Toward the Development of a Culturally Competent Mental Health Network for African Americans: A Programmatic Precursor

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ONTRACK Program Resources

I. Purpose and Background

Providers and clinicians have an important role in improving the day-to-day functioning and quality of life of African Americans and their communities. Given the impacts of individual and structural forms of oppression, competent care requires thoughtful consideration of historical, sociocultural, and individual factors that influence care. In order to improve the behavioral and mental health care of Black clients, while reducing racial/cultural biases towards Black clients, providers and clinicians must consider the following:

- Re-assessing professional practices and systems of care to gauge whether these practices connect with core values of Black culture, such as family, kinship, community and spirituality. Generalized and/or Eurocentric treatment approaches do not easily align with vital components of the Black community, forged under structures of residential segregation.[1]
- Examining how implicit biases and other forms of racial discrimination may contribute to hypervigilance, anxiety, or depressive symptoms among Black clients.
- Educating oneself on the experience of Black communities within the local jurisdiction.
- Actively listening and critically evaluating each relationship to build and strengthen your alliance with clients.
- Properly screening and following through with quality assessments that utilize a bio-psychosocial model. This will help gather unabridged evaluations of clients and pinpoint the most appropriate diagnosis for clients.
- Keeping relation-based talk therapy the center of all treatment paradigms, from the start, and then providing consistency in care.

This report outlines findings of based practices in the prevention and early intervention of African Americans, a precursor to the development of a community-based network of behavioral health providers dedicated to taking to scale the well-being of African Americans in local jurisdictions.

[1] Boyd, Rhea, The Case for Desegregation, The Lancet 2019 Jun 22;393(10190):2484-2485. doi: 10.1016/S0140-6736(19)31353-4. https://pubmed.ncbi.nlm.nih.gov/31232362/

African Americans occupy a unique niche in the history of the United States, and in contemporary national life. The creation of a color-based, racial caste system emerged with enslavement of Black humans, and after slavery, continued to be a means of allocating resources such as citizenship, gainful employment, and access to quality education and healthcare for much of the nation's history with impacts that continue to this day. The behavioral health of African Americans can be appreciated only within this wider historical context of the Americanization process and the historically race-based restrictions on the allocation of public and private resources. The forging of social ties have produced a resilient African American community—that, despite the "Many Thousands Gone" has overcome adversity and maintained a high degree of mental health through their own community-defined practices. Consequently, due to the cumulative impact of the political and social sorting of resources, African Americans are significantly overrepresented in the most vulnerable segments of the population. More African Americans than whites or members of other racial and ethnic minority groups reside in poverty-dense zip codes, are homeless, incarcerated, or supervised by the child welfare system.

Research has found that although only about 1 person in 3 of all respondents needing care received it, African Americans were distinguished by even lower levels of use (Ward et al, 2013). After eliminating the impact of sociodemographic differences and differences in need, the percentage of African Americans receiving treatment from any source was only about half that of whites (American

	Total	White non-Hispanic	Asian*	Hispanic or Latino	Black non-Hispanic†	Native American or Alaska Native
Wealth: median household assets (2011)	$68 828	$110 500	$89 339	$7683	$6314	NR
Poverty: proportion living below poverty level, all ages (2014); children <18 years (2014)	14·8%; 21·0%	10·1%; 12·0%	12·0%; 12·0%	23·6%; 32·0%	26·2%; 38·0%	28·3%; 35·0%
Unemployment rate (2014)	6·2%	5·3%	5·0%	7·4%	11·3%	11·3%
Incarceration: male inmates per 100 000 (2008)	982	610	185	836	3611	1573
Proportion with no health insurance, age <65 years (2014)	13·3%	13·3%	10·8%	25·5%	13·7%	28·3%
Infant mortality per 1000 livebirths (2013)	6·0	5·1	4·1	5·0	10·8	7·6
Self-assessed health status (age-adjusted): proportion with fair or poor health (2014)	8·9%	8·3%	7·3%	12·2%	13·6%	14·1%
Potential life lost: person-years per 100 000 before the age of 75 years (2014)	6621·1	6659·4	2954·4	4676·8	9490·6	6954·0
Proportion reporting serious psychological distress‡ in the past 30 days, age ≥18 years, age-adjusted (2013–14)	3·4%	3·4%	3·5%	1·9%	4·5%	5·4%
Life expectancy at birth (2014), years	78·8	79·0	NR	81·8	75·6	NR
Diabetes-related mortality: age-adjusted mortality per 100 000 (2014)	20·9	19·3	15·0	25·1	37·3	31·3
Mortality related to heart disease: age-adjusted mortality per 100 000 (2014)	167·0	165·9	86·1	116·0	206·3	119·1

