

6 Drug Cultures and the Culture of Recovery

IN THIS CHAPTER

- What Are Drug Cultures?
- The Role of Drug Cultures in Substance Abuse Treatment

Lisa is a 19-year-old White college student living in San Diego, CA, who was sent to treatment by her parents after failing her college classes and being placed on academic probation. While home on break earlier that year, her parents found pills in her room but let her return to school after she promised to stop using. The academic probation is only part of the reason her parents sent her to treatment. They were also concerned about her recent weight loss, as her older sister had previously struggled with bulimia.

Lisa began using marijuana at age 15 with a cousin. In her first year of high school, she had difficulty fitting in. However, the next year, she became friendly with an electronic dance music clique that helped her define an identity for herself and introduced her to ecstasy (3,4-methylenedioxymethamphetamine, or MDMA), methamphetamine, and various hallucinogens, along with new ideas about politics, music, and art. She has since found similar friends at college and keeps in touch with several members of her high school clique.

In treatment, Lisa tells her counselor that she has long felt neglected by her parents, who are too interested in material things. She sees her drug use and that of her friends as a rebellion against the materialistic attitudes of their parents. She also dismisses her family's cultural heritage, insisting that her parents only identify as Americans even though they are first-generation Americans with European backgrounds. She talks at length about ways to acquire and prepare relatively unknown hallucinogens, the best music to listen to while using, and how to evaluate the quality of marijuana.

Lisa says that she doesn't believe she has a problem. She thinks that her failing grades reflect her lack of interest in college, which she says she is attending only because people expect it of her. When asked what she would rather be doing, she says she does not have any clearly defined goals and just wants to do "something with art

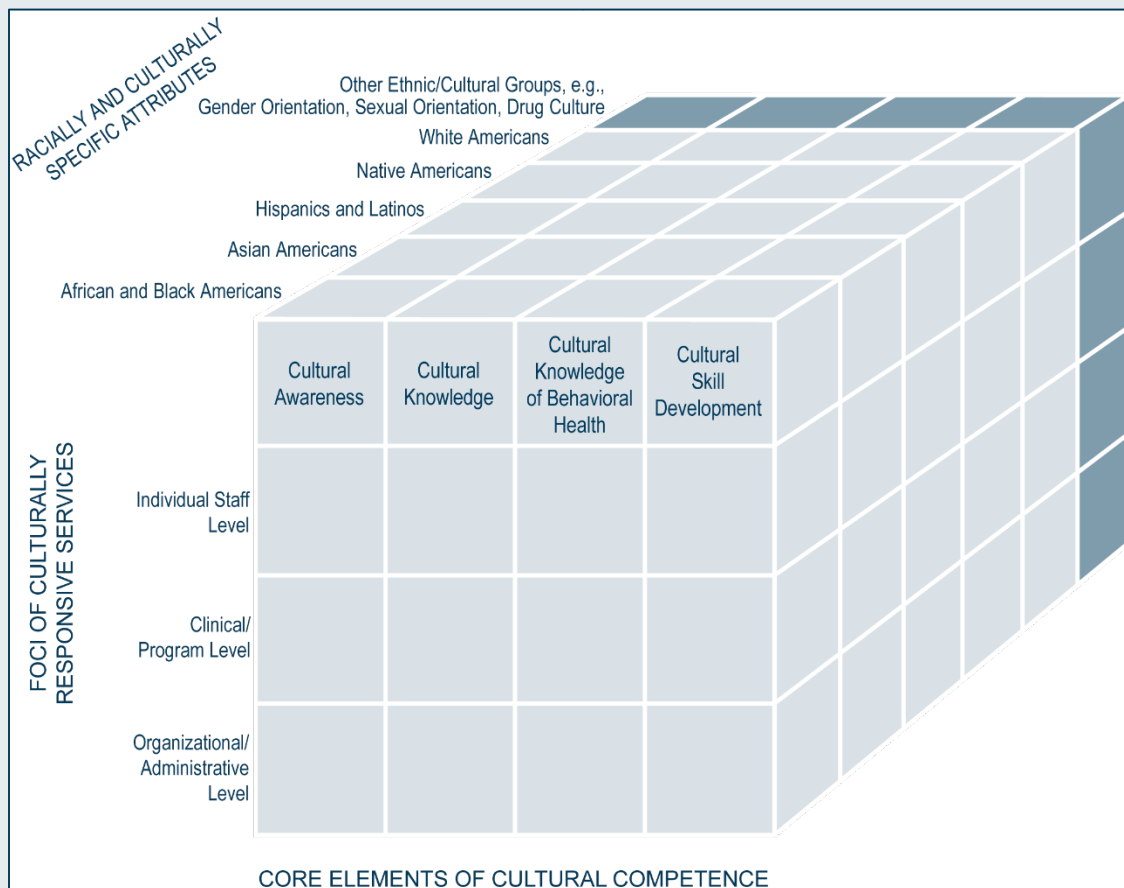
This Treatment Improvement Protocol (TIP) emphasizes the concept that many subcultures exist within and across diverse ethnic and racial populations and cultures. Drug cultures are a formidable example—these are cultures that can influence the presentation of mental, substance use, and co-occurring disorders as well as prevention and treatment strategies and outcomes.

or music.” Lisa points out that, unlike most of her classmates, she doesn’t drink and has stopped doing addictive drugs like ecstasy and methamphetamine, which were responsible for her weight loss. She is convinced that she can continue to smoke pot and *Salvia divinorum*,

which she notes “isn’t even illegal,” and take other botanical hallucinogens. She is adamant about keeping her friends, who she says have been supportive of her and are not materialistic “sellouts” like her parents.

Her counselor places a priority on connecting Lisa with other people her age who are in recovery. She asks a client who graduated from the program and is only a year older than Lisa to accompany her to Narcotics Anonymous (NA) meetings attended mostly by younger people in recovery. The counselor also encourages Lisa’s friendships with other young people in the program. When Lisa complains about her parents’ materialism and the materialism of mainstream culture, her counselor brings up the spiritual elements of mutual-help recovery groups and how they provide an

Multidimensional Model for Developing Cultural Competence: Drug Cultures



alternative model for interacting with others. The counselor begins to help Lisa explore how her drug use may be an attempt to fill her unmet emotional and social needs and may hinder the development of her own interests, identity, and goals.

Treatment providers should consider how cultural aspects of substance use reinforce substance use, substance use disorders, and relapses. Factors to note include clients' possible self-medication of psychological distress or mental disorders. Beyond specific biopsychosocial issues that contribute to the risk of substance-related disorders and the initiation and progression of use, counselors and treatment organizations must continually acquire knowledge about the ever-changing, diverse drug cultures in which client populations may participate and which reinforce the use of drugs and alcohol. Moreover, behavioral health service providers and program administrators need to translate this knowledge into clinical and administrative practices that address and counter the influence of these cultures within the treatment environment (e.g., by instituting policies that ban styles of dress that indicate affiliation with a particular drug culture).

Adopting Sue's multidimensional model (2001) for developing cultural competence, this chapter identifies drug cultures as a domain that requires proficiency in clinical skills, programmatic development, and administrative practices. It explores the concept of drug cultures, the relationship between drug cultures and mainstream culture, the values and rituals of drug cultures, and how and why people value their participation in drug cultures. This chapter describes how counselors can determine a client's level of involvement in a drug culture, how they can help clients identify and develop alternatives to the drug cultures in which they participate, and the importance of assisting clients in developing a culture of recovery.

What Are Drug Cultures?

Up to this point, this TIP has focused on cultures based on ethnicity, race, language, and national origin. The TIP looks primarily at those cultural groups because they are the major cultural forces that shape an individual's life and worldview. However, there are other types of cultural groups (sometimes referred to as subcultures) that are also organized around shared values, beliefs, customs, and traditions; these cultural groups can have, as their core organizing theme, such factors as sexuality, musical styles, political ideologies, and so on. For most clients in treatment for substance use disorders (including those who have a co-occurring mental disorder), the drug subculture will likely have affected their substance use and can affect their recovery; that is the primary rationale for the development of this unique chapter. Research literature in this topic area is considerably limited.

Some people question whether a given drug culture is in fact a subculture, but many seem to have all the elements ascribed to a culture (see Chapter 1). A drug culture has its own history (pertaining to drug use) that is usually orally transmitted. It has certain shared values, beliefs, customs, and traditions, and it has its own rituals and behaviors that evolve over time. Members of a drug culture often share similar ways of dressing, socialization patterns, language, and style of communication. Some even develop a social hierarchy that gives different status to different members of the culture based on their roles within that culture (Jenkot 2008). As with other cultures, drug cultures are localized to some extent. For example, people who use methamphetamines in Hawaii and Missouri could share certain attitudes, but they will also exhibit regional differences. The text boxes in this chapter offer examples of the distinct values, languages,

rituals, and types of artistic expression associated with particular drug cultures.

Many subcultures exist outside mainstream society and thus are prone to fragmentation. A single subculture can split into three or four related subcultures over time. This is especially true of drug cultures, in which people use different substances, are from different locales, or have different socioeconomic statuses; they may also have very different cultural attitudes related to the use of substances. Bourgois and Schonberg (2007) described how ethnic and racial differences can affect the drug cultures of users of the same drugs to the point that even such things as injection practices can differ between Black and White heroin users in the same city. Exhibit 6-1 lists some of the ways in which drug cultures can differ from one another.

Differences in the physiological and psychological effects of drugs account for some differences among drug cultures. For example, the drug culture of people who use heroin is typically less frenetic than the drug culture involving methamphetamine use. However, other differences seem to be more clearly related to the historical development of the culture itself or to the effects of larger social forces. Cultural and socioeconomic components contributed to the rise in methamphetamine use among gay men on the West Coast (Reback 1997) and among Whites of lower socioeconomic status in rural Missouri (Topolski and Anderson-Harper 2004). However, in these two cases, the details of those

Exhibit 6-1: How Drug Cultures Differ

- There is overlap among members, but drug cultures differ based on substance used—even among people from similar ethnic and socioeconomic backgrounds. The drug culture of heroin use (McCoy et al. 2005; Pierce 1999; Spunt 2003) differs from the drug culture of ecstasy use (Reynolds 1998).
- Drug cultures differ according to geographic area; people who use heroin in the Northeast United States are more likely to inhale than inject the drug, whereas the opposite is true among people in the Western United States who use heroin (Office of Applied Studies [OAS] 2004).
- Drug cultures can differ according to other social factors, such as socioeconomic status. The drug culture of young, affluent people who use heroin can occasionally mirror the drug culture of the street user, but it will also have notable differences (McCoy et al. 2005; Pierce 1999; Spunt 2003).
- Drug cultures (even involving the same drugs and the same locales) change over time; older people from New York who use heroin and who entered the drug culture in the 1950s or 1960s feel marginalized within the current drug scene, which they see as promoting a different set of values (Anderson and Levy 2003).

change factors are quite different. In Missouri, the low cost and easy production of the drug influenced development of a methamphetamine drug culture. Missouri leads the nation in the number of methamphetamine labs seized by police; a disproportionately large number of seizures occur in rural areas (Carbone-Lopez et al. 2012; Topolski and Anderson-Harper 2004). The popularity of the drug among

How To Identify Key Characteristics of a Drug Culture

Counselors and clinical supervisors must acquire knowledge about drug cultures represented within the client population. Drug cultures can change rapidly and vary across racial and ethnic groups, geographic areas, socioeconomic levels, and generations, so staying informed is challenging. Besides needing an understanding of current drug cultures (to help prevent infiltration of related behaviors and attitudes within the treatment environment), counselors also need to help clients understand how such cultures support use and pose dynamic relapse risks.

(Continued on the next page.)

How To Identify and Discuss Key Characteristics of a Drug Culture (continued)

Counselors can use this exercise to begin to educate clients about the influence of drug cultures and help them identify the specific behaviors, values, and attitudes that constitute their experience of using alcohol and drugs. It can be a helpful tool in improving clients' understanding of the reinforcing aspects of alcohol and drug use beyond physiological effects. In addition, this exercise can be used as a training tool in clinical supervision to help counselors understand the influence and potential reinforcing qualities of a drug culture among clients and within the treatment milieu.

Materials needed: Diagram handout and pencils.

Instructions:

- Determine whether this exercise is more appropriate as an individual or group exercise. Assess the newness and variability of recovery within the group constellation. If several group members support recovery-related behavior, conducting this exercise may be a beneficial educational tool and means of intervention with clients who continue to identify mainly with their drug culture. Conversely, if most group members are new or have had difficulty accepting treatment or treatment guidelines, this exercise may be more aptly used as an individual tool.
- Attention: In group settings, strict parameters need to be established at the beginning of the session to ensure that the discussion remains centered on attitudes, values, and behaviors surrounding drug and alcohol use—not on specific techniques or procedures for using drugs or rituals surrounding intake or injection.
- Start the discussion by first presenting the idea that drug cultures exist—describing the main elements that constitute culture (refer to Chapter 1 or the categories identified in the “Drug Culture” diagram below). Next, provide examples of how drug culture can support continued use and relapse. Keep in mind that not all clients are engaged in a drug culture.
- Following the general introduction, review each block in the diagram and ask clients to provide examples related to their own use and involvement with drugs and alcohol. After discussing their examples, ask them to identify the most significant behaviors, attitudes, and values that reinforce their use (e.g., a feeling of acceptance or camaraderie).
- Counselors can redirect this general discussion to related topics—for example, by identifying behaviors, values, and attitudes likely to support recovery or by shifting from discussion to role-plays that will help clients address relapse risks associated with their drug culture and practice coping skills (e.g., assertiveness or refusal skills to counter the influence of others once they are discharged from the program or to address situations that arise during the course of treatment).

