

**I. RATIONALE:**

This Practice Guidance describes how to integrate cultural competence into substance abuse treatment. Cultural competence is critical to ensuring equitable access to and engagement in treatment and recovery – a fundamental [BSAS Principle of Care](#)<sup>1</sup>. Cultural competence:

- Reduces treatment disparities which adversely affect racial, ethnic, linguistic and cultural minorities;
- Supports best and evidence-based practices; and
- Improves outcomes.

Essential elements of this integration are: understanding disparities and culture, establishing the organization’s commitment to cultural competence, and integrating cultural competence into treatment relationships.

**Disparities:** Disparities are consistent differences in the quality of care that cannot be explained by factors such as insurance, socio-economic status or availability of services.<sup>2</sup> Racial, ethnic, linguistic and cultural minorities consistently experience lower quality of care, as evidenced by differences in access, appropriateness and outcomes of care. Healthcare disparities are well documented and arise from broad system-wide factors, organizational factors, and factors in the individual encounters between persons needing service and practitioners.<sup>3</sup> These disparities are also evident in substance abuse treatment, for example:

- Hispanics who need treatment are less likely to receive treatment than non-Hispanics.<sup>4</sup>
- When substance abuse and co-occurring problems are severe, Hispanics and African Americans are less likely to receive appropriate treatment;<sup>5,i</sup>
- In some studies<sup>ii</sup> of access to treatment, as many as 8 out of 10 persons with disabilities who needed substance abuse treatment were unable to access it;
- Racial and ethnic minorities are disproportionately affected by consequences of substance use, such as HIV/AIDS, liver disease, socio-economic losses and involvement in the criminal justice system.<sup>6</sup>
- Despite rates of substance use at least equal to those of the general population, LGBTQ adults continue to experience disparities in access to care;<sup>7</sup>

<sup>1</sup> Available at: <http://www.mass.gov/eohhs/gov/departments/dph/programs/substance-abuse/providers/program-licensing/principles-of-care-and-practice-guidance.html>

<sup>2</sup> Institute of Medicine *Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare* <http://www.iom.edu/Reports/2002/Unequal-Treatment-Confronting-Racial-and-Ethnic-Disparities-in-Health-Care.aspx>

<sup>3</sup> *ibid*

<sup>4</sup> NSDUH Report: Need for and Receipt of Substance Use Treatment among Hispanics, October 25, 2012. <http://www.samhsa.gov/data/2k12/NSDUH117/NSDUHSR117HispanicTreatmentNeeds2012.pdf>

<sup>5</sup> *ibid*

<sup>6</sup> NIDA, [Health Disparities Strategic Plan \(2009-2013\)](#)

<sup>7</sup> *A Provider’s Introduction to Substance Abuse Treatment for Lesbian, Gay, Bisexual and Transgender Individuals*, Substance Abuse and Mental Health Services Administration, 2001. Available at <http://store.samhsa.gov/home>. Search for SMA1204104

- Most major studies of need for and access to treatment exclude Native Americans, Asians and Pacific Islanders.<sup>8</sup>

BSAS has issued [Practice Guidance](#)<sup>9</sup> describing disparities for LGBTQ adults and for persons with disabilities, the adverse effects of these disparities on access to and engagement in treatment, and actions that can address these adverse effects. Other Practice Guidance address veterans, older adults, youth, and other groups.

Finally, it is important to keep in mind that while disparities are usually reported by ‘category’, people do not think of themselves as belonging to a ‘category’. Rather, identity arises from a varied mix of characteristics including ethnicity, language, gender identity, sexual orientation, spiritual beliefs, race, geography, and many others. Some individuals will experience disparities on the basis of more than one characteristic.

**Culture:** National Standards for Culturally and Linguistically Appropriate Services (CLAS)<sup>10</sup> define culture as

An integrated pattern of thoughts, communications, actions, customs, beliefs, values, and institutions associated, wholly or partially, with racial, ethnic, or linguistic groups, as well as with religious, spiritual, biological, geographical, or sociological characteristics.

In other words, a wide range of factors contributes to an individual’s cultural identity.

Organizations develop their own customs, beliefs and values, some of which may arise from treatment philosophies (e.g. approaches that emphasize powerlessness). Individual staff members, too, hold their own sets of customs, beliefs and values. Efforts to make services more responsive will require explicitly acknowledging the influence of the organization’s and staff members’ cultures.