NR=not reported. *Economic data and data on self-reported health and psychological distress are for Asians only; all other health data reported combine Asians and Pacific Islanders. †Wealth, poverty, and potential life lost before the age of 75 years are reported for the black population only; all other data are for the black non-Hispanic population. ‡Serious psychological distress in the past 30 days among adults aged 18 years and older is measured using the Kessler 6 scale (range=0–24; serious psychological distress: ≥13). Sources: wealth data taken from the US Census;[3] poverty data for adults taken from the National Center for Health Statistics,[3] and poverty data for children taken from the National Center for Education Statistics;[3] unemployment data taken from the US Bureau of Labor Statistics;[4] incarceration data taken from the Kaiser Family Foundation;[5] data on uninsured individuals taken from the National Center for Health Statistics;[2] data on infant mortality, self-assessed health status, potential life lost, serious psychological distress, life expectancy, diabetes-related mortality, and mortality related to heart disease taken from the National Center for Health Statistics.[2]

Table: Social and health inequities in the USA

Psychiatric Association, 2017). Most African Americans who received care relied on the safety net public sector programs.

More recent National Comorbidity Survey (NCS) examined how many persons used mental health services. Results indicated that only 16 percent of African Americans with a diagnosable mood disorder saw a mental health specialist, and fewer than one-third consulted a health care provider of any kind. The NCS also compared the use of mental health services by various ethnic groups and concluded that African Americans received less care than did white Americans (Elhai & Ford, 2007).

Disparities between African Americans and whites also exist after initial barriers have been overcome. After entering care, African Americans are more likely than whites to terminate prematurely (Sue et al., 1994). They are also more likely to receive emergency care (Hu et al., 1991). These differences may come about because African Americans are relatively often coerced or otherwise legally obligated to undergo treatment (Takeuchi & Cheung, 1998.)

A known contributor to these behavioral and mental health utilization disparities is the negative experiences and racial micro-aggressions Black clients experience as a result of systemic racism[2] and implicit biases. Individuals of African descent have commonly experience racial microaggressions.[3] Racial microaggressions are communications of assumptions, including assumptions of intellectual inferiority, assumptions of criminality, assumed superiority of White values and culture, and assumed universality of the Black experience. People of African descent experience unrelenting forms of direct, vicarious and institutional oppression, marginalization, discrimination and microaggressions. Many of these incidents manifest as hyper-surveillance, stigmatization, provocative irritations and recurrent indignities, and people of African descent experience these microaggressions daily. These negative events can accumulate and compound into experiences of racial battle fatigue, a sense of powerlessness, and race-based trauma, some of which is experienced by a collective group of individuals during the same time period. The creation of a network of providers for African Americans will require that providers, regardless of race, address the implicit biases that is a part of the air Americans breathe.

We now turn to a brief outline of common procedures, or beneficiary pathways that structure how provider's work with clients, and how they can be enhanced for African Americans.

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[2] Zenzi D Bailey, et al, Structural Racism and Health Inequities in the USA: evidence and interventions, *Lancet* 2017; 389: 1453-63. https://pubmed.ncbi.nlm.nih.gov/28402827/

[3] Williams, M. T., Skinta, M. D., Kanter, J. K., Martin-Willett, R., Mier-Chairez, J., Debreaux, M., & Rosen, D. C. (2020). *A qualitative study of microaggressions against African Americans on predominantly White campuses. BMC Psychology,* 8(111), 1-13. doi: 10.1186/s40359-020-00472-8

Williams, M. T., Kanter, J. W., Peña, A., Ching, T. W. C., & Oshin, L. (2020). *Reducing microaggressions and promoting interracial connection: The Racial Harmony Workshop. Journal of Contextual and Behavioral Science,* 16, 153-161. doi: 10.1016/j.jcbs.2020.04.008

II. Outreach

According to SAMHSA's 2018 National Survey on Drug Use and Health (SAMSHA 2018):