Drug Culture		
<p>Establishing Trust and Credibility <i>How do you go about establishing credibility?</i></p>	<p>Socialization <i>How were you introduced to the culture?</i></p>	<p>Values <i>What values are upheld or devalued in the group?</i></p>
<p>Status <i>In what ways can you obtain status or be seen as a success?</i></p>	<p>Rules <i>Are there spoken and unspoken rules or norms?</i></p>	<p>Gender Roles and Relationships <i>What gender expectations exist surrounding drug use?</i></p>
<p>Concepts of Sanction, Punishment, and Conflict Mediation <i>How does the group deal with in-group conflicts?</i></p>	<p>Symbols and Images <i>Are there symbols that represent a particular association with a group or substance?</i></p>	<p>Dress <i>Are there specific ways to dress that show allegiance to a specific substance or group?</i></p>
<p>View of Past, Present, and Future <i>Are there specific beliefs about the past, present, and/or future?</i></p>	<p>Language & Communication <i>Are there special verbal or nonverbal ways to communicate about substance-related activities?</i></p>	<p>Attitudes <i>What are common attitudes toward others (nonusers, police, etc.)?</i></p>

Whites could be linked to the historical development of the methamphetamine trade by White motorcycle gangs (Morgan and Beck 1997). On the other hand, most gay men who use the drug report having first used it at parties with the expectation of involvement in sexual activity (Hunt et al. 2006). In studies of gay men who used methamphetamine, the main reason for use was to heighten sexual experience (Halkitis et al. 2005; Kurtz 2005; Reback 1997). Morgan and Beck (1997) found that increased sexual activity was one reason why certain women and heterosexual men used methamphetamine, but it was not as important a reason as it was for gay men.

This chapter aims to explain that people who use drugs participate in a drug culture, and further, that they value this participation. However, not all people who abuse substances are part of a drug culture. White (1996) draws attention to a set of individuals whom he calls “acultural addicts.” These people initiate and sustain their substance use in relative isolation from other people who use drugs. Examples of acultural addicts include the medical professional who does not have to use illegal drug networks to abuse prescription medication, or the older, middle-class individual who “pill

shops” from multiple doctors and procures drugs for misuse from pharmacies. Although drug cultures typically play a greater role in the lives of people who use illicit drugs, people who use legal substances—such as alcohol—are also likely to participate in such a culture (Gordon et al. 2012). Drinking cultures can develop among heavy drinkers at a bar or a college fraternity or sorority house that works to encourage new people to use, supports high levels of continued or binge use, reinforces denial, and develops rituals and customary behaviors surrounding drinking. In this chapter, drug culture refers to cultures that evolve from drug and alcohol use.

The Relationship Between Drug Cultures and Mainstream Culture

To some extent, subcultures define themselves in opposition to the mainstream culture. Subcultures may reject some, if not all, of the values and beliefs of the mainstream culture in favor of their own, and they will often adapt some elements of that culture in ways quite different from those originally intended (Hebdige 1991; Issitt 2009; Exhibit 6-2). Individuals often identify with subcultures—such as drug cultures—because they feel excluded from or

Exhibit 6-2: The Language of a Drug Culture

One of the defining features of any culture is the language it uses; this need not be an entire language, and may simply comprise certain jargon or slang and a particular style of communication. The use of slang regarding drugs and drug activity is a well-recognized aspect of drug culture. Not as well-known is the diversity of that language and how it varies across time and place. Rather than coining new words, the language of drug culture often borrows words from mainstream culture and adapts them to new purposes.

For example, Williams (1992) examined the use of Star Trek terminology among people who used crack cocaine in New York during the 1980s. They adopted the persona of members of the Star Trek Enterprise crew in their use of language—such as “going on a mission” when they went looking for cocaine; “beam me up, Scotty” when they wanted to get high; and referring to crack cocaine itself as “Scotty.” Crack cocaine users even created an imaginary book entitled *The Book of Tech* that they referred to as if it contained important information for people who use and sell crack cocaine (e.g., how to cook freebase cocaine from cocaine hydrochloride). This language (and other terms derived from other sources) helped members of this drug culture recognize other members. People who did not understand the terms used were typically taken advantage of during drug transactions.

unable to participate in mainstream society. The subculture provides an alternative source of social support and cultural activities, but those activities can run counter to the best interests of the individual. Many subcultures are neither harmful nor antisocial, but their focus is on the substance(s) of abuse, not on the people who participate in the culture or their well-being.

Mainstream culture in the United States has historically frowned on most substance use and certainly substance abuse (Corrigan et al. 2009; White 1979, 1998). This can extend to legal substances such as alcohol or tobacco (including, in recent years, the increased prohibition against cigarette smoking in public spaces and its growing social unacceptability in private spaces). As a result, mainstream culture does not—for the most part—have an accepted role for most types of substance use, unlike many older cultures, which may accept use, for example, as part of specific religious rituals. Thus, people who experiment with drugs in the United States usually do so in highly marginalized social settings, which can contribute to the development of substance use disorders (Wilcox 1998). Individuals who are curious about substance use, particularly young people, are therefore more likely to become involved in a drug culture that encourages excessive use and experimentation with other, often stronger, substances (for a review of intervention strategies to reduce discrimination related to substance use disorders, see Livingston et al. 2012).

When people who abuse substances are marginalized, they tend not to seek access to mainstream institutions that typically provide sociocultural support (Myers et al. 2009). This can result in even stronger bonding with the drug culture. A marginalized person's behavior is seen as abnormal even if he or she attempts to act differently, thus further reducing the

chances of any attempt to change behavior (Cohen 1992). The drug culture enables its members to view substance use disorders as normal or even as status symbols. The disorder becomes a source of pride, and people may celebrate their drug-related identity with other members of the culture (Pearson and Bourgois 1995; White 1996). Social stigma also aids in the formation of oppositional values and beliefs that can promote unity among members of the drug culture (Exhibit 6-3).

When people with substance use disorders experience discrimination, they are likely to delay entering treatment and can have less positive treatment outcomes (Fortney et al. 2004; Link et al. 1997; Semple et al. 2005). Discrimination can also increase denial and step up the individual's attempts to hide substance use (Mateu-Gelabert et al. 2005). The immorality that mainstream society attaches to substance use and abuse can unintentionally serve to strengthen individuals' ties with the drug culture and decrease the likelihood that they will seek treatment.

The relationship between the drug and mainstream cultures is not unidirectional. Since the beginning of a definable drug culture, that culture has had an effect on mainstream cultural institutions, particularly through music (Exhibit 6-4), art, and literature. These connections can add significantly to the attraction a drug culture holds for some individuals (especially the young and those who pride themselves on being nonconformists) and create a greater risk for substance use escalating to abuse and relapse.

Understanding Why People Are Attracted to Drug Cultures

To understand what an individual gains from participating in a drug culture, it is important first to examine some of the factors involved

Exhibit 6-3: The Values and Beliefs of a Heroin Culture

Many core values of illicit drug cultures involve rejecting mainstream society and its cultural values. Stephens (1991) analyzed value statements from people addicted to heroin and extracted the core tenets of this drug culture's value system. They are:

- Antisocial viewpoint—Members of this drug culture share a viewpoint that sees all people as basically dishonest and egocentric; they are especially distrustful of those who do not use heroin.
- Rejection of middle-class values—Members denigrate values such as the need for hard work, security, and honesty.
- Excitement/hedonism—Members value immediate gratification and the intense pursuit of pleasure over more stable and lasting values.
- Importance of outward appearances—As much as members of the drug culture may complain about the mainstream culture's shallowness, they strongly believe in conspicuous consumption and the importance of owning things that give an image of prosperity.
- Valence of street addict subcultures—Members of this drug culture value the continued participation of others in the culture, even to the point of expecting individuals who have stopped using to continue to participate in the culture.
- Emotional detachment—People involved in this drug culture value emotional aloofness and see emotional involvement with others as a weakness.

These core values (initially examined by Stephens et al. 1976) were taken from a specific drug culture (heroin), but they can be found in many other drug cultures that center on the use of illicit drugs. However, these same values will not be upheld in every drug culture. For instance, the drug culture of people who use MDMA does not appear to value emotional aloofness, but rather to appreciate the drug's ability to create a feeling of emotional intimacy among those who use it (Gourley 2004; Reynolds 1998). Drug cultures involving legal substances (notably alcohol) are less likely to reject the core values of mainstream society and are less likely to be rejected by that society. They will, however, still value excitement/hedonism and the participation of others in the subculture.

Exhibit 6-4: Music and Drug Cultures

Since the 1920s, when marijuana use became associated with jazz musicians, there has been a connection between certain music subcultures and particular types of substance use (Blake 2007; Gahlinger 2001). As Blackman (1996) notes, "Before the emergence of post-war youth culture, there was a direct connection between the development of the popular music—jazz—and the use of illicit drugs in terms of musicians who used drugs, including heroin, cocaine, and cannabis and their narratives about these drugs through songs" (p. 137). Early Federal legislation criminalizing marijuana was motivated, in part, by use of the drug by jazz musicians and fear that their example would influence youth (Whitebread 1995).

In recent years, the link between drug culture and music has been exemplified by the importance of MDMA in the rave music scene (Kotarba 2007; Murguia et al. 2007). Reynolds (1998) credits the development of rave music to MDMA's ability to create a feeling of intimacy among relative strangers and the way in which people who use it respond to repetitive, up-tempo music. Conversely, Adlaf and Smart (1997) found that adolescents in Canada typically became involved in the rave music scene after starting to use MDMA and other drugs. Regardless of how the relationship developed, MDMA and rave music are so closely linked that it is hard to tell where the music culture ends and the drug culture begins.

Blackman (1996) states that drug use has become an essential element of youth culture mainly through its association with musical artists. Similarly, Knutagard (1996) observes how different youth cultures, each defined in part by its members' choices in music and substance use, have made some types of substance use acceptable to many young people. Esan (2007) notes that urban music and drug

Exhibit 6-4: Music and Drug Cultures (continued)

culture have a shared appeal to young people based on their apparently antagonistic relationship to mainstream culture. Since the 1990s, rock group confessional memoirs have become increasingly popular, often depicting a lifestyle and culture of excess and providing explicit details of drug use and methods; consumption-driven, high-risk, or excessive behaviors; tragic consequences of use; and, sometimes, the author's participation in rehabilitation (Oksanen 2012).

Certain drugs and the drug-dealing lifestyle are featured prominently in different types of music, including hip hop (Esan 2007; Schensul et al. 2000) or *narcocorridos* (a popular form of Mexican and Mexican American border music that tells of the lives of drug traffickers [Edberg 2004]). However, even music that is not overtly concerned with drug use can become connected to a drug culture or to substance use in an individual's mind. According to White (1996), links between particular songs and the recall of euphoric drug experiences are especially common and may need to be addressed explicitly in treatment. Hearing these songs can act as a trigger for drug use and can, therefore, be a potential cause of relapse.

in substance use and the development of substance use disorders. Despite having differing theories about the root causes of substance use disorders, most researchers would agree that substance abuse is, to some extent, a learned behavior. Beginning with Becker's (1953) seminal work, research has shown that many commonly abused substances are not automatically experienced as pleasurable by people who use them for the first time (Fekjaer 1994). For instance, many people find the taste of alcoholic beverages disagreeable during their first experience with them, and they only learn to experience these effects as pleasurable over time. Expectations can also be important among people who use drugs; those who have greater expectancies of pleasure typically have a more intense and pleasurable experience. These expectancies may play a part in the development of substance use disorders (Fekjaer 1994; Leventhal and Schmitz 2006).

Additionally, drug-seeking and other behaviors associated with substance use have a reinforcing effect beyond that of the actual drugs. Activities such as rituals of use (Exhibit 6-5), which make up part of the drug culture, provide a focus for those who use drugs when the drugs themselves are unavailable and help them shift attention away from problems they might otherwise need to face (Lende 2005).

Drug cultures serve as an initiating force as well as a sustaining force for substance use and abuse (White 1996). As an initiating force, the culture provides a way for people new to drug use to learn what to expect and how to appreciate the experience of getting high. As White (1996) notes, the drug culture teaches the new user "how to recognize and enjoy drug effects" (p. 46). There are also practical matters involved in using substances (e.g., how much to take, how to ingest the substance for strongest effect) that people new to drug use may not know when they first begin to experiment with drugs. The skills needed to use some drugs can be quite complicated, as shown in Exhibit 6-6.

The drug culture has an appeal all its own that promotes initiation into drug use. Stephens (1991) uses examples from a number of ethnographic studies to show how people can be as taken by the excitement of the drug culture as they are by the drug itself. Media portrayals, along with singer or music group autobiographies, that glamorize the drug lifestyle may increase its lure (Manning 2007; Oksanen 2012). In buying (and perhaps selling) drugs, individuals can find excitement that is missing in their lives. They can likewise find a sense of purpose they otherwise lack in the daily need to seek out and acquire drugs. In successfully navigating the difficulties of living as a person

Exhibit 6-5: The Rituals of Drug Cultures

Several authors have noted that illicit drug use and alcohol use typically involve ritualized behaviors (Alverson 2005; Carlson 2006; Carnes et al. 2004; Grund 1993; White 1996). The rituals of substance use affect where, when, and how substances are used. Substance-related rituals serve both instrumental and social functions. Instrumental functions include maximizing drug effects, minimizing negative effects of drug use, and preventing secondary problems. Socially, the rituals display one's affiliation with the drug culture to other people and help create a sense of community within the culture. Obviously, the social function is more central to group activities than to solitary rituals.

Most drug-related social rituals involve sharing substances or sharing the experience of intoxication. Some drug cultures (e.g., marijuana) encourage the sharing of substances, but even when they are not shared, drugs are often used with other people who use, such as in crack houses and shooting galleries (Bourgois 1998; Grund 1993; Williams 1992). Rituals involving shared substance use and public substance use strengthen the bonds between members of a drug culture and sustain the drug culture. Some social rituals are so important to members of the drug culture that they participate in them even when they have no drugs, such as when marijuana smokers smoke an inert substance (e.g., horse manure, banana peels) together when they have no marijuana (White 1996). Drug use can also be incorporated into other ritualized behaviors, such as sexual activity (Carnes et al. 2004).