The term ‘culturally competent’ is used here to focus on action and interaction, with particular attention to two major arenas. The first is establishing comprehensive organizational commitment to Culturally and Linguistically Appropriate Services (CLAS). The second is promoting treatment relationships in which culture is openly discussed and where effects of culture are understood, through all phases of treatment and in all encounters among individuals, agencies and staff.

**Organizational Commitment:** The National Culturally and Linguistically Appropriate Services (CLAS) Standards in Health and Health Care establish principles upon which organizations can “provide effective, equitable, understandable and respectful quality care and services, responsive to diverse cultural health beliefs and practice, preferred

<sup>8</sup> Substance Abuse Policy Research Program, RWJF, [http://sapr.org/knowledgeassets/knowledge\\_results.cfm?KAID=11](http://sapr.org/knowledgeassets/knowledge_results.cfm?KAID=11)

<sup>9</sup> <http://www.mass.gov/eohhs/gov/departments/dph/programs/substance-abuse/providers/program-licensing/principles-of-care-and-practice-guidance.html>

<sup>10</sup> DPH Office of Health Equity, Culturally and Linguistically Appropriate Services at <http://www.mass.gov/eohhs/gov/departments/dph/programs/admin/health-equity/clas/>

US DHHS Office of Minority Health National CLAS Standards at: <http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlID=15>

languages, health literacy and other communication needs.”<sup>11</sup> In summary, these standards define areas the organization should address, including:

- Governance, leadership and workforce: for example, educating managers and organization leaders; training and recruiting a diverse workforce.
- Communication and language assistance: for example, offering language assistance in the form of interpreters and translations; providing easy to understand print and multimedia materials and signage in languages commonly used in the community served.
- Community Engagement: including periodically assessing community substance abuse treatment needs and using this information to plan services; partnering with community to design, implement and evaluate agency policy, practices and services.
- Continuous improvement and accountability: linking ongoing data collection and assessment systems to culturally competent goals.

[\*Making CLAS Happen\*](#)<sup>12</sup> and *the Blueprint for Advancing and Sustaining CLAS Policy and Practice*<sup>13</sup> provide detailed guidance on implementing CLAS and on maintaining continuous quality improvement efforts. *Making CLAS Happen*, developed by the Massachusetts Department of Public Health, Office of Health Equity (OHE), contains a comprehensive array of organizational tools. OHE has also developed a [CLAS Agency Self-Assessment](#),<sup>14</sup> a brief, 8-item tool for setting priorities and goals. OHE, with the Bureau of Health Information, Statistics and Evaluation, has also developed [Standards for Collection of Race, Ethnicity and Language Data](#),<sup>15</sup> which describes approaches to and resources for effective data collection.

**Treatment Relationship:** The second critical arena for action is the treatment relationship.<sup>16</sup> The Institute of Medicine and the USDHHS Office of Minority Health<sup>17</sup> point out that miscommunication and misunderstanding between the individual and the health care practitioner contribute to continuing disparities. Those engaged in a treatment relationship – whether it is an initial encounter on the phone, or ongoing counseling -- bring to the encounter their ‘prior beliefs’, i.e. assumptions based on their own culture, previous experience, and the natural tendency to group individuals according to categories such as gender, race, ethnicity, age etc. This is true for both the individual seeking service and the provider. The more these beliefs are acknowledged, and when appropriate, brought into the conversation, the less likely they are to cause misunderstanding and confusion. Supervision and training can build skill in such conversations. Staff, then, will

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<sup>11</sup> CLAS Standard 1, USDHHS, Office of Minority Health, CLAS and CLAS Standards:

<https://www.thinkculturalhealth.hhs.gov/Content/clas.asp>

<sup>12</sup> <http://www.mass.gov/eohhs/gov/departments/dph/programs/admin/health-equity/clas/making-clas-happen.html>

<sup>13</sup> Available through: <https://www.thinkculturalhealth.hhs.gov/content/clas.asp>

<sup>14</sup> Available at: <http://www.mass.gov/eohhs/gov/departments/dph/programs/admin/health-equity/clas/request-for-responses.html>

<sup>15</sup> <http://www.mass.gov/eohhs/gov/departments/dph/programs/admin/health-equity/data-and-statistics.html>

<sup>16</sup> The Institute of Medicine refers to this as the ‘clinical encounter’. IOM, op cit

<sup>17</sup> Institute of Medicine *Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare*

<http://www.iom.edu/Reports/2002/Unequal-Treatment-Confronting-Racial-and-Ethnic-Disparities-in-Health-Care.aspx>; and CLAS Blueprint, <https://www.thinkculturalhealth.hhs.gov/Content/clas.asp>

be better equipped to discover and understand the ‘prior beliefs’ of the individual seeking care, and understand what treatment means to the individual.