- Sixteen percent (4.8 million) of Black and African American people reported having a mental illness, and 22.4 percent of those (1.1 million people) reported a serious mental illness over the past year.
- Serious mental illness (SMI) rose among all ages of Black and African American people between 2008 and 2018.
- Despite rates being less than the overall U.S. population, major depressive episodes increased from 9 percent-10.3 percent in Black and African American youth ages 12-17, 6.1 percent to 9.4 percent in young adults 18-25, and 5.7 percent to 6.3 percent in the 26-49 age range between 2015 and 2018.
- Suicidal thoughts, plans, and attempts are also rising among Black and African American young adults. While still lower than the overall U.S. population aged 18-25, 9.5 percent (439,000) of Black and African American 18-25-year-olds had serious thoughts of suicide in 2018, compared to 6 percent (277,000) in 2008. 3.6 percent (166,000) made a plan in 2018, compared to 2.1 percent (96,000) in 2008, and 2.4 percent (111,000) made an attempt in 2018, compared to 1.5 percent (70,000) in 2008.
- Binge drinking, smoking (cigarettes and marijuana), illicit drug use and prescription pain reliever misuse are more frequent among African American adults with mental illnesses.

Given the forces described in the previous section, African Americans tend to mistrust healthcare providers. Unfortunately, African American providers, who are known to give more appropriate and effective care to Black and African American help-seekers, and retain them longer, make up a very small portion of the behavioral health provider workforce (Phillips, 2020). Because of these factors and others, African American people are more likely to experience chronic and persistent, rather than episodic, mental health conditions.

A lack of trust in mental health care and a mislabeling of Black people's presenting concerns make Black populations more apprehensive to seek counseling. Financial constraints and a lack of access to culturally responsive mental health care are additional barriers. All of this makes outreach to the Black community more needed while at the same time more difficult. There are ethical constraints around how behavioral health care providers can market themselves. For example, a provider cannot say "Hey, 'Black folk' come to my agency because we are cultural competent and will treat you better than those other

providers." However, providers can educate the community on who the provider is, what they provide, and what their values are. An examples of how this can be done is utilizing the Black church. Faith leaders are often both spiritual and political leaders in the Black community. Avent Harris notes that collaboration with churches is crucial. "A lot of times, how Black Americans conceptualize events, crises, pain and suffering is coming from their spiritual beliefs systems." Providers and motivated clinicians could meet with Black pastors and offer to speak in their Sunday morning services, co-sponsor a mental health day or provide referral resources. Other potential community outreach targets include, historically Black Greek-letter organizations, Black advocacy organizations like local chapter of the NAACP, schools, and even Black Barbershops (https://www.blackbarbershop.org/).

III. Environment

To create an environment that reflects the populations served, provider need to conduct an environmental review of the organization's physical facilities. The design of the facility, including use of space and décor, should be inviting, comfortable, and culturally sensitive. The plan should establish how to make facilities more accessible and culturally appropriate. In addition, the organization should create an environment that reflects the culture(s) of its clients not only within the facility, but through business practices, such as using local and community vendors. It is not possible to capture every aspect of diversity within each cultural group. Behavioral health workers should acknowledge that there will be many individual variations in how people interact with their environments, as well as in how environmental context affects behavioral health, however every attempt should be made to create an environment that Black clients find welcoming. Examples of areas that a provider can evaluate to measure their level of environmental cultural responsiveness to Black clients include:

- Percentage of African American staff
- Inclusion of ethnic foods in vending machine, potluck, agency menu (residential)
- Photos and pictures with African American faces and themes
- Quotes, books, magazines etc. around program
- Colors and décor
- Observance of African American holidays and historical events
- Knowledge of and access to resources in the community that are culturally competent to engage African Americans in service
- Connection to the local African American resources and community-defined programming and resources

IV. Treatment

To be culturally responsive, provider and clinician must learn to use a diagnostic system and treatment modality that affirms an African/African American way of being in an anti-African environment without stereotype and the affirmation of the client's individuality and uniqueness. Specifically, clinicians must: 1. become knowledgeable of the client's professed worldview orientation and the importance that spirituality may (or may not) play in the client's life; 2. take into account the psychological impact of systemic racism; 3. develop the capacity to engage in holistic and integrative analyses that have the potential to restore to health the family, and community as well as the individual; 4. engage in therapeutic practices that are culturally congruent and consistent with the client's health and well-being; and 5. be able to embrace and act on a standard of ethics and ethical practice consistent with culturally congruent care.