Individuals develop their own drug-related rituals through the influence of other members of the culture and also through trial and error. This allows them to determine what works best for them to maximize the drug's effect and minimize related problems. For example, Grund (1993) found, through observing the rituals surrounding the injection of cocaine and heroin among people in the Netherlands, that specific rituals governed the timing and administration of the drugs so that heroin lessened the unpleasant side effects of the cocaine. Other recent examples are the combination of energy drinks with alcohol to delay the normal onset of sleepiness (Howland and Rohsenow 2013; Substance Abuse and Mental Health Services Administration [SAMHSA] 2013c) and the combination of methylphenidate with alcohol to intensify euphoric effects (for review of central nervous system stimulant use and emergency room information, see SAMHSA 2013b).

Exhibit 6-6: Questions Regarding Knowledge and Skill Demands of Heroin Use

- If first use is by snorting, how is it done (assuming the person has never taken a drug intranasally)? Is there a special technique for using heroin this way?
- If first use is by injection, is it best to inject the drug under the skin (skin-popping) or into a vein?
- What equipment is required? If one doesn't have a hypodermic syringe, what other equipment can be substituted to make up a set of "works" or an "outfit"?
- How is heroin prepared (cooked) for injection?
- What techniques or procedures are used to inject the drug?
- What does one do if the needle clogs?
- Is there any way to test the purity of the drug?
- How much of the drug constitutes a desirable dose?
- If more than one person is using and an outfit is being shared, who uses it first?
- If sharing, how can the works be cleaned to prevent the transmission of disease?
- How does one know if he or she has injected too much?
- Are there any unpleasant side effects one should anticipate?
- How long will the effects of the drug last?
- Is there any way to maximize the drug's effects?
- Is there anything one should not do while high on the drug?
- How much time must pass before the drug can be used again?
- If a bruise or an abscess develops at the injection site, how can it be hidden and treated (without seeing a physician)?

Source: White 1996.

who uses drugs, they can gain approval from peers who use drugs and a feeling that they are successful at something.

In some communities, participation in the drug trade—an aspect of a drug culture—is simply one of the few economic opportunities available and is a means of gaining the admiration and respect of peers (Bourgois 2003; Simon and Burns 1997). However, drug dealing as a source of status is not limited to economically deprived communities. In studying drug dealing among relatively affluent college students at a private college, Mohamed and Fritsvold (2006) found that the most important motives for dealing were ego gratification, status, and the desire to assume an outlaw image.

Marginalized adolescents and young adults find drug cultures particularly appealing. Many individual, family, and social risk factors associated with adolescent substance abuse are also risk factors for youth involvement with a drug culture. Individual factors—such as feelings of alienation from society and a strong rejection of authority—can cause youth to look outside the traditional cultural institutions available to them (family, church, school, etc.) and instead seek acceptance in a subculture, such as a drug culture (Hebdige 1991; Moshier et al. 2012). Individual traits like sensation-seeking and poor impulse control, which can interfere with functioning in mainstream society, are often tolerated or can be freely expressed in a drug culture. Family involvement with drugs is a significant risk factor due to additional exposure to the drug lifestyle, as well as early learning of the values and behaviors (e.g., lying to cover for parents' illicit activities) associated with it (Haight et al. 2005). Social risk factors (e.g., rejection by peers, poverty, failure in school) can also increase young people's alienation from traditional cultural institutions. The need for social

acceptance is a major reason many young people begin to use drugs, as social acceptance can be found with less effort within the drug culture.

In addition to helping initiate drug use, drug cultures serve as sustaining forces. They support continued use and reinforce denial that a problem with alcohol or drugs exists. The importance of the drug culture to the person using drugs often increases with time as the person's association with it deepens (Moshier et al. 2012). White (1996) notes that as a person progresses from experimentation to abuse and/or dependence, he or she develops a more intense need to “seek for supports to sustain the drug relationship” (p. 9). In addition to gaining social sanction for their substance use, participants in the drug culture learn many skills that can help them avoid the pitfalls of the substance-abusing lifestyle and thus continue their use. They learn how to avoid arrest, how to get money to support their habit, and how to find a new supplier when necessary.

The more an individual's needs are met within a drug culture, the harder it will be to leave that culture behind. White (1996) gives an example of a person who was initially attracted in youth to a drug culture because of a desire for social acceptance and then grew up within that culture. Through involvement in the drug culture, he was able to gain a measure of self-esteem, change his family dynamic, explore his sexuality, develop lasting friendships, and find a career path (albeit a criminal one). For this individual, who had so much of his life invested in the drug culture, it was as difficult to conceive of leaving that culture as it was to conceive of stopping his substance use.

Online Drug Cultures

One major change that has occurred in drug cultures in recent years is the development of

How To Lead an Exercise Examining Benefits, Losses, and the Future

Counselors and clinical supervisors can help clients identify reinforcing aspects (besides physiological effects) of their drug and alcohol use and the losses associated with use, including unmet goals and dreams. The physiological, social, and emotional gains and losses that have transpired during their use (whether or not they associate these losses with their use) can serve as risks for relapse. This exercise works well as an interactive psychoeducational lecture for clients, as a training tool for counselors, and as a group counseling exercise. It can also be adapted for individual sessions.

Materials needed: Group room with sufficient space to move around.

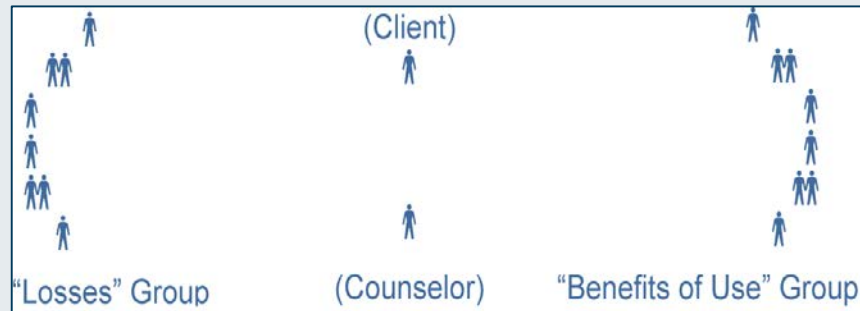
Instructions:

- Select an amenable client aware of the losses and consequences associated with his/her use. Later in the exercise, select other clients to give other group members a more direct experience.
- Divide the group in two. For large groups, select only 6 to 8 people for each side. Have each subgroup stand on opposite sides of the room facing each other. One group will represent the benefits of use; the other, losses associated with use (see diagram for room set-up).
- Rather than using the client's personal benefits and losses (at least initially), ask group members to brainstorm about their experiences that represent each side. Begin with the side of the room that represents "benefits of use" and ask everyone in the room to name some benefits. Then, assign a specific benefit to each person in the "benefits of use" group and create a one-line message for each (a first-person statement describing the benefit), asking the representative client to remember the line. For example, if the group named a benefit of use as immediate acceptance from others who use, assign this benefit to one person and create a message to capture it: "I make you feel like you belong," or "We are family now." Continue brainstorming until you have assigned six or more benefits.
- Next, go to the opposite group that represents the losses associated with use and begin to solicit losses from everyone in the room. Assign a loss to each person in the "loss" group, create a one-line message that coincides with each loss, and then ask an individual to remember each loss message (e.g., "I am the loss of your children," "I am the loss of your self-respect," "I am the loss of your health"). In addition, ask the group to name future goals and plans that were curtailed because of use. Assign these losses as well, following the same format (e.g., "I am the loss of a college degree," "I am the loss of intimate relationships," "I am the loss of belief in the future"). Note: If you run out of people, you can assign two roles to one person.
- At this point, the exercise can already be a powerful experience for many clients. Now, have the person who was originally selected as the client stand facing the "benefits of use" group. Have the client process what it is like to see the benefits of use. You can also have each person in the "benefits of use" group state his or her one-line message to help facilitate this process. Stand with the client as he or she moves to the "loss" group. Again, have the client stand and face this group while asking him or her what it is like to see the losses, including the losses related to goals and the future. Note: It is not important as an exercise to have benefits or losses specific only to this client. It is far better to gain a sample from the entire group so that everyone is involved and to maximize the exercise's effectiveness as a psychoeducational tool.
- After the client has stood in front of both groups, ask him or her to move back and forth between each group several times to see what emotional changes occur in experiencing each group. It is important to process this experience as a group. You can invite other members to switch out of their roles and stand in as clients to experience this exercise more directly. Clients are likely to see how seductive the "benefits of use" group can be and how this attraction can lead back to relapse. This exercise may also help clients connect with the losses associated with their use. At times, clients may gain awareness that the very losses associated with their use can also serve as a trigger for use as a means of self-medicating feelings.

(Continued on the next page.)

How To Lead an Exercise Examining Benefits, Losses, and the Future (continued)

- Allot sufficient time for this psychoeducational lecture—not only to demonstrate the benefits and losses associated with use, but also to enable the group to process their thoughts and feelings.

Group Room Setup

Internet communities organized around drug use (Gatson 2007a; Murguia et al. 2007) and drug use facilitation, including information on use, production, and sales (Bowker 2011; U.S. Department of Justice 2002). Such communities develop around Web sites or discussion boards where individuals can describe their drug-related experiences, find information on acquiring and using drugs, and discuss related issues ranging from musical interests to legal problems. Many of the Web sites where these online communities develop are originally created to lessen the negative consequences of substance use by informing people about various related legal and medical issues (Gatson 2007b; Murguia et al. 2007). As in other drug cultures, users of these Web sites and discussion boards develop their own language and values relating to drug use. Club drugs and hallucinogenics are the most often-discussed types of drugs, but online communities involve the discussion of all types of licit and illicit substances, including stimulants and opioids (Gatson 2007a; Murguia et al. 2007; Tackett-Gibson 2007).

Murguia et al. (2007) reported on a survey of adult (ages 18 and older) participants in one online community. The self-selected survey sample included 1,038 respondents, 80 percent

of whom were from the United States. Respondents were likely to be young (90 percent were under 30), male (76 percent), White (92 percent), relatively affluent (58 percent had household incomes of \$45,000 or more), employed (41 percent were employed full time; another 28 percent, part time), and/or in school (57 percent were attending school full or part time). According to the 2011 National Survey on Drug Use and Health, approximately 0.3 percent of individuals 12 years of age or older purchase prescription drugs through the Internet (SAMHSA, 2012b).

The Role of Drug Cultures in Substance Abuse Treatment

Most people seek some kind of social affiliation; it is one aspect of life that gives meaning to day-to-day existence. Behavioral health service providers can better understand and help their clients if they have an understanding of the culture(s) with which they identify. This understanding can be even more important when addressing the role of drug culture in a client's life because, of all cultural affiliations, it is likely to be the one most intimately connected with his or her substance

abuse. The drug culture is likely to have had a considerable influence on the client's behaviors related to substance use.

Drug Cultures in Assessment and Engagement

The first step in understanding the role a drug culture plays in a client's life is to assess which drug culture(s) the client has been involved with and his or her level of involvement. There are no textbooks that can inform providers about the drug cultures in their areas, but counselors probably know quite a bit about them already, as they learn much about drug cultures through talking with their clients. Counselors who are themselves in recovery may be familiar with some clients' substance-using lifestyles and social environments or will have insight into how to explore the issue with clients. They can also educate their colleagues.

Providers who have never personally abused substances can learn from recovered counselors as well as from their clients. However, asking a client point-blank about his or her involvement in a drug culture is likely to be answered with a blank stare. Instead, talking to

clients about their relationships, daily activities and habits relating to substance use, values, and views of other people and the world can allow providers to develop a good sense of the meanings drug cultures hold for clients.

To engage a client in treatment, understanding his or her relationship with a drug culture may be as important as understanding elements of that client's racial or ethnic identity. Clients are unlikely to self-identify as members of the drug culture in the same way that they would identify as an African American or Asian American, for example, but they can still be offended or distrustful if they think the provider or program does not understand how their lifestyle relates to their substance use. Affiliation with a drug culture is a source of client identity; the client's place in the drug culture can be important to his or her self-esteem.

After the assessment and engagement stage, the provider's attitude toward the client's participation in a drug culture will be significantly different from his or her attitude toward the client's other cultural affiliations. As most providers already know (even if they do not use the term drug culture), if a client

How To Learn About Clients' Daily Routines and Rituals

One way to gain an understanding of a client's involvement in a specific drug culture is to learn about his or her daily routines and rituals. Keep in mind that there can be different routines on weekends or specific days of the week; ask about exceptions to the typical daily schedule.

Materials needed: Weekly calendar.

Instructions:

- To elicit information about the client's daily activities, use a cue or anchor to initiate this exploration, such as a calendar highlighting each day of a week—Monday through Sunday.
- Placing the calendar in front of the client, ask him or her to describe a typical day, beginning with the time that he or she generally wakes up and building on the morning routines (e.g., "What does an average morning look like for you?").
- Encourage the client to provide a specific account of his or her routine rather than a general response. Important information can be obtained by asking the client about feelings or reactions to daily activities as they unfold in the session.
- After completing an example of an entire day, ask the client if there are exceptions to this schedule that routinely occur on another day of the week or during the weekend. Once these are processed, it can be beneficial to ask what it was like for him or her to talk about these daily routines.

“The culture of recovery is an informal social network in which group norms (prescribed patterns of perceiving, thinking, feeling, and behaving) reinforce sobriety and long-term recovery from addiction.”

(White 1996, p. 222)

continues to be closely affiliated with the drug-using life, then he or she is more likely to relapse. The people, places, things, thoughts, and attitudes related to drug and/or alcohol use act as triggers to resume use of substances. Behavioral health service providers need to help their clients weaken and eventually eliminate their connections to the drug culture. White (1996) identifies an important issue to address during transition from engagement to treatment—in the process of engaging clients, providers help them identify how their connections to the drug culture prevent them from reaching their goals and how the loss of these connections would affect them if they chose to cut ties with the drug culture.