Cultural competency training is an important element in understanding different cultures and how culture, experience and ‘categorizing’ individuals can affect the treatment relationship. However, to be fully responsive, treatment relationships should mirror the comprehensive organizational effort: planned, forthright conversations in individual and group supervision; consideration of cultural aspects in all workforce development efforts; and specifically addressing cultural influences in case and multi-disciplinary team reviews. These efforts enable staff to develop skills necessary to engage individuals in developing shared understanding how culture influences treatment and recovery. Staff skill in assessing and responding to individuals’ health literacy – the capacity to take in, understand and assess health information – is fundamental.<sup>18</sup> This capacity is supported by, among other factors, bilingual and diverse staff, access to trained interpreters, and easily understood written materials -- keeping in mind that the individual’s first ‘treatment encounter’ may be a brochure, website or a reception area. Availability of such resources should be evident, in notices and brochures for example, to individuals seeking services.

These two arenas – organizational commitment and treatment relationship -- are intertwined, and can be readily integrated with existing effective, evidence based best practices. Treatment approaches such as motivational interviewing, cognitive-behavioral treatment, or twelve-step facilitation are effective with individuals from a wide range of backgrounds. However, culturally competent treatment acknowledges that principles, values and beliefs of effective practices will elicit different responses influenced by the culture of the individuals involved. These responses should be part of the conversation.

Overt, organized efforts to address disparities can result in system improvements, as ongoing efforts to make services responsive to the needs of women are demonstrating.<sup>19</sup> Prior to the late 1980s, the specific needs of women were generally not studied, reported or differentiated from those of men. Early studies showed that while substance use rates of men and women were similar, there were significant negative disparities in women’s access to and outcomes of treatment. Concerted efforts since the early 1990s to address these disparities have improved access to and outcomes for women, and have also resulted in better system-wide understanding of the importance of family relationships, parenting and trauma-informed services.

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<sup>18</sup> For guidelines and information, see ‘Understanding Health Literacy’ at <http://www.health.gov/communication/literacy/quickguide/factsbasic.htm>

<sup>19</sup> Source for this section: Brady, T. M., & Ashley, O. S. (Eds.). (2005). Women in substance abuse treatment: Results from the Alcohol and Drug Services Study (ADSS) (DHHS Publication No. SMA 04-3968, Analytic Series A-26). Rockville, MD: Substance Abuse and Mental Health Services Administration, Office of Applied Studies. <http://www.samhsa.gov/data/womentx/womentx.pdf>

## II. GUIDANCE:

### A. Organization:

#### Policy:

- Agency affirms its commitment to the National Standards for Culturally and Linguistically Appropriate Services (CLAS);<sup>20</sup>
- Policy affirms services are culturally competent;
- Manuals and information for individuals served establish expectations for respectful interactions, prohibiting derogatory language.
- Policy prohibits allowing family, friends or peers in treatment from serving as interpreters.

#### Operations:

- Agency develops, implements and promotes a strategic plan to meet CLAS standards using tools contained in the [Making CLAS Happen: Six Areas for Action](#);<sup>21</sup>
- Agency completes an annual assessment and review using guidelines and tools described in *Making CLAS Happen: Six Areas for Action*, Chapter 4 Benchmark: Plan and Evaluate;<sup>22</sup> annual assessment includes completion of the [CLAS Agency Self-Assessment](#);<sup>23</sup>
- Agency specifically addresses language access using guidelines and tools described in *Making CLAS Happen: Six Areas for Action*, Chapter 6 Ensure Language Access,<sup>24</sup> including:
  - Assessing language service needs;
  - Developing resources and mechanisms for providing professional interpreter services and translations of written materials including brochures, informational materials and signage;
- Agency public relations and marketing materials depict a diverse work force;
- Clinical leadership ensures race, ethnicity, language and culture are explicitly discussed in case reviews and Multi-Disciplinary Team reviews.