a. Intake

African American clients generally respond better to an egalitarian and authentic relationship with counselors. Paniagua (1998) suggests that in the initial sessions with African American clients, counselors should develop a collaborative client–counselor relationship. Counselors should request personal information gradually rather than attempting to gain information as quickly as possible, avoid information-gathering methods that clients could perceive as an interrogation, pace the session, and not force a data-gathering agenda. Counselors must also establish credibility with clients. Additional methods that may enhance engagement and promote participation with Black clients include peer-supported interventions and strategies that promote empowerment by emphasizing strengths rather than deficits. It is important to explore with Black clients the strengths that have brought them this far. What personal, community, or family strengths have helped them through difficult times? What strengths will support their recovery efforts?

b. Screening & Assessment

A number of studies have found biases that result in African Americans being over diagnosed for some disorders and underdiagnosed for others, such as schizophrenia. African Americans are less likely than White Americans to receive treatment for anxiety and mood disorders, but they are more likely to receive treatment for drug use disorders. To be culturally responsive providers and clinician should consider clients' cultural backgrounds when evaluating and assessing mental and substance use disorders. Concerns surrounding diagnoses of mental and substance use disorders (and the cross-cultural applicability of those diagnoses) include the

appropriateness of specific test items or questions, diagnostic criteria, and psychologically oriented concepts. Importantly, there is emerging research that supports the use of certain screening and assessment tools that have been found to be particularly effective when working BIPOC clients.

Examples are:

Multiculturally Sensitive Mental Health Scale (MSMHS), which responds to the need to assess African Americans' mental health, including perceptions of racism: https://www.semanticscholar.org/paper/Multiculturally-Sensitive-Mental-Health-Scale-and-Chao-Green/8082ab608b2698dc682019dd9670cf1adf76d66a

Instrument	Description	Clinical Utility with Specific Racial/Ethnic Groups
Beck Anxiety Inventory (BAI; Beck and Steer 1990)	The BAI is a 21-item scale that distinguishes anxiety from depression.	**Populations researched:** African Americans (Chapman et al. 2009).
Beck Depression Inventory (BDI) and Beck Depression Inventory, 2nd Edition (BDI-II; Beck et al. 1996)	The BDI is a 21-item instrument used to assess the intensity of depression.	Several versions of the BDI are available with cultural specificity. **Populations researched:** African Americans (Dutton et al. 2004; Grothe et al. 2005; Joe et al. 2008), Asian Americans (Carmody 2005; Crocker et al. 1994), Hmong (Mouanoutoua et al. 1991), Mexican Americans (Gatewood-Colwell et al. 1989), and Latinos (Contreras et al. 2004).
Mini International Neuropsychiatric Interview (M.I.N.I.; Sheehan et al. 1998)	This is a short, structured, diagnostic interview that assesses the most common mental disorders (including substance use disorders).	Populations researched: African Americans (Black et al. 2004). The Major Depressive Episode and Posttraumatic Stress Disorder (PTSD) sections of the M.I.N.I. have been adapted for use in screening for PTSD in refugees, and found effective across cultures in a multinational sample (Eytan et al. 2007)., 1998).

Instrument	Description	Clinical Utility with Specific Racial/Ethnic Groups
CAGE (Ewing 1984; Mayfield et al. 1974)	This is a set of four questions used to detect possible alcohol use disorder.	Populations researched: African Americans (Cherpitel 1997; Frank et al. 2008); Latino (Saitz et al. 1999).
Short Michigan Alcohol Screening Test (S-MAST; Selzer et al. 1975)	The S-MAST screens for alcohol use disorder.	Populations researched: African Americans, Arab Muslims, American Indians, Asian Indians, and Thai (Al-Ansari and Negrete 1990; Pal et al. 2004; Nanakorn et al. 2000; Robin et al. 2004).

