan, Cham. https://doi.org/10.1007/978-3-319-70332-9_2
St. Jean, N.E., Endale, T., & NCTSN Culture Consortium. (2020). Cultural Responsiveness to Racial Trauma: Understanding Racial Trauma, Why It Matters, and What to Do. Los Angeles, CA, and Durham, NC: National Center for Child Traumatic Stress

Miriam Komaromy, Elena Mendez-Escobar, Erin Madden; Addressing Racial Trauma in the Treatment of Substance Use Disorders. Pediatrics January 2021; 147 (Supplement 2): S268–S270. 10.1542/peds.2020-023523L

3) Commitment to Individualize

The third principle is to commit to individualizing each service user to honor their experiences, background and complex life stories. This requires avoidance of stereotyping which is the use of a fixed, oversimplified, and often biased belief about a group of people. Stereotypes are typically rationally unsupported generalizations, and, once a person becomes accustomed to stereotypical thinking, they may not be able to see individuals for who they are. Public discourse often creates and reinforces narratives about individuals as members of groups that are unjust, inaccurate and pathologizing. An effort to individualize each service user can circumvent these problematic narratives and their impact on the provision of high quality, equitable care for service users at risk of opioid misuse, those who misuse opioids and those with OUD who are racially and ethnically minoritized.

Strategy A

Incorporating a cultural formulation into intakes, treatment and goal-setting can support this principle. A cultural formulation clarifies the meanings and expectations of health, illness, and treatment from the service user's perspective. Service providers can make use of the DSM Cultural Formulation Interview (CFI) when engaging service users and as service offerings are developed.

Cultural formulation components include:

- 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

In each clinical interaction, make an effort to incorporate questions from the DSM V CFI to better understand the service user. Additional steps can include incorporating the inquiries into intakes, progress notes and discharge documents to support current and future care needs.

Reflection Questions

What are the most common stereotypes applied to service users at risk of opioid misuse, those who misuse opioids and those with OUD who are racially and ethnically minoritized?

How can racial stereotypes harm service users at risk of opioid misuse, those who misuse opioids and those with OUD who are racially and ethnically minoritized?

How will you honor collective experiences of racially and ethnically minoritized groups (such as experiences of discrimination in health care settings) while also honoring each individual's unique history and experiences?

Have you ever made use of the CFI or its components in your clinical work? Why or why not?

Resources:

Aggarwal, N. K., & Lewis-Fernández, R. (2020). An Introduction to the Cultural Formulation Interview. Focus (American Psychiatric Publishing), 18(1), 77–82. https://doi.org/10.1176/appi.focus.18103
APA DSM5 CFI https://www.psychiatry.org/File%20Library/Psychiatrists/Practice/DSM/APA_DSM5_Cultural-Formulation-Interview.pdf

The DSM-5 Cultural Formulation Interview and the Evolution of Cultural Assessment in Psychiatry. Psychiatric Times 2015 https://www.psychiatrictimes.com/view/dsm-5-cultural-formulation-interview-and-evolution-cultural-assessment-psychiatry

4) Commitment to Focus

The fourth principle is to commit to focusing on rapport building using humility and demonstrating trustworthiness to build human connections with service users. A history of medical mistreatment of racially and ethnically minoritized service users has directly contributed to mistrust and distrust of healthcare services and professionals. Rapport building, establishing a mutually trusting and respectful helping relationship, is essential to increasing trustworthiness as a service provider. Trustworthiness is the quality of being deserving of trust or confidence. In addition, adopting a stance of cultural humility can support rapport building. This stance requires a willingness and openness to demonstrate respect and a lack of superiority when interacting with those whose cultural identities, values, and worldviews differ from their own. This cross cultural skill extends beyond cultural competence to fully meet the demands of culturally responsive service provision.

Strategy A

Components of cultural humility important for rapport building include a service provider:

- considering sociocultural factors during assessment
- individualizing treatment based on unique needs
- factoring in client strengths
- maintaining overall respect for the person with whom you are working

These components incorporate a number of the six REACH principles and reflect a type of learning orientation to service provision that has no specific endpoint. Cultural humility as a commitment is a continual process that requires self-reflection and self-critique that avoids uncritical consumption of stereotypic representations of individuals and

groups. While distinct from cultural competency, it can support competence in its ability to increase the cross cultural effectiveness of the workforce in its work with service users from racially and ethnically minoritized backgrounds.