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<sup>20</sup> USDHHS, Office of Minority Health, CLAS and CLAS Standards:

<https://www.thinkculturalhealth.hhs.gov/Content/clas.asp>

<sup>21</sup> Massachusetts Department of Public Health, Office of Health Equity

<http://www.mass.gov/eohhs/gov/departments/dph/programs/admin/health-equity/clas/making-clas-happen.html>

<sup>22</sup> Ibid

<sup>23</sup> <http://www.mass.gov/eohhs/gov/departments/dph/programs/admin/health-equity/clas/request-for-responses.html>

<sup>24</sup> Massachusetts Department of Public Health, Office of Health Equity

### Supervision, Training and Workforce Development:

- Recruitment and professional development efforts focus on building a diverse and culturally competent workforce;
- Training and supervision, both individual and group, focus on:
  - Raising awareness of impact of disparities, assumptions and stereotypes on engagement and successful treatment;
  - Bringing to surface and discussing staff beliefs, attitudes and values related to race, ethnicity, linguistic minorities and culture;
  - Understanding that in the treatment relationship, the individual served is the expert on his or her culture;
  - Promoting recognition that culturally responsive care improves capacity to provide high-quality care.
- Training focuses on building skills in:
  - Eliciting the individual's understanding of substance use, substance use disorders, treatment and recovery;
  - Eliciting the individual's preferences in integrating alternative or complementary recovery resources;
  - Recognizing gaps or difficulties in communicating, and developing strategies for bridging gaps, including:
    - Identifying need for and obtaining interpreter services;
    - Promoting staff ability to explain treatment and the treatment service system in plain language, i.e. avoiding jargon, explaining acronyms; and
    - Checking with individuals in treatment to ensure understanding;
  - Assessing individual preferences about cultural values and how these might be integrated into treatment, for example: sharing personal information; gender roles; value of traditional medicine; how decisions are made; locus of control/authority; involvement of family and/or significant relationships.

### **B. Service Delivery and Treatment:**

#### Assessment and Re-assessment:

- Staff discuss and record the individual's beliefs and values about substance use, treatment and recovery;
- Staff identify need for interpreter services;
- Staff collect and record information about individual's significant cultural and community connections.

Treatment Planning: Plans specify:

- Inclusion of cultural practices that support recovery;
- Links to community supports identified as important by the individual;
- Plan for obtaining interpreter services.

Service Provision:

- Staff periodically assess individual's understanding of terms and acronyms;
- Staff and individuals integrate cultural beliefs and practices supporting treatment and recovery planning.

Education:

- Substance abuse education includes discussion of the ways in which cultural beliefs, values and practices may affect recovery.

### III. MEASURES:

- Periodic surveys collect individuals' assessments of degree to which they participated in treatment.<sup>25</sup>
- Annual completion of CLAS Agency Self-Assessment Tool.<sup>26</sup>
- Agency incorporates MA DPH, Office of Health Equity [Departmental Standards for Collection of Race, Ethnicity and Language Data](#)<sup>27</sup> into data collection and analysis systems.
- Annual review of data on staff diversity and cultural competency training participation.

### IV. RESOURCES:

DPH and BSAS:

[BSAS Principles of Care and Practice Guidance](#):<sup>28</sup>

Treatment Services for Lesbian, Gay, Bisexual, Transgender and Queer  
(LGBTQ) Adults  
Access for Persons with Disabilities  
Treatment Services For Youth and Their Families

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<sup>25</sup> Paul-Emilie, Kimani. *Patients' Racial Preferences and the Medical Culture of Accommodation*.  
[http://papers.ssrn.com/sol3/papers.cfm?abstract\\_id=222227](http://papers.ssrn.com/sol3/papers.cfm?abstract_id=222227)

<sup>26</sup> Available at: <http://www.mass.gov/eohhs/gov/departments/dph/programs/admin/health-equity/clas/request-for-responses.html>

<sup>27</sup> Available at <http://www.mass.gov/eohhs/gov/departments/dph/programs/admin/health-equity/>

<sup>28</sup> Available at: <http://www.mass.gov/eohhs/gov/departments/dph/programs/substance-abuse/providers/program-licensing/principles-of-care-and-practice-guidance.html>

## Engaging Veterans in Treatment

DPH Office of Health Equity: <http://www.mass.gov/dph/healthequity>  
[MA CLAS – Manual, statistics, training](#)  
[Interpreter Services](#)

Massachusetts:

Training:

[Culture InSight](#) a program of Harvard Pilgrim Health Care which provides cultural competency training, consulting and organizational development services to health and human services professionals and their organizations.