The UConn RACIAL/ ETHNIC STRESS & TRAUMA SURVEY (UnRESTS) also provides racial and cultural measures to determine the relationship between a client's race, culture, and treatment planning needs.[4]

c. Treatment planning

Treatment planning is a dynamic process that evolves along with an understanding of the clients' histories and treatment needs. Counselors should be flexible in designing treatment plans to meet client needs and, when appropriate, should draw upon the institutions and resources of clients' cultural communities. Culturally responsive treatment planning is achieved through active listening and should consider client values, beliefs, and expectations. Client health beliefs and treatment preferences, such as racial affinity groups for African Americans, should be incorporated in addressing specific presenting problems. Many African Americans seek help for psychological concerns and substance abuse from alternative sources (e.g., clergy, elders, social supports. Others prefer treatment programs that use principles and approaches specific to their cultures. Counselors can suggest appropriate traditional treatment resources to supplement clinical treatment activities. To be culturally responsive, providers and clinicians need to incorporate culture-based goals and objectives, when determined with the client, into treatment plans and establish and support open client–counselor dialog to get feedback on the proposed

[4] UConn RACIAL/ ETHNIC STRESS & TRAUMA SURVEY (UnRESTS) https://www.mentalhealthdisparities.org/trauma-research.php

plan's relevance. Doing so can improve client engagement in treatment services, compliance with treatment planning and recommendations, and treatment outcomes.

d. Counseling Approaches

As individuals of African descent experience various adversities, crises and traumas related to racism and cultural discrimination on individual, community and generational levels, counselors can offer supports for healing trauma. Counselors must be aware of this history and the current sociopolitical institutions that traumatize and retraumatize individuals of African descent before healing work can begin.

Postmodern, humanistic and cognitive approaches have proved to be efficacious for counseling people of African descent. Specifically, Cognitive Behavioral (CBT), Reality Therapy/Choice Theory, and Solution Focused, have shown evidence of being effective treatment modalities with Black client populations.

CBT focuses on challenging and changing unhelpful cognitive distortions and behaviors, improving emotional regulation, and the development of personal coping strategies that target solving current problems. Originally, it was designed to treat depression, but its uses have been expanded to include treatment of a number of mental health conditions, including anxiety. CBT includes a number of cognitive or behavior psychotherapies that treat defined psychopathologies using evidence-based techniques and strategies. Cognitive–behavioral therapy (CBT) has certain distinct advantages for African American clients; it fosters a collaborative relationship and recognizes that clients are experts on their own problems (Kelly and Parsons 2008). Maude-Griffin et al. (1998) compared CBT and 12-Step facilitation for a group of mostly African American (80 percent) men who were homeless and found that CBT achieved significantly better abstinence outcomes.[5]

Reality Therapy/Choice Theory RC/TC is practiced and taught in many cultures and countries. The underlying theoretical basis, choice theory, states that all human beings are motivated by five current genetic instructions: survival or self-preservation, belonging, power or achievement, freedom or independence, fun or enjoyment. The effective reality therapist learns to adapt the methodology to individuals and groups from many cultures, such as Africa-centered reality theory, a community adapted practice.[6]

[5] http://stanhuey.com/wp-content/uploads/2015/07/Jones-Huey-Rubenson-2018-Cultural-Competence-Therapy-with-African-Americans.pdf

[6] Karen Y. Holmes, Ph.D. and Karen B. White, Psy.D., CTRTC Norfolk State University, Defining the Experiences of Black Women: A Choice Theory®/Reality Therapy Approach to Understanding the Strong Black Woman

The delivery system employs specific tools for helping clients identify and clarify their wants and desires, their hopes and their dreams. Clients are led to examine specific actions, cognition, and feelings which are seen in reality therapy as behaviors chosen to impact the external world of clients for the purpose of satisfying their needs. The cornerstone in the practice of reality therapy is the self-evaluation by clients. Counselors ask clients to examine the effectiveness of their choices especially as they impact their relationships with people important to them.

Clients also examine the attainability of their wants, as well as their degree of commitment in attaining their wants. Importantly as it relates to Black clients RT/CT does not TELL clients what they should want or what their perception of what their Reality should be, but rather acknowledges the unique challenges the Black client faces, empowers them to choose the best strategy available to them under the current circumstance to address those challenges, and helps them move toward the goals they set for themselves. Included in the process is realistic planning for need satisfaction especially for enhancing the clients' interpersonal relationships.[7]

Solution-focused therapy - also known as solution-focused brief therapy or brief therapy - is an approach to psychotherapy based on solution-building rather than problem-solving. Although it acknowledges present problems and past causes, it predominantly explores an individual's current resources and future hopes. According to Tashika L Holloway, EdD, LPC, Licensed Professional Counselor who specializes in working with African-American clients its important therapists are solution-focused when it comes to counseling Black men and women. She states, "In my recent dissertation research with Black counselors, some of the most significant factors were overcoming unrealistic expectations about counseling and retaining Black clients in counseling," she explains. "For example, Black clients often expect to be in counseling for a shorter period of time or want advice. As a result, counselors may need to be more solution-focused even if this is not the counselor's preferred counseling style. Black men and women more often present to counseling in times of crisis and if we feel our specific problem was not addressed or solution offered, then we may not feel it was effective or useful and not return for the next session."[8]