Strategy B

Use of the National CLAS standards in your organization and clinical practice can support rapport building and demonstrate trustworthiness to service users. The National CLAS Standards are a set of 15 action steps intended to advance health equity, improve quality, and help eliminate health care disparities by providing a blueprint for individuals and health and health care organizations to implement culturally and linguistically appropriate services. The principle standard is to 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.

Strategy C

An additional strategy to embody this principle can be to adopt the AAMC 10 principles of trustworthiness as a service provider and organization. This effort can be supported by first understanding the 10 principles and then connecting each to your practice and your organization's service delivery to service users at risk of opioid misuse, those who misuse opioids and those with OUD who are racially and ethnically minoritized.

Principle 1: The community is already educated; that's why it doesn't trust you.

Principle 2: You are not the only experts.

Principle 3: Without action, your organizational pledge is only performance.

Principle 4: An office of community engagement is insufficient.

Principle 5: It doesn't start or end with a community advisory board.

Principle 6: Diversity is more than skin deep.

Principle 7: There's more than one gay bar, one "Black church," and one bodega in your community.

Principle 8: Show your work.

Principle 9: If you're gonna do it, take your time, do it right.

Principle 10: The project may be over, but the work is not.

Reflection Questions

What are the limitations of cultural competence and potential harms? How might cultural humility address all or some of these?

Has the workforce in your context embraced cultural humility as an approach to service development and delivery? Why or why not?

What are culturally and linguistically appropriate services and how are they relevant to providing care to racially and ethnically minoritized service users?

What aspects of National CLAS culturally CAPABLE materials are currently in your organization's resources provided to service users? Which might be added?

How might you distinguish between trust and trustworthiness and its relevance to your work with service users at risk of opioid misuse, those who misuse opioids and those with OUD who are racially and ethnically minoritized?

What steps have you taken to date to increase your trustworthiness with service users at risk of opioid misuse, those who misuse opioids and those with OUD who are racially and ethnically minoritized? What steps has your organization taken?

What specific action steps will you take to increase your trustworthiness with service users at risk of opioid misuse, those who misuse opioids and those with OUD who are racially and ethnically minoritized? What action steps will you recommend to your organization?

Resources:

Cultural Considerations in Addiction Treatment: The Application of Cultural Humility. Connie T. Jones, PhD, LCMHCA, LCAS, NCC, ACS and Susan F. Branco, PhD, LPC, LCPC, NCC, ACS, BC-TMH
Cultural Humility Webinar Series, National Association for Alcoholism and Drug Abuse Counselors https://www.naadac.org/cultural-humility-webinars

Prasad, S. J., Nair, P., Gadhvi, K., Barai, I., Danish, H. S., & Philip, A. B. (2016). Cultural humility: treating the service user, not the illness. Medical education online, 21, 30908. https://doi.org/10.3402/meo.v21.30908
National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care, US Department of Health and Human Services, https://thinkculturalhealth.hhs.gov/assets/pdfs/EnhancedNationalCLASStandards.pdf

https://thinkculturalhealth.hhs.gov/assets/pdfs/resource-library/developing-culturally-capable-materials.pdf
AAMC The Principles of Trustworthiness https://www.aamchealthjustice.org/resources/trustworthiness-toolkit

5) Commitment to Center

The fifth principle is to commit to centering lived experiences, community expertise and community will in developing and implementing relevant interventions. Lived experience is the personal knowledge about the world gained through direct, first-hand involvement in everyday events rather than through representations constructed by other people. It is also described as the experiences of people on whom a social issue or combination of issues has had a direct impact. Many of the most successful efforts to address the prevention, diagnostic and treatment needs of service users at risk of opioid misuse, those who misuse opioids and those with OUD who are racially and ethnically minoritized have been informed by this principle.

Strategy A

One strategy for this is to make use of community engagement strategies rooted in respect for lived experience when working with individual service users and communities.

Community engagement approaches include a spectrum of involvement:
- Community informed: to provide the public with balanced and objective information to assist them in understanding the problem, alternative, opportunities and/or solutions
- Community consulted: to obtain public feedback on analysis, alternatives and/or decisions
- Community involved: to work directly with the public throughout the process to ensure public concerns and aspirations are consistently understood and considered
- Community collaboration: to partner with the public in each aspect of the decision making including the development of alternatives and the identification of the preferred solution
- Community empowered: to place final decision making in the hands of the public

Strategy B

Harm reduction, as a component of gradualism in addiction treatment, can represent a bridge to community expertise in service provision. Harm reduction is a population health strategy that recognizes incremental behavior change and its potential among to address the prevention, diagnostic and treatment needs of service users at risk of opioid misuse, those who misuse opioids and those with OUD who are racially and ethnically minoritized. The shifting of behaviors related to opioid use to healthier ends of the spectrum can reduce the morbidity and mortality experienced by those who misuse opioids and those with OUD who are racially and ethnically minoritized.