Finding Alternatives to Drug Cultures

A client can meet the psychosocial needs previously satisfied by the drug culture in a number of ways. Strengthening cultural identity can be a positive action for the client; in some cases, the client’s family or cultural peers can serve as a replacement for involvement in the drug culture. This option is particularly helpful when the client’s connection to a drug culture is relatively weak and his or her traditional culture is relatively strong. However, when this option is unavailable or insufficient, clinicians must focus on replacing the client’s ties with the drug culture (or the culture of addiction) with new ties to a culture of recovery.

To help clients break ties with drug cultures, programs need to challenge clients’ continued involvement with elements of those cultures

(e.g., style of dress, music, language, or communication patterns). This can occur through two basic processes: replacing the element with something new that is positively associated with a culture of recovery (e.g., replacing a marijuana leaf keychain with an NA keychain), and reframing something so that it is no longer associated with drug use or the drug culture (e.g., listening to music that was associated with the drug culture at a sober dance with others in recovery; White 1996). The process will depend on the nature of the cultural element.

Developing a Culture of Recovery

Just as people who are actively using or abusing substances bond over that common experience to create a drug culture that supports their continued substance use, people in recovery can participate in activities with others who are having similar experiences to build a culture of recovery. There is no single drug culture; likewise, there is no single culture of recovery. However, large international mutual-help organizations like Alcoholics Anonymous (AA) do represent the culture of recovery for many individuals (Exhibit 6-7). Even within such organizations, though, there is some cultural diversity; regional differences exist, for example, in meeting-related rituals or attitudes toward certain issues (e.g., use of prescribed psychotropic medication, approaches to spirituality).

The planned TIP, *Relapse Prevention and Recovery Promotion in Behavioral Health Services* (SAMHSA planned e), provides more information on using mutual-help groups in

Recovery from mental and substance use disorders is a process of change through which people improve their health and wellness, live in a self-directed manner, and work toward achieving their full potential.

(SAMHSA 2011b)

treatment settings and in long-term recovery. It contains detailed information about potential recovery supports that behavioral health programs can use to foster cultures of recovery among clients and program graduates.

Most treatment programs try to foster a culture of recovery for their clients. Some modalities, with therapeutic communities being the lead example, focus on this issue as a primary treatment strategy. Even one-on-one outpatient treatment programs typically encourage attendance at mutual-help groups, such as AA, to meet sociocultural recovery needs. Most providers also recognize that clients need to

replace the activities, beliefs, people, places, and things associated with substance abuse with new recovery-related associations—the central purpose of creating a culture of recovery.

Even programs that already recognize the need to create a culture of recovery for their clients can make doing so more of a focus in treatment. White (1996) explores ways to do this, including:

- Teaching clients about the existence of drug cultures and their potential influence in clients' lives.
- Teaching clients about cultures of recovery and discussing how elements of the drug

Exhibit 6-7: 12-Step Group Values and the Culture of Recovery

For historical reasons, cultures of recovery (like the recovery process in general) in the United States have been greatly influenced by 12-Step groups such as AA and NA (White 1998). These groups provide a clearly defined culture of recovery for a great many people. They provide members with a set of rituals, daily activities, customs, traditions, values, and beliefs.

The 12 Steps and 12 Traditions represent the core principles, values, and beliefs of such groups. Wilcox (1998) defines these values as surrender; faith; acceptance, tolerance, and patience; honesty, openness, and willingness; humility; willingness to examine character defects; taking life one day at a time; and keeping things simple. As seen by comparing these values with those common to the heroin culture described in the "The Values and Beliefs of a Heroin Culture" box earlier in this chapter, one of the ways in which 12-Step groups work is by instilling a set of values contrary to those found in drug cultures. However, they also provide members with a new set of values that are in some ways distinct from the values of the mainstream culture that were rejected when the individual began his or her involvement in the drug culture (Wilcox 1998).

Many of the values of AA and other 12-Step groups are embodied in rituals that take place in meetings and in members' daily lives. White (1998) lists four ritual categories:

- **Centering rituals** help members stay focused on recovery by reading recovery literature, handling recovery tokens or symbols, and taking regular self-assessments or personal inventories each day.
- **Mirroring rituals** keep members in contact with one another and help them practice sober living together. Attending meetings, telling one's story, speaking regularly by phone, and using slogans (e.g., "keep it simple," "pass it on"), among others, are mirroring activities.
- **Acts of personal responsibility** include being honest and becoming time-conscious and punctual. Activities include the creation of new rituals of daily living related to sleeping, hygiene, and other areas of self-care while also being reliable and courteous.
- **Acts of service** involve performing rituals to help others in recovery. These acts are related to the Twelfth Step, which directs members to carry the message of their spiritual awakening to others who abuse alcohol or are dependent on it, thereby encouraging them to practice the 12 Steps. Acts of service recognize that people in recovery have something of value to offer those still abusing alcohol.

These rituals aid the processes of personal transformation and integration into a new cultural group.

culture can be replaced by elements of a culture of recovery.

- Establishing clear boundaries for appropriate behavior (e.g., behavior that does not reflect drug cultures) in the program and consistently correcting behaviors that violate boundaries (e.g., wearing shirts depicting pot leaves; displaying gang-affiliated symbols, gestures, and tattoos).
- Working to shape a peer culture within the program so that longer-term clients and staff members can socialize new clients to a culture of recovery.
- Having regular assessments of clients and the entire program in which staff members and clients determine areas where work is needed to minimize cultural attitudes that can undermine treatment.
- Involving clients' families (when appropriate) in the treatment process so they can support clients' recovery as well as participate in their own healing process.

White (1996) suggests that programs build linkages with mutual-help groups; include mutual-help meetings in their programs or provide access to community mutual-help meetings; and include mutual-help rituals, symbols, language, and values in treatment processes.

Other activities that can improve integration into a recovery culture include SAMHSA's Recovery Community Services Program (http://www.samhsa.gov/grants/2011/ti_11_04.aspx), which was developed to provide and evaluate peer-based recovery support services, and Recovery Community Centers, which provide space for recovering people to socialize, organize, and develop a recovery culture (White and Kurtz 2006). Developing a culture

of recovery involves connecting individuals back to the larger community and to their cultures of origin (Davidson et al. 2008). This can require efforts to educate the community about recovery as well (e.g., by promoting a recovery month in the community, hosting recovery walks or similar events, or offering outreach to community groups, such as churches or fraternal/benevolent societies).

Programs that do not have a plan for creating a culture of recovery among clients risk their clients returning to the drug culture or holding on to elements of that culture because it meets their basic and social needs. In the worst case scenario, clients will recreate a drug culture among themselves within the program. In the best case, staff members will have a plan for creating a culture of recovery within their treatment population.

SAMHSA's Guiding Principles of Recovery

- Recovery emerges from hope.
- Recovery is person driven.
- Recovery occurs via many pathways.
- Recovery is holistic.
- Recovery is supported by peers and allies.
- Recovery is supported through relationship and social networks.
- Recovery is culturally based and influenced.
- Recovery is supported by addressing trauma.
- Recovery involves individual, family, and community strengths and responsibility.
- Recovery is based on respect.

More information on the Guiding Principles of Recovery is available at the SAMHSA Store (<http://store.samhsa.gov/shin/content//PEP12-RECDEF/PEP12-RECDEF.pdf>).

Source: SAMHSA 2012c.

Appendix A—Bibliography

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Appendix B—Instruments To Measure Identity and Acculturation

Some researchers have tested the usefulness of acculturation and identity models with people who abuse substances. For example, Peña and colleagues' racial identity attitude scale was found, in a study of African American men in treatment for cocaine dependence, to help counselors better understand the roles that ethnic and cultural identity play in clients' substance abuse issues (Peña et al. 2000). In 1980, Cuellar and colleagues published their acculturation rating scale for Mexican Americans, which conceptualized acculturation as progressing across a 5-point continuum ranging from Mexican or low acculturated (level 1) to American or high acculturated (level 5). The mid-level designation of bicultural (level 3) was set as the midpoint between the two extremes, although various investigators have questioned this assumption (Oetting and Beauvais 1990; Sayegh and Lasry 1993). Since then, scholars have developed new ways to conceptualize identity and acculturation, ranging from simple scales to

complex multidimensional models (Skinner 2001). The table that begins on the next page summarizes the instruments available to measure acculturation and ethnic identity. (See also the Center of Excellence for Cultural Competence for additional resources at <http://nyculturalcompetence.org>).

Other scales have been developed to examine specific culture-related variables, including *machismo* (Cuellar et al. 1995; Fragoso and Kashubeck 2000), *simpatía* (Griffith et al. 1998), *familismo* (Sabogal et al. 1987), traditionalism–modernism (Ramirez 1999), and family traditionalism and rural preferences (Castro and Gutierrez 1997). Counselors can use acculturation scales to help match patients to providers, to make treatment plans, and to identify the role of identity in substance abuse. Although these instruments can be helpful, the counselor must not rely solely on them to determine the client's identity or level of acculturation.

Acculturation and Ethnic Identity Measures

Instrument	Description	Cultural Group
African American Acculturation Scale-Revised (Klonoff and Landrine 2000)	This scale measures eight dimensions of African American culture: (1) traditional beliefs and practices, (2) traditional family structure and practices, (3) traditional socialization, (4) preparation and consumption of traditional foods, (5) preference for African American things, (6) interracial attitudes, (7) superstitions, and (8) traditional health beliefs and practices.	African Americans
Black Racial Identity Attitude Scale—Form B (Helms 1990)	This scale measures beliefs or attitudes of Blacks toward both Blacks and Whites using 5-point scales. It is available in short and long forms.	African Americans
Cross Racial Identity Scale (Worrell et al. 2001)	This scale measures six identity clusters associated with four stages of racial identity development.	African Americans
Multidimensional Inventory of Black Identity (MIBI; Sellers et al. 1997)	The MIBI measures centrality of Black identity, ideology, and regard for a Black identity. It is available online at http://sitemaker.umich.edu/aaril/files/mibiscaleandscoring.pdf .	African Americans
Scale To Assess African American Acculturation (Snowden and Hines 1999)	This is a 10-item scale that assesses media preferences, racial bias in relationships, race-related attitudes, and comfort in interacting with other races.	African Americans
African Self-Consciousness Scale (Baldwin and Bell 1985)	This scale measures within-group variability in the level of acculturation/cultural identity continuum (Baldwin and Bell 1985) based on degree of Afrocentricity or Nigrescence (White and Parham 1996). It indicates a client's level of involvement in traditional African American culture or the core African-oriented culture.	African Americans/African Immigrants
Native American Acculturation Scale (Garrett and Pichette 2000)	The Native American Acculturation scale asks 20 questions to ascertain a client's level of involvement with Native American culture.	Native Americans
Rosebud Personal Opinion Survey (Hoffmann et al. 1985)	This assessment evaluates components of acculturation, including language use, values, social behaviors, social networks, religious affiliation and practice, home community, education, ancestry, and cultural identification.	Native Americans
Asian American Multidimensional Acculturation Scale (AAMAS; Gim Chung et al. 2004)	The AAMAS was developed to be easy to use with a variety of Asian American ethnic groups. It includes questions relating to cultural identity, language use, cultural knowledge, and food preferences.	Asian Americans

(Continued on the next page.)

Acculturation and Ethnic Identity Measures (continued)

Instrument	Description	Cultural Group
Cultural Adjustment Difficulties Checklist (CADC; Sodowsky and Lai 1997)	The CADC helps avoid potential problems relating to acculturation by asking about language use, social customs, family interactions, perceptions of prejudice, friendship networks, and cultural adjustment.	Asian Americans (East Asians)
East Asian Acculturation Measure (Barry 2001)	This instrument includes 29 items that assess assimilation, level of separation from other Asians, integration, and marginalization.	Asian Americans (East Asians)
General Ethnicity Questionnaire (GEQ; Tsai et al. 2000)	The GEQ is an instrument designed to be used with minor modifications for assessing cultural orientation with different cultural groups. There are original and abridged versions. The original includes 75 items asking about language use, social affiliations, cultural practices, and cultural identification.	Asian Americans (although designed to be multicultural in orientation)
Suinn-Lew Asian Self-Identity Acculturation Scale (Suinn et al. 1992)	This instrument was modeled after the Acculturation Rating Scale for Mexican Americans, and research indicates it has high reliability.	Asian Americans
Ethnocultural Identity Behavioral Index (Yamada et al. 1998)	This is a 19-item self-report assessment with high validity.	Asian Americans and Pacific Islanders
Internal-External Ethnic Identity Measure (Kwan 1997)	The instrument evaluates ethnic friendships and affiliation, ethnocommunal expression, ethnic food orientation, and family collectivism, in order to differentiate three Chinese American identity groups: (1) internal, (2) external, and (3) internal-external undifferentiated.	Chinese Americans
Marín and Marín Acculturation Scale (Marín et al. 1987)	This scale is a 12-item instrument that assesses three domains: (1) language use, (2) media preferences, and (3) ethnic diversity of social relations. It is available online at http://www.columbia.edu/cu/ssw/projects/pmap/docs/gupta_acculturation.pdf	Chinese Americans
Behavioral Acculturation Scale and Value Acculturation Scale (Szapocznik et al. 1978)	These two scales, used in conjunction with one another, ask individuals about behaviors and values in order to determine acculturation. If used singly, the behavioral scale is the superior measure for acculturation.	Cuban Americans
Na Mea Hawai'i (Hawaiian Ways), A Hawaiian Acculturation Scale (Rezentes 1993)	This is a 34-item scale. An adolescent version is available (Hishinuma et al. 2000).	Native Hawaiians

(Continued on the next page.)