[https://www.harvardpilgrim.org/portal/page?\\_pageid=1438,381769&\\_dad=portal&\\_schema=PORTAL](https://www.harvardpilgrim.org/portal/page?_pageid=1438,381769&_dad=portal&_schema=PORTAL)

[Center for Health Equity and Social Justice](#): a program of the Boston Public Health Commission providing training curricula and materials to educate community health workers, health care providers and public health professionals about the social determinants of health and racial and ethnic disparities.

<http://www.bphc.org/CHESI/Pages/default.aspx>

National Resources:

USDHHS, Office of Minority Health, CLAS and CLAS Standards:

<https://www.thinkculturalhealth.hhs.gov/Content/clas.asp>

Institute of Medicine: *Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare* <http://www.iom.edu/Reports/2002/Unequal-Treatment-Confronting-Racial-and-Ethnic-Disparities-in-Health-Care.aspx>

Health Literacy: For guidelines and information, see 'Understanding Health Literacy' at

<http://www.health.gov/communication/literacy/quickguide/factsbasic.htm>

For a simple summary of how beliefs about health arise – for individuals and groups,

see the Health Belief Model at: <http://sphweb.bumc.bu.edu/otlt/MPH-Modules/SB/SB721-Models/SB721-Models2.html>

Mental Health: Culture, Race & Ethnicity:

<http://www.ncbi.nlm.nih.gov/books/NBK44243/>

National Health Plan Collaborative (tool kits, see also RWJ Foundation)

<http://www.nationalhealthplancollaborative.org>

<http://www.rwjf.org/en/research-publications/find-rwjf-research/2008/09/the-national-health-plan-collaborative-toolkit.html>

RWJ Foundation:



Tool kit and an array of tools, including working with health plans:

<http://www.rwjf.org/qualityequality/product.jsp?id=33960>

Disparities:

[http://saprp.org/knowledgeassets/knowledge\\_results.cfm?KAID=11](http://saprp.org/knowledgeassets/knowledge_results.cfm?KAID=11)

Centers of Disease Control and Prevention:

CDC Health Disparities & Inequities Report 2011

<http://www.cdc.gov/minorityhealth/CHDIReport.html>

Practitioner's Guide for Advancing Health Equity:

<http://www.cdc.gov/nccdphp/dch/health-equity-guide/index.htm>

National Institute on Minority Health and Health Disparities

<http://www.nimhd.nih.gov>

National Survey on Drug Use and Health Reports:

[Need for and Receipt of Treatment - African Americans](#)

[NSDUH Need for and Receipt of Treatment - Hispanics](#)

[Need for and Receipt of Treatment - Native Americans](#)

NIDA Health Disparities resources

<http://www.drugabuse.gov/about-nida/organization/offices/office-nida-director-od/special-populations-office-spo/health-disparities>

Census: American Community Surveys: to assess community composition, get data by zip code on right hand column link <http://www.census.gov/acs/www/>

Patients' Racial Preferences and the Medical Culture of Accommodation, Kimani Paul-Emelie:

[http://papers.ssrn.com/sol3/papers.cfm?abstract\\_id=2222227#%23](http://papers.ssrn.com/sol3/papers.cfm?abstract_id=2222227#%23)

BSAS welcomes comments and suggestions. Contact: [BSAS.Feedback@state.ma.us](mailto:BSAS.Feedback@state.ma.us).

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<sup>i</sup> Schmidt, L, T Greenfield, N Mulia. *Unequal treatment: racial and ethnic disparities in alcoholism treatment services*. Alcohol Research & Health. 2006;29 (1) 49-54

<sup>ii</sup> West, S.L. et al, Rates of alcohol/other drug treatment denials to persons with physical disabilities: accessibility concerns. *Alcoholism Treatment Quarterly*, 27 (2009) 305–316.

West, S.L., et al, Physical inaccessibility negatively impacts the treatment participation of persons with disabilities. *Addictive Behaviors* 32 (2007) 1494–1497

West, S.L., et al., Prevalence of Persons with Disabilities in Alcohol/Other Drug Treatment in the United States *Alcoholism Treatment Quarterly*, 27 (2009)242–252.