Active Drug User Not Seeking Care--Focus on Harm Reduction, Practice Safer Use	Active Drug User Seeking Care--Reduce Drug Activity and/or Find Alternative Activities	Active Drug User Trying for Control (MAT or Abstinence)--Provide Support for Increased Skills for Positive Change

• Naloxone education & widespread distribution • Syringe exchange and safer injection education • Encourage safer administration (snorting, smoking, consuming orally, or stuffing rather than injecting) • Pharmacy sales of syringes • Legal safe injection sites • Provision of fentanyl test strips to heroin users* • Referrals for non-judgmental accessible care including testing for bloodborne infections • Low-threshold opioid substitution therapy	• Incorporation of SBIRT into primary care • Screening for co-morbidities associated with opioid addiction (sexually-transmitted infections and blood-borne infections such as HIV and hepatitis) • Access to medication assisted therapies and counseling • Use of navigators to support patient through maze of treatment • Motivational interviewing (what do they want to change) • Job training, skill building	• Counseling, therapy, including motivational interviewing • Integrated care, including speciality care if needed • Dental care • Access to medication assisted therapies and counseling • Address chronic pain with interdisciplinary team • Support for positive change • AA/NA • Peer empowerment • Sober housing • Job training, skill building • Legal advice

Table adapted from A Population Health Approach to America's Opioid Epidemic, Orthopaedic Nursing, 2019

* Modification: Provision of fentanyl test strips to users of drugs that may contain fentanyl

Reflection Questions

Which type(s) of community engaged efforts have you previously engaged in? If none, why might that be?

What might be some of the barriers to engaging the community in ways that involve, collaborate and empower their contributions to change?

What are your opinions on the value of lived experience in service development and delivery?

What action steps will you take to increase community engagement in service development and delivery in your current context?

How might harm reduction strategies directly address the needs of to address the prevention, diagnostic and treatment needs of service users at risk of opioid misuse, those who misuse opioids and those with OUD who are racially and ethnically minoritized?

Resources:

Collinson B, Best D. Promoting Recovery from Substance Misuse through Engagement with Community Assets: Asset Based Community Engagement. Substance Abuse: Research and Treatment. 2019;13. doi:10.1177/1178221819876575

Community Tool Box, Center for Community Health and Development at the University of Kansas. https://ctb.ku.edu/en/table-of-contents

The Value of Lived Experience in Social Change:The Need for Leadership and Organisational Development in the Social Sector, https://thelivedexperience.org/wp-content/uploads/2017/07/The-Lived-Experience-Baljeet-Sandhu-VLE-summary-web-ok-2.pdf

Chyrell D. Bellamy, Mark Costa, Janan Wyatt, Myra Mathis, Ariel Sloan, Mariana Budge, Kimberly Blackman, Luz Ocasio, Graziela Reis, Kimberly Guy, Reverend Robyn Anderson, Michelle Stewart Copes & Ayana Jordan (2021) A collaborative culturally-centered and community-driven faith-based opioid recovery initiative: the Imani Breakthrough project, Social Work in Mental Health, 19:6, 558-567, DOI: 10.1080/15332985.2021.1930329

https://dontdie.org/

Salmond, Susan; Allread, Virginia. A Population Health Approach to America's Opioid Epidemic. Orthopaedic Nursing 38(2):p 95-108, March/April 2019. | DOI: 10.1097/NOR.0000000000000521

6) Commitment to De-Bias

The sixth principle is to commit to de-bias your approach to prevention efforts, diagnosis, treatment and retention strategies. Service provider clinical bias influences how we use social and clinical data through the lens of an individual service user's personal characteristics and group memberships. Clinical De-biasing involves strategies to reduce the bias related factors that influence how we collect, integrate and interpret information to make clinical decisions. While this is one aspect of overall de-biasing, it is within the sphere of influence of individual service providers, thus, it represents a promising opportunity for improving the services offered to service users at risk of opioid misuse, those who misuse opioids and those with OUD who are racially and ethnically minoritized.