Acculturation and Ethnic Identity Measures (continued)

Instrument	Description	Cultural Group
Abbreviated Multi-dimensional Acculturation Scale (AMAS-ZABB; Zea et al. 2003)	The AMAS-ZABB is a multidimensional, bilinear, 42-item scale that evaluates identity, language competence, and cultural competence.	Latinos
Acculturation Scale (Marin et al. 1987)	This 12-item acculturation scale, available in English and Spanish, evaluates language use, media preferences, and social activities. It is available online at http://casaa.unm.edu/inst/MARIN%20Short%20Scale.pdf	Latinos
Bicultural Involvement Questionnaire (BIQ; Szapocznik et al. 1980)	The BIQ assesses language use and involvement in both Latino and mainstream American activities. It relates two sets of scores to derive a measure of bicultural involvement, with individuals who are highly involved in both cultures scoring highest on the scale.	Latinos
The Bidimensional Acculturation Scale for Hispanics (Marin and Gamba 1996)	This 24-item scale asks questions about language use, language proficiency, and media preferences.	Latinos
Brief Acculturation Scale for Hispanics (Norris et al. 1996)	This scale has only four items, but scores on the scale have been correlated highly with generation, nativity, length of time in the United States, language preferences, and subjective perceptions of acculturation.	Latinos
Multidimensional Measure of Cultural Identity for Latinos (Felix-Ortiz et al. 1994)	This measure places adolescents in one of four categories based on language, behavior/familiarity, and values/attitudes: (1) bicultural, (2) Latino-identified, (3) American-identified, and (4) low-level bicultural.	Latinos
Acculturation Rating Scale for Mexican Americans-I (ARSMA-I; Cuellar et al. 1980)	The ARSMA-I differentiates between 5 levels of acculturation: (1) Very Mexican, (2) Mexican-Oriented Bicultural, (3) True Bicultural, (4) Anglo-Oriented Bicultural, and (5) Very Anglicized. Established validity.	Mexican Americans
Acculturation Rating Scale for Mexican Americans-II (Cuellar et al. 1995)	This scale is like the ARSMA-I, except that it includes separate subscales to measure multidimensional aspects of cultural orientation toward Mexican and Anglo cultures independently.	Mexican Americans
Cultural Life Style Inventory (Mendoza 1989)	This self-report instrument, available in Spanish and English, evaluates five dimensions of acculturation: intrafamily language use, extrafamily language use, social activities and affiliations, cultural knowledge and activities, and cultural identification and pride.	Mexican Americans

(Continued on the next page.)

Acculturation and Ethnic Identity Measures (continued)

Instrument	Description	Cultural Group
Cultural Life Style Inventory (Mendoza 1989)	This self-report instrument, available in Spanish and English, evaluates acculturation on five dimensions: intrafamily language use, extrafamily language use, social activities and affiliations, cultural knowledge and activities, and cultural identification and pride.	Mexican Americans
Mexican American Acculturation Scale (Montgomery 1992)	This 28-item scale evaluates cultural orientation and comfort with ethnic identity. Items ask about language use, media preferences, cultural activities/traditions, and self-perceived ethnic identity.	Mexican Americans
Padilla's Acculturation Scale (Padilla 1980)	Padilla's Acculturation Scale is a 155-item questionnaire that assesses cultural knowledge and ethnic loyalties.	Mexican Americans
Bidimensional Acculturation Scale for Hispanics (Marín and Gamba 1996)	This scale measures evaluates two major dimensions of acculturation (Hispanic and non-Hispanic) using 12 items measuring 3 language-related areas. It has been found to have high consistency and validity.	Mexican Americans and Central Americans
Stephenson Multigroup Acculturation Scale (Stephenson 2000)	This is a 32-item instrument that evaluates immersion in both culture of origin and the dominant culture of the society.	Multicultural
Vancouver Index of Acculturation (Ryder et al. 2000)	This instrument includes 20 questions that assess interest/participation in one's "heritage culture" and "typical American culture" (available online at http://www2.psych.ubc.ca/~dpaulhus/Paulhus_measures/VIA.American.doc).	Multicultural
Bicultural Acculturation Scale (Cortés and Rogler 1994)	Developed for use with first- and second-generation Puerto Rican adults, this scale measures involvement in American culture and Puerto Rican culture, but it has limited evidence of validity and reliability.	Puerto Rican Americans
Psychological Acculturation Scale (Tropp et al. 1999)	The items on this scale pertain to the client's sense of psychological attachment to and belonging within Anglo American and Hispanic/Latino cultures.	Puerto Ricans on the U.S. mainland
Acculturation Scale for Southeast Asians (Anderson et al. 1993)	This 13-item scale evaluates languages proficiency and preferences regarding social interactions, cultural activities, and food. It includes two subscales for proficiency in languages, as well as language, social, and food preferences.	Cambodian, Laotian, and Vietnamese Americans
White Racial Identity Attitude Scale (Helms and Carter 1990)	This 50-item instrument rates items on a 5-point scale to measure attitudes associated with Helms's stages of racial identity development for Caucasians.	White Americans

Appendix C—Tools for Assessing Cultural Competence

There are numerous assessment tools available for evaluating cultural competence in clinical, training, and organizational settings. These tools are not specific to behavioral health treatment. Though more work is needed in developing empirically supported instruments to measure cultural competence, there is a wealth of multicultural counseling and healthcare assessment tools that can provide guidance in identifying areas for improvement of cultural competence. This appendix examines three resource areas: counselor self-assessment tools, guidelines and assessment tools to implement and evaluate culturally responsive services within treatment programs and organizations, and forms addressing client satisfaction with and feedback about culturally responsive services. Though not an exhaustive review of available tools, this appendix does provide samples of tools that are within the public domain. For additional resources and cultural competence assessment tools, visit the National Center for Cultural Competence (<http://nccc.georgetown.edu>) or refer to the University of Michigan Health System's Program for Multicultural Health (<http://www.med.umich.edu/multicultural/>).

Counselor Self-Assessment Tools

Multicultural Counseling Self Efficacy Scale—Racial Diversity Form

This 60-item self-report instrument assesses perceived ability to perform various counselor behaviors in individual counseling with a racially diverse client population. For additional information on psychometric properties and scoring, refer to Sheu and Lent (2007).

Self-Assessment Checklist for Personnel Providing Services and Supports to Children and Youth With Special Health Needs and Their Families

This instrument was developed by Tawara D. Goode of the Georgetown University Center for Child and Human Development. This version is adapted with permission from *Promoting Cultural Competence and Cultural Diversity in Early Intervention and Early Childhood Settings* (June 1989). It is available from the Web site of the National Center for Cultural Competence (<http://nccc.georgetown.edu/documents/ChecklistEIEC.pdf>).

Select A, B, or C for each numbered item listed:

A = Things I do frequently B = Things I do occasionally C = Things I do rarely or never

Physical Environment, Materials and Resources

_____ 1. I display pictures, posters, and other materials that reflect the cultures and ethnic backgrounds of children and families served by my program or agency.

_____ 2. I [e]nsure that magazines, brochures, and other printed materials in reception areas are of interest to and reflect the different cultures of children and families served by my program or agency.

_____ 3. When using videos, films, or other media resources for health education, treatment, or other interventions, I ensure that they reflect the cultures of children and families served by my program or agency.

_____ 4. When using food during an assessment, I [e]nsure that meals provided include foods that are unique to the cultural and ethnic backgrounds of children and families served by my program or agency.

_____ 5. I [e]nsure that toys and other play accessories in reception areas and those used during assessment are representative of the various cultural and ethnic groups within the local community and the society in general.

Communication Styles

_____ 6. For children who speak languages or dialects other than English, I attempt to learn and use key words in their language so that I am better able to communicate with them during assessment, treatment, or other interventions.

_____ 7. I attempt to determine any familial colloquialisms used by children and families that may have an impact on assessment, treatment, or other interventions.

_____ 8. I use visual aids, gestures, and physical prompts in my interactions with children who have limited English proficiency.

_____ 9. I use bilingual staff members or trained/certified interpreters for assessment, treatment, and other interventions with children who have limited English proficiency.

_____ 10. I use bilingual staff members or trained/certified interpreters during assessments, treatment sessions, meetings, and for other events for families who would require this level of assistance.

11. When interacting with parents who have limited English proficiency I always keep in mind that:

_____ Limitation in English proficiency is in no way a reflection of their level of intellectual functioning.

_____ Their limited ability to speak the language of the dominant culture has no bearing on their ability to communicate effectively in their language of origin.

_____ They may or may not be literate in their language of origin or English.

_____ 12. When possible, I ensure that all notices and communiqués to parents are written in their language of origin.

_____ 13. I understand that it may be necessary to use alternatives to written communications for some families, as word of mouth may be a preferred method of receiving information.

Values and Attitudes

_____ 14. I avoid imposing values that may conflict or be inconsistent with those of cultures or ethnic groups other than my own.

_____ 15. In group therapy or treatment situations, I discourage children from using racial and ethnic slurs by helping them understand that certain words can hurt others.

_____ 16. I screen books, movies, and other media resources for negative cultural, ethnic, or racial stereotypes before sharing them with the children and their parents served by my program or agency.

_____ 17. I intervene in an appropriate manner when I observe other staff members or parents within my program or agency engaging in behaviors that show cultural insensitivity, bias, or prejudice.

_____ 18. I understand and accept that family is defined differently by different cultures (e.g., extended family members, fictive kin, godparents).

_____ 19. I recognize and accept that individuals from culturally diverse backgrounds may desire varying degrees of acculturation into the dominant culture.

_____ 20. I accept and respect that male–female roles in families may vary significantly among different cultures (e.g., who makes major decisions for the family, play, and social interactions expected of male and female children).

_____ 21. I understand that age and lifecycle factors must be considered in interactions with individuals and families (e.g., high value placed on the decisions of elders or the role of the eldest male in families).

_____ 22. Even though my professional or moral viewpoints may differ, I accept the family/parents as the ultimate decisionmakers for services and supports for their children.

_____ 23. I recognize that the meaning or value of medical treatment and health education may vary greatly among cultures.

_____ 24. I recognize and understand that beliefs and concepts of emotional well-being vary significantly from culture to culture.

_____ 25. I understand that beliefs about mental illness and emotional disability are culturally based. I accept that responses to these conditions and related treatment/interventions are heavily influenced by culture.

_____ 26. I accept that religion and other beliefs may influence how families respond to illnesses, disease, disability, and death.

_____ 27. I recognize and accept that folk and religious beliefs may influence a family's reaction and approach to a child born with a disability or later diagnosed with a physical/emotional disability or special health care needs.

_____ 28. I understand that traditional approaches to disciplining children are influenced by culture.

_____ 29. I understand that families from different cultures will have different expectations of their children for acquiring toileting, dressing, feeding, and other self-help skills.

_____ 30. I accept and respect that customs and beliefs about food, its value, preparation, and use are different from culture to culture.

_____ 31. Before visiting or providing services in the home setting, I seek information on acceptable behaviors, courtesies, customs, and expectations that are unique to families of specific cultures and ethnic groups served by my program or agency.

_____ 32. I seek information from family members or other key community informants that will assist in service adaptation to respond to the needs and preferences of culturally and ethnically diverse children and families served by my program or agency.

_____ 33. I advocate for the review of my program's or agency's mission statement, goals, policies, and procedures to ensure that they incorporate principles and practices that promote cultural diversity and cultural competence.

There is no answer key with correct responses. However, if you frequently responded "C," you may not necessarily demonstrate values and engage in practices that promote a culturally diverse and culturally competent service delivery system for children with disabilities or special health care needs and their families.

Ethnic-Sensitive Inventory (ESI; Ho 1991, reproduced with permission)

Here are some statements made by some practitioners with ethnic minority clients. How often do you feel this way when you work with ethnic minority clients? Every statement should be answered by circling one number ranging from 5 (always) to 4 (frequently), 3 (occasionally), 2 (seldom), and 1 (never).

In working with ethnic minority clients, I . . .

- A. Realize that my own ethnic and class background may influence my effectiveness.
- B. Make an effort to ensure privacy and/or anonymity.
- C. Am aware of the systematic sources (racism, poverty, and prejudice) of their problems.
- D. Am against speedy contracting unless initiated by them.
- E. Assist them to understand whether the problem is of an individual or a collective nature.
- F. Am able to engage them in identifying major progress that has taken place.
- G. Consider it an obligation to familiarize myself with their culture, history, and other ethnically related responses to problems.

- H. Am able to understand and “tune in” the meaning of their ethnic dispositions, behaviors, and experiences.
- I. Can identify the links between systematic problems and individual concerns.
- J. Am against highly focused efforts to suggest behavioral change or introspection.
- K. Am aware that some techniques are too threatening to them.
- L. Am able at the termination phase to help them consider alternative sources of support.
- M. Am sensitive to their fear of racist or prejudiced orientations.
- N. Am able to move slowly in the effort to actively “reach for feelings.”
- O. Consider the implications of what is being suggested in relation to each client’s ethnic reality (unique dispositions, behaviors, and experiences).
- P. Clearly delineate agency functions and respectfully inform clients of my professional expectations of them.
- Q. Am aware that lack of progress may be related to ethnicity.
- R. Am able to understand that the worker–client relationship may last a long time.
- S. Am able to explain clearly the nature of the interview.
- T. Am respectful of their definition of the problem to be solved.
- U. Am able to specify the problem in practical, concrete terms.
- V. Am sensitive to treatment goals consonant to their culture.
- W. Am able to mobilize social and extended family networks.
- X. Am sensitive to the client’s premature termination of service.

Scoring: The 24 items include four items for each of six treatment phases of client–counselor interaction. The sum of the numbers circled for each item relating to a treatment phase is the score for that phase. The scoring grid is given below.

Process Phase	Items			
Precontact	A _____	G _____	M _____	S _____
Problem Identification	B _____	H _____	N _____	T _____
Problem Specification	C _____	I _____	O _____	U _____
Mutual Goal Formulation	D _____	J _____	P _____	V _____
Problem Solving	E _____	K _____	Q _____	W _____
Termination	F _____	L _____	R _____	X _____

Source: Ho 1991. Reproduced with permission.