[7] Elijah Mickel, African Centered Mediation: Building on Family Strengths, https://msutexas.edu/academics/education/_assets/files/international_journal_of_reality_therapy_fall2001.pdf

[8] Diane Bigler, Solution Focused Approach with African American Clients, Solution-Focused Approach with African American Clients. https://sk.sagepub.com/books/solution-focused-brief-therapy/n5.xml

Unlike these other adapted approaches community defined -practices are in the process of being codified within the behavioral health sanctioning bodies For example, an African-centered psychological approach is grounded in traditional African spiritual philosophy, as opposed to the de-spiritualized western modalities, but can easily be adapted for the specific religion/spirituality of persons of African descent. Because counseling is a sacred, cultural, and spiritual relationship between the counselor and the client, it is important that the foundation of the therapeutic relationship be built on authenticity, trust and respect. Important interventions for counseling individuals of African descent include a focus on identity congruence, invitation for repair and the use of spiritual or religious connections salient to the individual or community.[9] https://www.baatn.org.uk/wp-content/uploads/African-Centered-Psychology-1.pdf

e. Measuring Progress

A lack of research exists linking therapist's White privilege awareness to client outcomes in therapy. As a profession, counseling psychology has little understanding about how racial dynamics in therapy affect outcome; mostly professionals are left to work with speculations and assumptions – this is particularly problematic when cross-racial dyads in counseling involve White therapists and clients of Color. Clients of Color must contend with a great deal of extra distress stemming from racial oppression of which White therapists may not be aware. Under-prepared White therapists, then, potentially carry their known and unknown biases and a lack of awareness of oppression into counseling sessions with clients of Color. As a result, they may be unable to fully conceptualize and understand their clients' distress and thus their progress as well. This can affect Black clients receiving treatment and the correct level of care and also the clinician attitude toward the clients based on their perception of "lack of progress."

Unfortunately, mental health providers are not always motivated to track and measure outcomes[10] Counselors may say things like "the data is wrong, we shouldn't have to do it, and I am clinically trained and trust my instincts." Additionally, some providers are afraid their outcomes may indicate a lack of effectiveness, which could affect their funding. However, substantial evidence has shown that collecting client feedback in a session-by-session manner strengthens effectiveness for treatment outcome and therapeutic alliance. [11]

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[9] Cheryl Tawede Grills, Ph.D, African Centered Psychology: Strategies for Psychological Survival and Wellness, 2006. https://www.baatn.org.uk/wp-content/uploads/African-Centered-Psychology-1.pdf

[10] Chris Morkides, *Measuring Client Outcomes*, in Counseling Today. https://ct.counseling.org/2009/07/measuring-counselor-success/

[11] Tony Rousmaniere, *What Your Therapist Doesn't Know,* https://www.theatlantic.com/magazine/archive/2017/04/what-your-therapist-doesnt-know/517797/

Importantly, research has suggested that the relationship between counselor and client are critically important to Black clients due to a tendency to mistrust based on the negative experience with systemic racism. More specifically, it is the strength of "therapeutic alliance" that would be critically important when working with Black populations. Research shows repeatedly that clients' ratings of the alliance are far more predictive of improvement than the type of intervention or the therapist's ratings of the alliance.[12]

The ORS and SRS are examples of instruments that for a small fee can be effectively used to measure the progress (or lack thereof) and treatment outcomes for Black clients as they both are based on client feedback and measuring the strength of the therapeutic alliance. The Outcome Rating Scale (ORS) (Miller& Duncan, 2004) and the Session Rating Scale (SRS)(Miller & Bargmann, 2012; Miller & Duncan, 2004) were developed to be usable in every session.