Strategy A

One strategy to embody this principle is to increase your knowledge around how bias shapes the clinical encounter, service delivery, decision making and clinical interventions and to adopt evidence based approaches to mitigating the impact of bias in these areas.

As a service provider providing services to service users at risk of opioid misuse, those who misuse opioids and those with OUD who are racially and ethnically minoritized, it is essential that you engage in active de-biasing in order to increase the quality of care offered. The evidence base for service provider level strategies to mitigate the impact of racial bias on care include:

Counter-stereotypic imaging: intentionally spend time thinking about specific service users or imagined service users who do not conform to the most common ethno-racial stereotypes

Stereotype replacement: to address personal stereotyping, one can recognize that a response is based on stereotypes, label the response as stereotypical, and reflect on why the response occurred

Analytic thinking after decision making (as opposed to heuristics based decision making)

1) Self Awareness
    a) Why have I come to this conclusion?
    b) What supports my conclusion
    c) What opposes my conclusion

2) Self Critique
    a) Could I be wrong?
    b) What heuristics or cognitive biases are at risk? List them.
    c) Am I confident of the diagnosis or next step in the treatment plan?
       i) If yes, consider at least two alternative diagnoses or treatment options appropriate for this service user prior to moving forward
       ii) If no, proceed to gather additional data such as:
          1 History and exam
          2) Collateral information
          3) Testing and consultation

3) Consider the potential for cognitive errors

4) Reduce risk factors for cognitive errors such as fatigue, workload, distractions, time and resource pressures

Cognitive Bias	Definition
Anchoring Bias	The service provider fixates on a particular aspect of the service user's initial presentation, excluding other more relevant clinical facts
Availability Bias	More recent and readily available answers and solutions are preferentially favored because of ease of recall and incorrectly perceived importance
Confirmation Bias	Diagnosticians tend to interpret the information gained during a consultation to fit their preconceived diagnosis, rather than the converse
Diagnostic Momentum	Continuing a clinical course of action instigated by previous service providers without considering the information available and changing the plan if required (particularly if plan commenced by more senior service provider)
Emotional Bias	Countertransference, both negative and positive feelings toward service users, may result in diagnoses being missed.
Framing Effect	Reacting to a particular choice differently depending on how the information is presented to you
Fundamental Attribution Error	The tendency to be judgmental and blame service users for their illnesses (dispositional causes) rather than examine the circumstances (situational factors) that might have been responsible.