Evaluating Cultural Competence in Treatment Programs and Organizations

Agency Cultural Competence Checklist—Revised Form (Dana 1998, reproduced with permission)

Staff and policy attitudes

- Bilingual/bicultural
- Bilingual
- Bicultural
- Culture broker
- Flexible hours/appointments/home visits
- Treatment immediate/day/week
- Indigenous intake
- Match client–staff
- Agency environment reflects culture

Total possible = 9 Total obtained = _____

Services

- Culture-relevant assessment
- Cultural context for problems
- Cultural-specific intervention model
- Culture-specific services:
 - Prevention Crisis Brief Individual
 - Couple Family Child Outreach
 - Community Education Non-mental health
 - Resource linkage Natural helpers/systems

Total possible = 4 Total obtained = _____

Total possible services = 13 Total obtained = _____

Relationship to community

- Agency operated by minority community
- Agency in minority community
- Easy access
- Uses existing minority community facilities
- Agency ties to minority community
- Community advocate for services
- Community as adviser
- Community as evaluator

Total possible = 8 Total obtained = _____

Training

- _____ In-service training for minority staff
 _____ In-service training for nonminority staff

Total possible = 2 Total obtained = _____

Evaluation

- _____ Evaluation plan/tool
 _____ Clients as evaluators/planners

Total possible = 2 Total obtained = _____

Enhanced National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care

The standards presented in this section were developed by the Office of Minority Health (OMH 2013) in the Centers for Disease Control and Prevention (CDC) and are available online (<https://www.thinkculturalhealth.hhs.gov/pdfs/EnhancedNationalCLASStandards.pdf>). This section is reproduced from material in the public domain. Note that the Centers for Medicare and Medicaid Services (CMS) have also developed tools to assess linguistic competence and interpreter services as well as guidelines for planning culturally responsive services (see the CMS Web site at <http://www.cms.gov>). The National Standards for Culturally and Linguistically Appropriate Services (CLAS) are meant to advance health equity, improve quality, and help eliminate health disparities by establishing a blueprint for health and health care organizations to:

Principal standard

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

Governance, leadership, and workforce

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

Communication and language assistance

5. Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.
6. Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.
7. Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.

8. Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.

Engagement, continuous improvement, and accountability

9. Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organization’s planning and operations.
10. Conduct ongoing assessments of the organization’s CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities.
11. Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery.
12. Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.
13. Partner with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness.
14. Create conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints.
15. Communicate the organization’s progress in implementing and sustaining CLAS to all stakeholders, constituents, and the general public.

The Organizational Cultural Competence Assessment Profile

The Health Resources and Services Administration (HRSA) developed the Organizational Cultural Competence Assessment Profile from the cultural competence literature, guided by a team of experts. The profile was used during site visits to a variety of healthcare settings. It is an organizing framework and set of specific indicators to assist in examining, demonstrating, and documenting cultural responsiveness in organizations involved in the direct delivery of health care and services. The profile is not intended to be prescriptive; rather, it is designed to be adapted, modified, or applied in ways that best fit within an organization’s context. The profile is presented as a matrix that classifies indicators by critical domains of organizational functioning and by whether the indicators relate to the structures, processes, outputs, or outcomes of the organization. The indicators suggest that assessment of cultural competence should encompass both qualitative and quantitative data and evaluate progress toward achieving results, not just the end results. Although the profile can be used in whole or in part, the full application enables an organization to assess its level of cultural competence comprehensively. Adapted here from material in the public domain are the matrices for process and capacity/structure measures. For more information, see <http://www.hrsa.gov/culturalcompetence/healthdlvr.pdf>.

Sample of Process Measures by Domain

Domain	Topic Areas	Measures/Indicators
Communication	Interpreter	Yearly updated directory of trained interpreters is available within 24 hours for routine situations and within 1 hour or less for urgent situations.
Communication	Interpreter	Percentage of clients with limited English proficiency who have access to bilingual staff or interpretation services.

(Continued on the next page.)

Sample of Process Measures by Domain (continued)

Domain	Topic Areas	Measures/Indicators
Communication	Linguistically competent organization	Number of trained translators and interpreters available Number of staff proficient in languages of the community
Communication	Language ability, written and oral, of the consumer	Consumer reading and writing levels of primary languages and dialects is recorded.
Policies and procedures	Choice of health plan network	Contract continuation and renewal with health plan is contingent upon successful achievement of performance targets that demonstrate effective service, equitable access, and comparability of benefits for populations of racial/ethnic groups.
Policies and procedures	Staff hiring, recruitment	Number of multilingual/multicultural staff Ratio by culture of staff to clients
Family and community participation	Community and consumer participation	Degree to which families participate in key decisionmaking activities: <ul style="list-style-type: none"> • Family participation on advisory committees or task forces • Hiring of family members to serve as consultants to providers/programs • Inclusion of family members in planning, implementation, and evaluation of activities
Communication	Translated materials	Allocated resources for interpretation and translation services for medical encounters and health education/promotion material.
Communication	Linguistic capacity of the provider	Ability to conduct audit of the provider network, which includes the following components: <ul style="list-style-type: none"> • Languages and dialects of community available at point of first contact. • Number of trained translators and interpreters available. • Number of clinicians and staff proficient in languages of the community.
Communication	Provide information, education	<ul style="list-style-type: none"> • Organization has the capacity to disseminate information on health care plan benefits in languages of community. • Organization has the capacity to disseminate information and explanation of rights to enrollees.
Policies and procedures	Grievance and conflict resolution	Organization has structures in place to address cross-cultural ethical and legal conflicts in health care delivery and complaints or grievances by patients and staff about unfair, culturally insensitive, or discriminatory treatment, or difficulty in accessing services or denial of services.
Policies and procedures	Grievance and conflict resolution	Organization has feedback mechanisms in place to track number of grievances and complaints and number of incidents.
Policies and procedures	Planning and governance	Composition of the governing board, advisory committee, other policymaking and influencing groups, and consumers served reflects service area demographics.

Sample of Capacity/Structure Measures by Domain

Domain	Topic Areas	Measures/Indicators
Facility characteristics, capacity, and infrastructure	Available and accessible services	<ul style="list-style-type: none"> • Transportation is available from residential areas to culturally competent providers. • Organization has the flexibility to conduct home visits and community outreach. • Culturally responsive services are available evenings and weekends.
Facility characteristics, capacity, and infrastructure	Information systems	Capacity for tracking of access and utilization rates for population of different racial/ethnic groups in comparison to the overall service population.
Monitoring, evaluation, and research	Organizational assessment	Ability to conduct ongoing organizational self-assessments of cultural and linguistic competence and integration of measures of access, satisfaction, quality, and outcomes into other organizational internal audits and performance improvement programs.

Multiculturally Competent Service System Assessment Guide

Reproduced with permission from The Connecticut Department of Children and Families, Office of Multicultural Affairs (2002).

Instructions: Rate your organization on each item in Sections I through VIII using the following scale:

1 2 3 4 5

Not at all To a moderate degree To a great degree

Suggested Rating Interpretations:

#1 and #2: “Priority Concerns”; #3: “Needs Improvement”; #4 and #5: “Adequate”

When you have rated all items and assessed each section, please follow the instructions in Section IX to make an assessment of your program or agency and then formulate a culturally competent plan that addresses the need you feel is a priority.

I. Agency demographic data (assessment)

A culturally competent agency uses basic demographic information to assess and determine the cultural and linguistic needs of the service area.

- _____ Have you identified the demographic composition of the program’s service area (from recent census data, local planning documents, statement of need, etc.) which should include ethnicity, race, and primary language spoken as reported by the individuals?
- _____ Have you identified the demographic composition of the persons served?

- _____ Have you identified the staff composition (ethnicity, race, language capabilities) in relation to the demographic composition of your service area?
- _____ Have you compared the demographic composition of the staff with the client demographics?

II. Policies, procedures and governance

A culturally competent agency has a board of directors, advisory committee, or policy-making group that is proportionally representative of the staff, client/consumers, and community.

- _____ Has your organization appointed executives, managers, and administrators who take responsibility for, and have authority over, the development, implementation, and monitoring of the cultural competence plan?
- _____ Has your organization's director appointed a standing committee to advise management on matters pertaining to multicultural services?
- _____ Does your organization have a mission statement that commits to cultural competence and reflects compliance with all federal and state statutes, as well as any current *Connecticut Commission on Human Rights and Opportunities* nondiscriminatory policies and affirmative action policies?
- _____ Does your organization have culturally appropriate policies and procedures communicated orally and/or written in the principal language of the client/consumer to address confidentiality, individual patient rights and grievance procedures, medication fact sheets, legal assistance, etc. as needed and appropriately?

III. Services/programs

A culturally competent agency offers services that are culturally competent and in a language that ensures client/consumer comprehension.

A. Linguistic and communication support

- _____ Has the program arranged to provide materials and services in the language(s) of limited English-speaking clients/consumer (e.g., bilingual staff, in-house interpreters, or a contract with outside interpreter agency and/or telephone interpreters)?
- _____ Do medical records indicate the preferred languages of service recipients?
- _____ Is there a protocol to handle client/consumer/family complaints in languages other than English?
- _____ Are the forms that client/consumers sign written in their preferred language?
- _____ Are the persons answering the telephones, during and after-hours, able to communicate in the languages of the speakers?
- _____ Does the organization provide information about programs, policies, covered services, and procedures for accessing and utilizing services in the primary language(s) of client/consumers and families?
- _____ Does the organization have signs regarding language assistance posted at key locations?

___ Are there special protocols for addressing language issues at the emergency room, treatment rooms, intake, etc.?

___ Are cultural and linguistic supports available for clients/consumers throughout different service offerings along the service continuum?

B. Treatment/rehabilitation planning

___ Does the program consider the client/consumer's culture, ethnicity and language in treatment planning (assessment of needs, diagnosis, interventions, discharge planning, etc.)?

___ Does the program involve client/consumers and family members in all phases of treatment, assessment, and discharge planning?

___ Has the organization identified community resources (community councils, ethnic cultural social entities, spiritual leaders, faith communities, voluntary associations, etc.) that can exchange information and services with staff, client/consumers, and family members?

___ Have you identified natural community healers, spiritual healers, clergy, etc., when appropriate, in the development and/or implementation of the service plan?

___ Have you identified natural supports (relatives, traditional healers, spiritual resources, etc.) for purposes of reintegrating the individual into the community?

___ Have you used community resources and natural supports to reintegrate the individual into the community?

C. Cultural assessments

___ Is the client/consumer's culture/ethnicity taken into account when formulating a diagnosis or assessment?

___ Are culturally relevant assessment tools utilized to augment the assessment/diagnosis process?

___ Is the client/consumer's level of acculturation identified, described, and incorporated as part of cultural assessment?

___ Is the client/consumer's ethnicity/culture identified, described, and incorporated as part of cultural assessment?

D. Cultural accommodations

___ Are culturally appropriate, educative approaches, such as films, slide presentations, or video tapes, utilized for preparation and orientation of client/consumer family members to your program?

___ Does your program incorporate aspects of each client/consumer's ethnic/cultural heritage into the design of specialized interventions or services?

___ Does your program have ethnic/culture-specific group formats available for engagement, treatment, and/or rehabilitation?

___ Is there provider collaboration with natural community healers, spiritual healers, clergy, etc., where appropriate, in the development and/or implementation of the service plan?

E. Program accessibility

- ___ Do persons from different cultural and linguistic backgrounds have timely and convenient access to your services?
- ___ Are services located close to the neighborhoods where persons from different cultures and linguistic backgrounds reside?
- ___ Are your services readily accessible by public transportation?
- ___ Do your programs provide needed supports to families of clients/consumers (e.g., meeting rooms for extended families, child support, drop-in services)?
- ___ Do you have services available during evenings and weekends?

IV. Care management

- ___ Does the level and length of care meet the needs for clients/consumers from different cultural backgrounds?
- ___ Is the type of care for clients/consumers from different backgrounds consistently and effectively managed according to their identified cultural needs?
- ___ Is the management of the services for people from different groups compatible with their ethnic/cultural background?

V. Continuity of care

- ___ Do you have letters of agreement with culturally oriented community services and organizations?
- ___ Do you have integrated, planned, transitional arrangements between one service modality and another?
- ___ Do you have arrangements, financial or otherwise, for securing concrete services needed by clients/consumers (e.g., housing, income, employment, medical, dental, other emergency personal support needs)?

VI. Human resources development

A culturally competent agency implements staff training and development in cultural competence at all levels and across all disciplines, for leadership and governing entities as well as for management, supervisory, treatment, and support staff.

- ___ Are the principles of cultural competence (e.g., cultural awareness, language training, skills training in working with diverse populations) included in staff orientation and on-going training programs?
- ___ Is the program making use of other programs or organizations that specialize in serving persons with diverse cultural and linguistic backgrounds as a resource for staff education and training?
- ___ Is the program maximizing recruitment and retention efforts for staff who reflect the cultural and linguistic diversity of populations needing services?
- ___ Has the staff's training needs in cultural competence been assessed?

_____ Has the staff attended training programs on cultural competence in the past two years?
Describe: _____

VII. Quality monitoring and improvement

A culturally competent agency has a quality monitoring and improvement program that ensures access to culturally competent care.

- _____ Does the quality improvement (QI) plan address the cultural/ethnic and language needs?
- _____ Are client/consumers and families asked whether ethnicity/culture and language are appropriately addressed in order to receive culturally competent services in the organization?
- _____ Does the organization maintain copies of minutes, recommendations, and accomplishments of its multicultural advisory committee?
- _____ Is there a process for continually monitoring, evaluating, and rewarding the cultural competence of staff?

VIII. Information/management system

- _____ Does the organization monitor, survey, or otherwise access, the QI utilization patterns, Against Medical Advice (AMA) rates, etc., based on the culture/ethnicity and language?
- _____ Are client/consumer satisfaction surveys available in different languages in proportion to the demographic data?
- _____ Are there data collection systems developed and maintained to track clients/consumers by demographics, utilization and outcomes across levels of care, transfers, referrals, re-admissions, etc.?

IX. Formulating a culturally competent plan based on the assessment of your program or agency

Focus on the following critical areas of concern as you develop goals for a culturally competent plan for your agency's service system.

Access: Degree to which services to persons are quickly and readily available.