The *Session Rating Scale* (SRS) is a brief clinical alternative to longer research-based alliance measures to encourage routine conversations with clients about the alliance. The SRS contains four items. First, a relationship scale rates the meeting on a continuum from "*I did not feel heard, understood, and respected*" to "I *felt heard, understood, and respected.*" Second is a goals and topics scale that rates the conversation on a continuum from "We did not work on or talk about what I wanted to work on or talk about" to "*We worked on or talked about what I wanted to work on or talk about*." Third is an approach or method scale (an indication of a match with the client's theory of change) requiring the client to rate the meeting on a continuum from "*The approach is not a good fit for me*" to "*The approach is a good fit for me.*" Finally, the fourth scale looks at how the client perceives the encounter in total along the continuum: "*There was something missing in the session today*" to "*Overall, today's session was right for me.*"

The *Outcome Rating Scale* (ORS) assesses three dimensions:

a. Personal or symptomatic distress (measuring individual well-being)
b. Interpersonal well-being (measuring how well the client is getting along in intimate relationships)
c. Social role (measuring satisfaction with work/school and relationships outside of the home) Changes in these three areas are considered widely to be valid indicators of successful outcome. Because of its simplicity, ORS feedback is available immediately for use at the time the service is delivered.

[12] Scott D. Miller, *Research on the Outcome Rating Scale, Session Rating Scale & Feedback* https://www.scottdmiller.com/research-on-the-outcome-rating-scale-session-rating-scale-feedback/

A network of providers that all used such an instrument could create a consistent continuum of care within a treatment network.

f. Completion/Discharge

Black clients get discharged from treatment at 3 times the rate of White clients. Research suggests that implicit bias contributes to this outcome. Black client's behaviors tend to be overly attributed to "bad attitude" or "potentially violent." Providers can address this disparity and incorporate culturally responsive strategies into their discharge from treatment process.

1. Recommendation #1. Assign a client advocate, primary counselor, and/or knowledge about a program ombudsman immediately upon admission and assure that one-on-one time occurs often during the earliest period of treatment. This advocate needs to have been trained on the dynamics of cultural awareness, sensitivity, and responsiveness. The goals of such intense professional and peer-based supports are to constantly re-engage, re-motivate, process negative emotion, celebrate incremental progress and resolve problems that can escalate into premature service termination. One of the most crucial keys to increasing treatment completion rates among Black clients is the power of relationship.

2. Recommendation #2. Create a feedback loop between discharge processes and assessment and admission processes to determine the extent to which administrative discharges, clients leaving against staff advice, and transfers to other programs result from inadequate assessment, inappropriate admission, or level of care misplacement. Reducing failure to complete rates is likely contingent upon improving front-end assessment and placement decisions. Failure to consider alternatives to in-client/residential care and forcing such high intensity levels of care when Black clients present legitimate needs to remain in their homes (e.g., caretaking responsibilities) often contributes to early treatment cessation. Developing more nuanced screening and assessment tools and more clinically flexible decision trees for admission/placement could potentially lower treatment termination and administrative discharge rates among Black client populations.

g. Referrals

Clients from various racial, ethnic, and cultural populations seeking behavioral health services may face additional obstacles that can interfere with or prevent access to treatment and ancillary

services, compromise appropriate referrals, impede compliance with treatment recommendations, and produce poorer treatment outcomes. This has been especially true for Black clients. Case management provides a single professional contact through which clients gain access to a range of services. For Black clients, case managers can be critical in gaining access to the things they need to maintain the improved behavioral and psychological function they achieve as a result of their treatment.

The goal of case management is to help assess the need for and coordinate social, health, and other essential services for each client. Case management can be an immense help during treatment and recovery for a person that faces significant obstacles in getting their basic needs met. Case management focuses on the needs of individual clients and their families and anticipates how those needs will be affected as treatment proceeds. The case manager advocates for the client easing the way to effective treatment by assisting the client with critical aspects of life (e.g., food, childcare, employment, housing, legal problems). Like counselors, case managers should possess self-knowledge and basic knowledge of other cultures, traits conducive to working well with diverse groups, and the ability to apply cultural competence in practical ways (The Case Management Society of America's Standards of Practice for Case Management, 2010).