Strategy B

Use of systemic thinking can disrupt the biased beliefs, assumptions and actions we take in response to the needs of service users at risk of opioid misuse, those who misuse opioids and those with OUD who are racially and ethnically minoritized. Systems thinking is a tool that recognizes how different parts connect, behave, and support the actions of the whole. 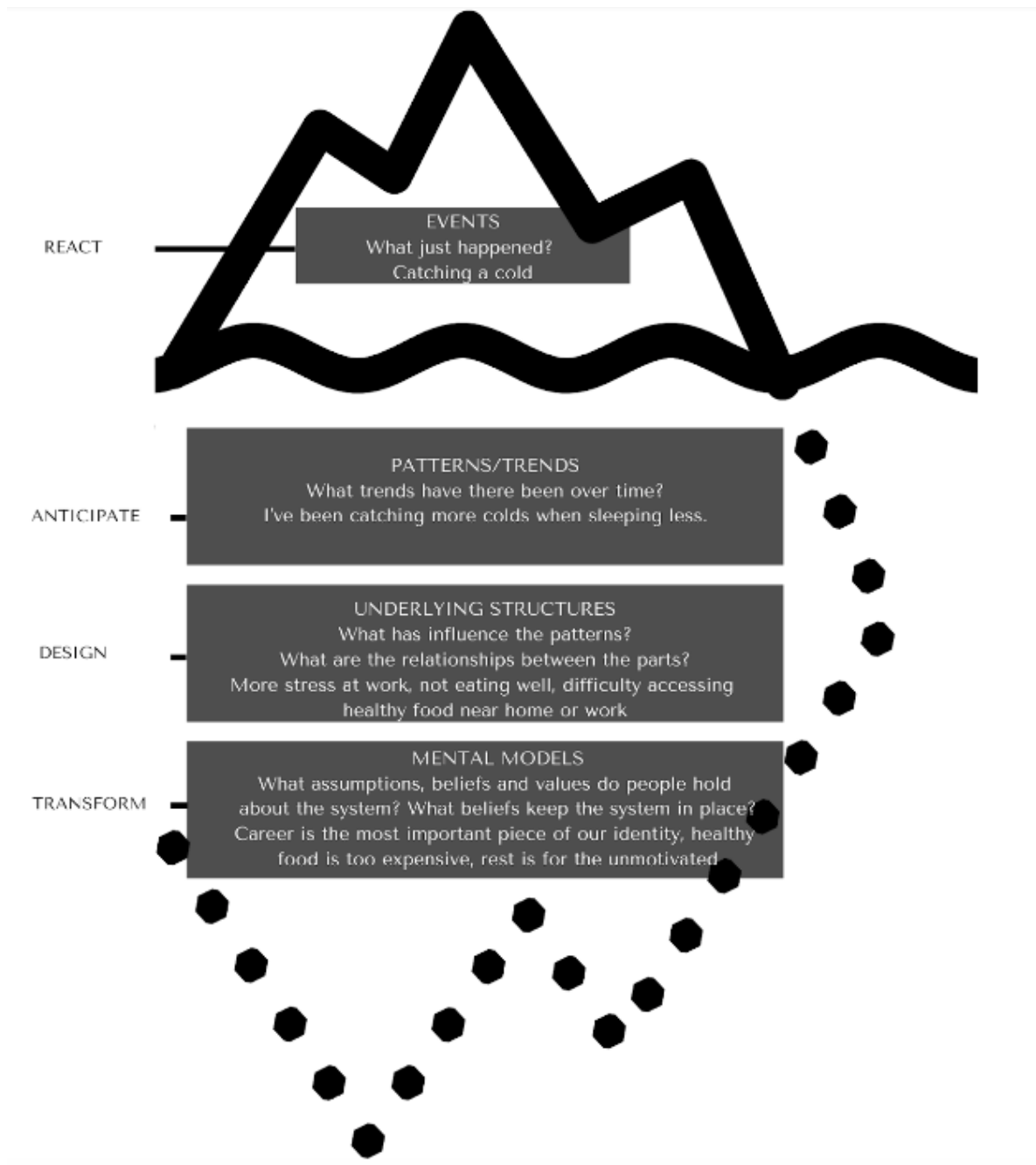Problematic racial ideologies that many service providers are socialized into adopting, such as race evasiveness, often prevent a nuanced consideration of systems level factors shaping the experiences of racially and ethnically minoritized service users. The iceberg approach can support service providers' efforts to adopt systems thinking in their context.

The Iceberg
A Tool for Guiding Systemic Thinking
Adapted from echochallenge.org Iceberg Model

REACT

EVENTS
What just happened?
Catching a cold

ANTICIPATE

PATTERNS/TRENDS
What trends have there been over time?
I've been catching more colds when sleeping less.

DESIGN

UNDERLYING STRUCTURES
What has influence the patterns?
What are the relationships between the parts?
More stress at work, not eating well, difficulty accessing
healthy food near home or work

TRANSFORM

MENTAL MODELS
What assumptions, beliefs and values do people hold
about the system? What beliefs keep the system in place?
Career is the most important piece of our identity, healthy
food is too expensive, rest is for the unmotivated

Strategy C

An additional strategy is to adopt an equity-minded orientation to service provision to service users at risk of opioid misuse, those who misuse opioids and those with OUD who are racially and ethnically minoritized. Equity-mindedness in healthcare service provision is a concept adapted by Vision for Equity LLC from the USC Center for Urban Education Equity-mindedness in Education Concept. It involves a direct confrontation of race evasive racial ideology, the identification of racism as a social and structural determinant of health and a commitment to improve existing policies and practices through incorporation of a race equity lens to service provision.

An equity minded service provider embodies and possesses the following:
- Awareness of racial identity and associated history
- Valuing of disaggregated data
- Reflective and critical of taken-for-granted

practices and their racial consequences
- Exercises agency to support racial equity
- Views the workplace and clinical setting as racialized spaces and actively self monitors interactions with racially minoritized global majority members

Outcomes of an equity orientation to service provision include a shaping of services relevant to access to care, the intake process, service user engagement, the provision of care and advocacy for policy.