Engagement: The skill and environment to promote a positive personal impact on the quality of the client's commitment to be in treatment.

Retention: The result of quality service that helps maintain a client in treatment with continued commitment.

Based on an assessment of your agency, determine whether, in your initial plan, you need to direct efforts of developing cultural competency toward one, or a combination, of the above critical areas. **Then, structure your agency's cultural competence plan using the following instructions:**

1. Based on the results of this assessment, summarize and describe your organization's perceived **strengths** in providing **services to persons from different cultural groups**. Please provide specific examples. Attach supporting documentation (e.g., Data, Policies, Procedures, etc.)

2. Based on your assessment, summarize and describe your organization’s primary areas considered either “**Priority Concerns**” (#1 and/or #2), or “**Needs Improvement**” (#3) in providing services to persons from different cultural groups.
3. Based on your organization’s **strengths** and **needs**, **prioritize** both the organizational goals and objectives addressed in your **cultural competence plan**. Describe clearly what you will do to provide services to persons who are culturally and linguistically different.
4. Using the developed goals and objectives, please describe in detail the plans, activities, and/or strategies you will implement to assist your organization in meeting each of the goals and objectives indicated.

Patient Satisfaction and Feedback on Clinical and Program Culturally Responsive Services

Iowa Cultural Understanding Assessment–Client Form

Please indicate your level of agreement with the statements below by circling the number to the right of the statement that best fits your opinion. All responses are confidential. When you have completed the survey, please either use the pre-addressed, stamped envelope to return the survey by mail or place it in the drop box at the facility. **Thank you very much for your participation!**

Demographic Information

What is your sex? ___ Male ___ Female

What is your race? ___ Alaskan Native ___ American Indian ___ Asian ___ Black or African American
 ___ Native Hawaiian or other Pacific Islander ___ White

Are you Hispanic or Latino? ___ Yes ___ No

STATEMENT	RESPONSE				
	Strongly Disagree	Disagree	Neither Agree Nor Disagree	Agree	Strongly Agree
1. The staff here understands some of the ideas that I, my family, and others from my cultural, racial, or ethnic group may have.	1	2	3	4	5
2. Staff here understands the importance of my cultural beliefs in my treatment process.	1	2	3	4	5
3. The staff here listens to me and my family when we talk to them.	1	2	3	4	5
4. If I want, the staff will help me get services from clergy or spiritual leaders.	1	2	3	4	5
5. The services I get here really help me work toward things like getting a job, taking care of my family, going to school, and being active with my friends, family, and community.	1	2	3	4	5

(Continued on the next page.)

Iowa Cultural Understanding Assessment–Client Form (continued)

STATEMENT	RESPONSE				
	Strongly Disagree	Disagree	Neither Agree Nor Disagree	Agree	Strongly Agree
6. The staff here seems to understand the experiences and problems I have in my past life.	1	2	3	4	5
7. The waiting room and/or facility has pictures or reading material that show people from my racial or ethnic group.	1	2	3	4	5
8. The staff here knows how to use their knowledge of my culture to help me address my current day-to-day needs.	1	2	3	4	5
9. The staff here understands that I might want to talk to a person from my own racial or ethnic group about getting the help I want.	1	2	3	4	5
10. The staff here respects my religious or spiritual beliefs.	1	2	3	4	5
11. Staff from this program comes to my community to let people like me and others know about the services they offer and how to get them.	1	2	3	4	5
12. The staff here asks me, my family, or others close to me to fill out forms that tell them what we think of the place and services.	1	2	3	4	5
13. Staff here understands that people of my racial or ethnic group are <i>not</i> all alike.	1	2	3	4	5
14. It was easy to get information I needed about housing, food, clothing, child care, and other social services from this place.	1	2	3	4	5
15. The staff here talks to me about the treatment they will give me to help me.	1	2	3	4	5
16. The staff here treats me with respect.	1	2	3	4	5
17. The staff seems to understand that I might feel more comfortable working with someone who is the same sex as me.	1	2	3	4	5

(Continued on the next page.)

Iowa Cultural Understanding Assessment–Client Form (continued)

STATEMENT	RESPONSE				
	Strongly Disagree	Disagree	Neither Agree Nor Disagree	Agree	Strongly Agree
18. Most of the time, I feel I can trust the staff here who work with me.	1	2	3	4	5
19. The waiting room has brochures or handouts that I can easily understand that tell me about services I can get here.	1	2	3	4	5
20. If I want, my family or friends are included in discussions about the help I need.	1	2	3	4	5
21. The services I get here deal with the problems that affect my day-to-day life such as family, work, money, relationships, etc.	1	2	3	4	5
22. Some of the staff here understand the difference between their culture and mine.	1	2	3	4	5
23. Some of the counselors are from my racial or ethnic group.	1	2	3	4	5
24. Staff members are willing to be flexible and provide alternative approaches or services to meet my cultural/ethnic treatment needs.	1	2	3	4	5
25. If I need it, there are translators or interpreters easily available to assist me and/or my family.	1	2	3	4	5

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Appendix D—Screening and Assessment Instruments

Important Note: The following tables provide an overview of selected instruments that screen and assess for substance use disorders and mental disorders and symptoms. These tables only represent a sample of instruments. In reviewing the tables, do not assume that the instruments have normative data across race and ethnicities. The citations and information

listed in this appendix serve only as a starting point for investigating the appropriateness of available instruments within specific populations. Citations reflect information about the effectiveness of the testing measurements as well as research that suggests modifications or reports testing discrepancies among racial and ethnic populations.

Screening and Assessment Instruments for Substance Use Disorders

Instrument	Description	Clinical Utility
Alcohol, Smoking, and Substance Involvement Screening Test (ASSIST; Humeniuk et al. 2010)	The ASSIST (version 3.1) has eight items to screen for use of tobacco products, alcohol, and drugs	ASSIST was developed by the World Health Organization (WHO) as a culturally neutral tool for use in primary and general medical care settings. This paper-pencil instrument takes 5 to 10 minutes to complete and is designed to be administered by a health worker. ASSIST determines a risk score for each substance; the score starts a discussion with clients about their substance use. For information about the instrument and its availability in other languages, see http://www.who.int/substance_abuse/activities/assist/en/
Alcohol Use Disorders Identification Test (AUDIT; Babor et al. 1992; Saunders et al. 1993)	This 10-item screening questionnaire was developed to identify people whose alcohol consumption is hazardous or harmful to their health.	The AUDIT was developed by WHO for use in multinational settings—the original sample included subjects from Australia, Bulgaria, Kenya, Mexico, Norway, and the United States (Allen et al. 1997; Saunders et al. 1993). Populations researched: Latinos (Cherpitel 1999; Cherpitel and Bazargan 2003; Cherpitel and Borges 2000; Frank et al. 2008; Reinert and Allen 2007; Volk et al. 1997), northern (Asian) Indians (Pal et al. 2004); Vietnamese (Giang et al. 2005); Brazilians (Lima et al. 2005), and Nigerians (Adewuya 2005).

(Continued on the next page.)

Screening and Assessment Instruments for Substance Use Disorders (continued)

Instrument	Description	Clinical Utility
		Languages available in: Numerous languages, including Spanish (de Torres et al. 2009; Medina-Mora et al. 1998), French (Gache et al. 2005), Mandarin and Cantonese (Leung and Arthur 2000), Nigerian languages (Adewuya 2005), Russian, German, and Korean (Kim et al. 2008).
Addiction Severity Index (McLellan et al. 1980). Available online at http://www.tresearch.org/index.php/tools/download-asi-instruments-manuals/	Currently in its 5th edition, this instrument assesses the severity of substance use disorders. It has 200 items distributed over seven subscales.	Populations researched: African Americans (Drake et al. 1995; Leonhard et al. 2000; McLellan et al. 1985), and Northern Plains American Indians (Carise and McLellan 1999). Languages available in: Numerous languages, including Spanish (Sandí Esquivel and Avila Corrales 1990; for multimedia version see Butler et al. 2009), French (Daepfen et al. 1996; Krenz et al. 2004), Japanese (Haraguchi et al. 2009), and Chinese (Liang et al. 2008).
Alcohol Use Disorder and Associated Disabilities Interview Schedule (AUDADIS; Grant and Hasin 1990). Available online at http://pubs.niaaa.nih.gov/publications/audadis.pdf	This structured interview is administered by nonprofessional interviewers to diagnose substance use disorders and assess some co-occurring mental disorders. It evaluates acculturation and racial/ethnic orientation. Currently in its 4th edition (AUDADIS-IV).	The AUDADIS has been found reliable in large general-population studies (Grant et al. 1995; Ruan et al. 2008). Populations researched: African Americans, Latinos, Asians, and Native Americans (Canino et al. 1999; Chatterji et al. 1997; Grant et al. 1995; Ruan et al. 2008). Languages available in: Chinese and Spanish (Canino et al. 1999; Horton et al. 2000; Leung and Arthur 2000).
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). Languages available in: Numerous languages, including Spanish, Creole, Chinese, and Japanese.
Composite International Diagnostic Interview-Substance Abuse Module (CIDI-SAM; Cottler 2000)	This structured, detailed interview diagnoses substance abuse and dependence; it is an expanded version of the substance use section of the CIDI.	The instrument has been well evaluated with international populations from a variety of different nations and found to have good reliability for most substances of abuse (Ustün et al. 1997). Populations researched: African Americans (Horton et al. 2000) and Brazilians (Quintana et al. 2004; 2007). Languages available in: Numerous languages, including Portuguese, Spanish, Arabic, Japanese, Vietnamese, and Malay.

(Continued on the next page.)

Screening and Assessment Instruments for Substance Use Disorders (continued)

Instrument	Description	Clinical Utility
Drug Abuse Screening Test (DAST; Skinner 1982)	This self-report instrument (10- and 20-item versions) identifies people who are abusing psychoactive drugs and measures degree of related problems.	No significant differences in DAST reliability across race or cultural background were found (Yudko et al. 2007). Languages available in: Numerous, including Spanish for the 10-item DAST (DAST-10; Bedregal et al. 2006), Portuguese, Hebrew, Arabic, and Thai.
Rapid Alcohol Problems Screen (RAPS; Cherpitel 1995, 2000)	The RAPS is a five-question test (also available in a newer four-item version, the RAPS-4) that combines optimal questions from other instruments.	The RAPS has high sensitivity across both ethnicity and gender (Cherpitel 1997; 2002). It has also been found to work significantly better than the AUDIT for screening African American and Latino men and to be on par with the AUDIT for women (Cherpitel and Bazargan 2003). Populations researched: Mexican Americans (Borges and Cherpitel 2001); residents of various countries (Argentina, Belarus, Brazil, Canada, China, Czech Republic, India, Mexico, Mozambique, Poland, South Africa, and Sweden; Cherpitel et al. 2005). Languages available in: Numerous, including Spanish, Chinese, and Portuguese.
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). Languages available in: Numerous, including Spanish, French, Thai, and Asian Indian languages.
TWEAK (Russell 1994)	TWEAK is a five-item screening instrument originally created to screen for risky drinking during pregnancy (but has been validated for a range of male and female populations).	Populations researched: Mexican Americans (Borges and Cherpitel 2001) and African Americans (Cherpitel 1997). Languages available in: Spanish (Cremonte and Cherpitel 2008).

Screening and Assessment Instruments for Mental Disorders and Symptoms

Instrument	Description	Clinical Utility With Specific Racial/Ethnic Groups
<p>Beck Anxiety Inventory (BAI; Beck and Steer 1990)</p>	<p>The BAI is a 21-item scale that distinguishes anxiety from depression.</p>	<p>Populations researched: African Americans (Chapman et al. 2009). Languages available in: Numerous languages, including Spanish (Novy et al. 2001), Arabic, Chinese, Farsi, Korean, and Turkish.</p>
<p>Beck Depression Inventory (BDI) and Beck Depression Inventory, 2nd Edition (BDI-II; Beck et al. 1996)</p>	<p>The BDI is a 21-item instrument used to assess the intensity of depression.</p>	<p>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). Languages available in: Numerous, including Spanish (Azocar et al. 2001; Bonilla et al. 2004; Carmody 2005; Wiebe and Penley 2005), Chinese (Yeung et al. 2002; Zheng and Lin 1991), French, Arabic (Abdel-Khalek 1998; Alansari 2006), Hebrew, and Farsi (Ghassemzadeh et al. 2005).</p>
<p>Center for Epidemiological Studies-Depression Scale (CES-D; Radloff 1977)</p>	<p>The CES-D is a 20-item self-report scale designed to measure depressive symptoms.</p>	<p>May underestimate symptoms in African Americans (Bardwell and Dimsdale 2001; Cole et al. 2000). Populations researched: Latinos (Batistoni et al. 2007; Garcia and Marks 1989; Posner et al 2001; Reuland et al. 2009; Roberts et al.1990), Asian Indians (Diwan et al. 2004; Gupta et al. 2006), Native Americans (Chapleski et al. 1997), and African Americans (Canady et al. 2009; Makambi et al. 2009; Nguyen et al. 2004). Languages available in: Numerous languages, including Spanish (Reuland et al. 2009), Chinese (Lin 1989), Greek, Korean, and Portuguese.</p>
<p>Geriatric Depression Scale (Sheikh and Yesavage 1986)</p>	<p>Available in 30- and 15-item forms, this instrument screens for depression in older adults.</p>	<p>Populations researched: Latinos (Reuland et al. 2009) and Asians (Broekman et al. 2008; Nyunt et al. 2009). Languages available in: Available in 30 languages and validated with a number of different populations (available online at http://www.stanford.edu/~yesavage/GDS.html).</p>
<p>Millon Clinical Multiaxial Inventory-III (Millon et al. 2009)</p>	<p>Assesses 13 personality disorders (DSM-III-R Axis II disorders) and 9 clinical syndromes (DSM-III-R Axis I disorders); includes scales to assess substance related problems.</p>	<p>Populations researched: African Americans (Calsyn et al.1991; Craig and Olson 1998) and Latinos (Fernández-Montalvo et al. 2006). Languages available in: Multiple languages, including Spanish, Korean, Cantonese, and Portuguese.</p>