What is crucial is that a case manager be knowledgeable regarding the principles of culturally responsive services to ensure that the agencies, programs, and or services they refer their Black clients to have demonstrated cultural respect and sensitivity. What has been lacking for African Americans, given their multiple needs is a community-based system of care that manages referrals in a way that provides accountability mechanisms for culturally competent care among all providers in the system.

h. Aftercare

African Americans appear to be responsive to continuing care participation and recovery activities associated with substance use and mental disorders, yet research is very limited. African Americans in recovery from alcohol dependence were more than twice as likely as White Americans to maintain abstinence rather than just limiting alcohol con-assumption or changing drinking patterns. African American men who had been mandated to out-client treatment by a parole or probation office found that participants assigned to a continuing care intervention were almost three times as likely to be abstinent and five times less likely to be using any drugs on a weekly basis during the 6-month follow-up period compared with those who did not receive continuing care (Brown et al. 2004). Having a menu of community supports from which Black clients can choose honors their right

to self-determination and is critically important as systemic obstacles disproportionally affect their post-treatment outcomes. The list should include both traditional and non-traditional, community-defined options. Beyond that traditional resources of housing, transportation, and social services, examples of nontraditional resources within the communities that can support Black clients behavioral and mental health:

- GED programs
- Community colleges
- Vocational schools
- Churches that provide resources and help with recovery support
- Black focused support groups within the community
- Ex-offenders in long-term recovery
- Programs that help with expungement
- Industries that have histories of hiring individuals in recovery

The Hurdle Network is an example of a private sector, culturally responsive network. (https://hurdle.co/our-approach/)

VI. Policies

We can never become truly competent in another's culture. We can demonstrate a lifelong commitment to self-evaluation and self-critique" —Minkler (2005). Journal of Urban Health

a. Governance.

In essence, policies and procedures are the backbone of an organization's implementation of culturally responsive services. By creating, reviewing, and adapting clinical and administrative policies and procedures in response to the ever-changing needs of client populations, the agency is able to provide counselors and other workers with support and the means to respond in a consistent, yet flexible, manner. What is most important as it relates to working with Black client populations is the providers Racial Equity Policy. Racial Equity Policy includes elimination of policies, practices, attitudes and cultural messages that reinforce differential outcomes by race or ethnicity. Suggested components include:

- Provide a vision of racial equity
- Justify the need for the policy
- Lead with race

- Recognize the role of partnerships
- Recognize the role of resource allocation
- Offer concrete next steps and accountability mechanisms
- Provide definitions

b. Self-Assessment

An organization must have an awareness of how it functions within the context of a multi-racial/cultural environment, evaluating operational aspects of the agency as well as staff ability and competence in providing culturally congruent services to racially and ethnically diverse populations. Therefore, an agency's policies should include assessing how well it currently provides culturally responsive treatment. An honest and thorough organizational self-assessment can serve as a blueprint for the cultural competence plan and as a benchmark to evaluate progress across time (other workers with support and the means to respond in a consistent, yet flexible, manner. The toolkit will eventually provide a list of recommendations for both instruments and strategies for assessing your agencies deficiency in cultural responsiveness as it relates to working with Black client populations as well as creating a corrective action plan.

c. Staff Recruitment, Retention, and Promotion

To determine whether it adequately reflects the population it serves, an organization has to assess its personnel, including counselors, administrators, and board of directors. According to a 10-year study that collected data on treatment admissions, racial and ethnic composition of treatment populations has not significantly changed. Racially diverse groups (excluding non-Latino Whites) represent approximately 40 percent of treatment admissions (Substance Abuse and Mental Health Services Administration [SAMHSA] 2011c), yet 80 percent of counselors are non-Latino Whites (Duffy et al. 2004). In striving to improve cultural responsiveness, staff composition should be a major strategic planning consideration. As much as possible, the staff should mirror the client population. This toolkit will provide strategies to increase Black staff recruitment, retention, and promotion which are an important part of an agency being culturally response to its Black client's populations.

d. Training

A critically important culturally responsive policy is training. The primary purpose of training is to increase cultural competence in the delivery of services, beginning with outreach and extending to continuing care services that support behavioral and mental health. Training

should increase staff self-awareness and cultural knowledge, review culturally responsive policies and procedures, and improve culturally responsive clinical skills (Anderson et al. 2003; Brach and Fraser 2000; Lie et al. 2011). Implicit Bias training should be "mandatory" for all employees as part of an agency's culturally responsive policy.

Implicit bias training (or unconscious bias training) programs are designed to expose people to their implicit biases, provide tools to adjust automatic patterns of thinking, and ultimately eliminate discriminatory behaviors. The organization should be prepared to do this and offer relevant professional development experiences consistent with counselors' personal goals and assigned responsibilities as well as the organization's goals for culturally responsive services. Board members, volunteers, and stakeholders should all receive appropriate training.

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