Scope of Service	Reflection Questions
Improve access	• time of day to address work schedules that include late shifts and multiple jobs • targeted marketing and advertising to racially and ethnically minoritized communities • scholarship programs for financially limited persons with SUD • transparency on recognition of how racism shapes SUD services and the need for antiracism in the program's policies, practices and norms
Improve intake process	• ensure screenings include assessment for SDOH that might prove as barriers to engagement to inform future iterations of change (structural vulnerability tool as an example) • ensure screenings specifically address experiences of or concerns for discrimination and mistreatment related to accessing treatment • collect demographic information on self-identified race/ethnicity as well as other identities that can ultimately be disaggregated to assess for disparities (and to inform future iterations of change; who's missing? not being retained?)
Increase service user engagement	• give appointment reminders 1-2 days prior to scheduled appointment, using preferred reminder strategy • make follow-up calls to no shows within 24 hours • use regular satisfaction surveys to understand engagement needs of individual; implement timely strategies for improvement based on results • ensure peer specialists, if available, are calling members in between appointments for a check in and confirm next appointment
Improve the the provision of care	• create a widely publicized and transparent process for reporting and addressing experiences of or concerns for discrimination and mistreatment related to accessing treatment • develop a systems resource guide for clients/patients • attend programming from intersectional support groups to increase a knowledge base/skill set for culturally responsive care • increase the racial literacy of staff and leadership • train staff and leadership to recognize and respond to racial microaggressions in the workplace and in treatment contexts • clinical leadership ensures race, ethnicity, language and culture are explicitly discussed in case reviews and multi-disciplinary team reviews • raise awareness of impact of disparities, assumptions and stereotypes on engagement and successful treatment • bring to surface and discussing staff beliefs, attitudes and values related to race, ethnicity, linguistic minorities and culture • understand that in the treatment relationship, the individual served is the expert on his or her culture • promote recognition that culturally responsive care improves capacity to provide high-quality care
Increase the focus on equity in advocacy	• prioritize crisis services in communities of color that may avoid emergency services due to fear of police response • implement an ongoing process that includes representative members of local/state BIPOC communities to evaluate current mental health services in order to identify disparities, analyze barriers to care, implement effective policy changes, and hold stakeholders accountable • ensure all social determinants that are affecting racially minoritized communities' mental health outcomes are being considered and identified

Reflection Questions

How might cognitive errors coupled with racial bias impact your clinical decision making?

What aspects of analytic thinking might you incorporate into daily practice to reduce the impact of cognitive errors?

What is your understanding of bias and its relationship to racial and ethnic inequities?

What levels of bias in service development and delivery are usually focused on? What levels are usually ignored?

What implicit biases can you identify that exist within your organization? What process did you use to uncover these biases?

What opportunities during an assessment exist for mitigating the impact of bias?

What opportunities during an intervention exist for mitigating the impact of bias?

What opportunities during advocacy efforts exist for mitigating the impact of bias?

How might de-biasing your service delivery and its development support achieving health equity?

Which aspects of an equity-minded orientation do you currently adopt? Which do you need to grow further in embodying?

Which aspects of an equity-minded orientation does your organization currently adopt? Which does the organization need to grow further in embodying?

Resources:

Sara Matsuzaka & Margaret Knapp (2019): Anti-racism and substance use treatment: Addiction does not discriminate, but do we?, Journal of Ethnicity in Substance Abuse, DOI: 10.1080/15332640.2018.1548323

Dismantling racism against Black, Indigenous, and people of color across the substance use continuum: A position statement of the association for multidisciplinary education and research in substance use and addiction https://www.tandfonline.com/doi/abs/10.1080/08897077.2020.1867288

How to Debias Your Organization: How to make your organization more innovative, open minded and critical in its thinking and judgment, The Behavioral Architects 2020 https://www.thebearchitects.com/assets/uploads/ip/TBA%20Articles/How%20to%20Debias%20Your%20Organisation_C.pdf

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Wyatt R, Laderman M, Botwinick L, Mate K, Whittington J. Achieving Health Equity: A Guide for Health Care Organizations. IHI White Paper. Cambridge, Massachusetts: Institute for Healthcare Improvement; 2016. (Available at ihi.org)

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Plack, M. M., Goldman, E. F., Scott, A. R., & Brundage, S. B. (2019).

Systems thinking in the healthcare professions: A guide for educators and clinicians. Washington, DC: The George Washington University. https://hsrc.himmelfarb.gwu.edu/cgi/viewcontent.cgi?article=1000&context=educational_resources_teaching