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Instruments To Screen and Assess Mental Disorders and Symptoms (continued)

<p>Minnesota Multiphasic Personality Inventory, 2nd Edition (MMPI-2) (Butcher et al. 1989)</p>	<p>The MMPI-2 measures personality traits and symptom patterns.</p>	<p>Normed for Asian Americans, African Americans, Latinos, and American Indians (Hathaway et al. 1989). Populations researched: African Americans (Castro et al. 2008; McNulty et al. 2003; Monnot et al. 2009; Whatley et al. 2003) and Asian Americans (Tsai and Pike 2000; Tsushima and Tsushima 2009). Languages available in: Numerous, including French, Hmong, and Spanish (Velasquez et al. 2000).</p>
<p>Mini International Neuropsychiatric Interview (M.I.N.I.; Sheehan et al. 1998)</p>	<p>This is a short, structured, diagnostic interview that assesses the most common mental disorders (including substance use disorders).</p>	<p>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). Languages available in: Over 43 languages, including French, Italian (Rossi et al. 2004), Japanese (Otsubo et al. 2005), Spanish, Italian, and Arabic (Amorim et al. 1998; Lecrubier et al. 1997; Sheehan et al. 1997, 1998).</p>
<p>Schedules for Clinical Assessment in Neuropsychiatry, 2nd Version (SCAN-2; Wing et al. 1998)</p>	<p>The SCAN-2 is a set of instruments that measure psychopathology and behavior associated with major mental disorders.</p>	<p>Populations researched: The SCAN-2 was developed by WHO with an international sample that included participants from Turkey, Greece, India, the United States, Nigeria, Romania, Mexico, Spain, and South Korea and is intended to be cross-culturally appropriate (Room et al. 1996). Languages available in: Chinese (Cheng et al. 2001), Danish, Dutch, English, French, German, Greek, Italian, Kannada, Portuguese, Spanish, Thai, Turkish, and Yoruba.</p>
<p>Symptom Checklist-90-R (SCL-90R; Derogatis 1992)</p>	<p>This 90-item checklist evaluates psychiatric symptoms and their intensity in nine different categories and screens for a broad range of mental disorders.</p>	<p>The SCL-90R has been normed for adult inpatient and outpatient psychiatric patients and adult and adolescent nonpatients across a number of ethnic groups (Derogatis 1992). Populations researched: Latinos (Martinez et al. 2005) and African Americans (Ayalon and Young 2009). Languages available in: Spanish, French, Armenian, and Persian.</p>

Appendix E—Cultural Formulation in Diagnosis and Cultural Concepts of Distress

Cultural Formulation in Diagnosis

Clinicians need to consider the effects of culture when diagnosing clients. The following cultural formulation adopted by the American Psychiatric Association (APA) in the *Diagnostic and Statistical Manual of Mental Disorders*, Fifth Edition (DSM-5; 2013, pp. 749–759) provides a systematic outline for incorporating culturally relevant information when conducting a multi-axial diagnostic assessment. Whether or not they are credentialed to diagnose disorders, counselors and other clinical staff can use the main content areas listed below to guide the interview, initial intake, and treatment planning processes. (For review, see Mezzich and Caracci 2008; for Native American application, specifically Lakota, refer to Brave Heart 2001.)

1. Cultural identity of the person. Note the person's ethnic or cultural reference groups. For immigrants and ethnic minorities, also note degree of involvement with culture of origin and host culture (where applicable). Also note language ability, use, and preference (including multilingualism).

2. Cultural explanations of the person's illness. Identify the following: the predomi-

nant idioms of distress through which symptoms or the need for social support are communicated (e.g., “nerves,” possessing spirits, somatic complaints, inexplicable misfortune), the meaning and perceived severity of the individual's symptoms in relation to norms of the cultural reference group, any local illness category used by the individual's family and community to identify a condition (see the “Cultural Concepts of Distress” section of this appendix), the perceived causes or explanatory models that the individual and the reference group use to explain the illness, and current preferences for and past experiences with professional and popular sources of care.

3. Cultural factors related to psychosocial environment and level of functioning. Note culturally relevant interpretations of social stressors, available social supports, and levels of functioning and disability, including stresses in the local social environment and the role of religion and kin networks in providing emotional, instrumental, and informational support.

4. Cultural elements of the relationship between client and clinician. Indicate differences in culture and social status between client and clinician, as well as any problems these differences may cause in diagnosis and

treatment (e.g., difficulty communicating in the client’s first language, eliciting symptoms or understanding their cultural significance, negotiating an appropriate relationship or level of intimacy, determining whether a behavior is normative or pathological).

5. Overall cultural assessment for diagnosis and care. Conclude cultural formulation by discussing how cultural considerations specifically influence comprehensive diagnosis and care.

Cultural Concepts of Distress

Just as standard screening instruments can sometimes be of limited use with culturally

diverse populations, so too are standard diagnoses. Expressions of psychological problems are, in part, culturally specific, and behavior that is aberrant in one culture can be standard in another. For example, seemingly paranoid thoughts are to be expected in clients who have migrated from countries with oppressive governments. Culture plays a large role in understanding phenomena that might be construed as mental illnesses in Western medicine. These cultural concepts of distress may or may not be linked to particular DSM-5 diagnostic criteria (APA 2013). The table that follows lists DSM-5 cultural concepts of distress; other concepts exist that are not recognized in DSM-5.

DSM-5 Cultural Concepts of Distress

Syndrome	Description	Populations
Ataque de nervios	Commonly reported symptoms include uncontrollable shouting, attacks of crying, trembling, heat in the chest rising into the head, and verbal or physical aggression. Dissociative experiences, seizurelike or fainting episodes, and suicidal gestures are prominent in some attacks but absent in others. A general feature of an ataque de nervios is a sense of being out of control. Ataques de nervios frequently occur as a direct result of a stressful event relating to the family (e.g., death of a close relative, separation or divorce from a spouse, conflict with spouse or children, or witnessing an accident involving a family member). People can experience amnesia for what occurred during the ataque de nervios, but they otherwise return rapidly to their usual level of functioning. Although descriptions of some ataques de nervios most closely fit with the DSM-IV description of panic attacks, the association of most ataques with a precipitating event and the frequent absence of the hallmark symptoms of acute fear or apprehension distinguish them from panic disorder. Ataques range from normal expressions of distress not associated with a mental disorder to symptom presentations associated with anxiety, mood dissociative, or somatoform disorders.	Caribbean, Latin American, Latin Mediterranean
Dhat (<i>jiryān</i> in India, <i>skra prameha</i> in Sri Lanka, <i>shen-k’uei</i> in China)	A folk diagnosis for severe anxiety and hypochondriacal concerns associated with the discharge of semen, whitish discoloration of the urine, weakness, and exhaustion.	Asian Indian

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DSM-5 Cultural Concepts of Distress (continued)

Nervios	Refers both to a general state of vulnerability to stress and to a syndrome evoked by difficult life circumstances. <i>Nervios</i> includes a wide range of symptoms of emotional distress, somatic disturbance, and inability to function. Common symptoms include headaches and “brain aches,” irritability, stomach disturbances, sleep difficulties, nervousness, tearfulness, inability to concentrate, trembling, tingling sensations, and <i>mareos</i> (dizziness with occasional vertigo-like exacerbations). <i>Nervios</i> tends to be an ongoing problem, although it is variable in the degree of disability manifested. <i>Nervios</i> is a broad syndrome that ranges from cases free of a mental disorder to presentations resembling adjustment, anxiety, depressive, dissociative, somatoform, or psychotic disorders. Differential diagnosis depends on the constellation of symptoms, the kind of social events associated with onset and progress, and the level of disability experienced.	Latin American
Shenjing shuairuo	A condition characterized by physical and mental fatigue, headaches, difficulty concentrating, dizziness, sleep disturbance, and memory loss. Other symptoms include gastrointestinal problems, sexual dysfunction, irritability, excitability, and autonomic nervous system disturbances.	Chinese
Susto (<i>espanto, pismo, tripa ida, perdida del alma, or chibih</i>)	An illness attributed to a frightening event that causes the soul to leave the body and results in unhappiness and sickness. Individuals with <i>susto</i> also experience significant strains in key social roles. Symptoms can appear days or years after the fright is experienced. In extreme cases, <i>susto</i> can result in death. Typical symptoms include appetite disturbances, inadequate or excessive sleep, troubled sleep or dreams, sadness, lack of motivation, and feelings of low self-worth or dirtiness. Somatic symptoms accompanying <i>susto</i> include muscle aches and pains, headache, stomachache, and diarrhea. Ritual healings focus on calling the soul back to the body and cleansing the person to restore bodily and spiritual balance. <i>Susto</i> can be related to major depressive disorder, posttraumatic stress disorder, and somatoform disorders. Similar etiological beliefs and symptom configurations are found in many parts of the world.	Latino American, Mexican, Central and South American
Taijin kyofusho	This syndrome refers to an individual’s intense fear that his or her body, its parts, or its functions displease, embarrass, or are offensive to other people in appearance, odor, facial expressions, or movement. This syndrome is included in the official Japanese diagnostic system for mental disorders.	Japanese

Source: APA 2013. Used with permission.

Appendix F—Cultural Resources

General Resources

Addiction Technology Transfer Centers

<http://www.nattc.org>

The Addiction Technology Transfer Centers Network identifies and advances opportunities for improving substance abuse treatment. The Network comprises 14 regional centers as well as a national office serving the United States and its territories. Regional centers cater to unique needs in their areas while supporting national initiatives. Improving cultural competence is a major focus for the Network, which seeks to improve substance abuse treatment by identifying standards of culturally competent treatment and generating ways to foster their adoption in the field.

Agency for Healthcare Research and Quality—Minority Health

<http://www.ahrq.gov/research/findings/factsheets/minority/index.html>

This site provides research findings, papers, and press releases related to minority health.

American Translators Association

<http://www.atanet.org>

The American Translators Association (ATA) offers a certification program that evaluates the competence of translators according to

guidelines that reflect current professional practice. The ATA also has online directories available. The Directory of Translation and Interpreting Services is an online directory of individual translators and interpreters. The Directory of Language Services Companies is a directory of companies that offer translating or interpreting services.

Center for Research on Ethnicity, Culture, and Health

<http://www.crech.org>

Established in 1998 in the University of Michigan's School of Public Health, the Center provides a forum for basic and applied public health research on relationships among ethnicity, culture, socioeconomic status, and health. It develops new interdisciplinary frameworks for understanding these relationships while promoting effective collaboration among public health academicians, healthcare providers, and communities to reduce racial and ethnic disparities in health care.

Community Toolbox: Cultural Competence in a Multicultural World

<http://ctb.ku.edu/en/table-of-contents/culture/cultural-competence>

The cultural competence section of this Web site provides information (including examples and links) on a number of relevant topics, such

as how to build relationships with people from different cultures, reduce prejudice and racism, build organizations and communities that are responsive to people from diverse cultures, and heal the effects of internalized oppression.

The Cross Cultural Health Care Program

<http://www.xculture.org>

Since 1992, the Cross Cultural Health Care Program (CCHCP) has been addressing broad cultural issues that affect the health of individuals and families in ethnic minority communities in Seattle and nationwide. Through a combination of cultural competency trainings, interpreter trainings, research projects, community coalition building, and other services, CCHCP serves as a bridge between communities and healthcare institutions to ensure full access to quality health care that is culturally and linguistically appropriate.

Cultural Competence Standards in Managed Care Mental Health Services

Western Interstate Commission for Higher Education. *Cultural Competence Standards in Managed Mental Health Care for Four Underserved/Underrepresented Racial/Ethnic Groups*. Boulder, CO: Western Interstate Commission for Higher Education, 1998.

The Center for Mental Health Services (CMHS) presents cultural competence standards for managed care mental health services to improve the availability of high-quality services for four underserved and/or underrepresented racial and ethnic groups—African Americans, Latinos, Native Americans, and Asian/Pacific Islander Americans. With help from the Western Interstate Commission for Higher Education Mental Health Program, CMHS convened national panels representing each major racial/ethnic group. Mental health

professionals, families, and consumers on the panels prepared the document.

Diversity Rx

<http://www.diversityrx.org>

This Web site offers resources relating to cross-cultural communication issues in healthcare settings and information on interpreter practice, legal issues relating to language barriers and access to linguistically appropriate services, and the ways language and culture can affect the use of healthcare services.

Health Resources and Services Administration Culture, Language and Health Literacy Page

<http://www.hrsa.gov/culturalcompetence/>

The Health Resources and Services Administration Culture, Language and Health Literacy Web site provides links to various online resources relating to cultural competence in general and to providing culturally competent health care to a number of specific cultural/ethnic groups.

Instruments for Measuring Acculturation, University of Calgary

http://www.ucalgary.ca/~taras/_private/Acculturation_Survey_Catalogue.pdf

This document gives information on acculturation and cultural identity measures, presenting many in full. It does not always include scoring information but typically provides questions from each instrument.

Minority Health Project

<http://www.minority.unc.edu/>

The Minority Health Project (MHP) of the University of North Carolina's Gillings School of Global Public Health seeks to improve the

quality of racial and ethnic population data, to expand the capacity for conducting statistical research and developing research proposals on minority health, and to foster a network of researchers in minority health. MHP collaborates with the Center for Health Statistics Research, the University of North Carolina, the National Center for Health Statistics, and the Association of Schools of Public Health to conduct educational programs and provide information on minority health research and data sources.

National Center for Cultural Competence

<http://nccc.georgetown.edu>

The National Center for Cultural Competence's (NCCC) mission is to increase the capacity of health and mental health programs to design, implement, and evaluate culturally and linguistically responsive service delivery systems. NCCC conducts training, technical assistance, and consultation; participates in networking, linkages, and information exchange; and engages in knowledge and product development and dissemination.

The National Center on Minority Health and Health Disparities

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

The Center's mission is to promote minority health and reduce health disparities. It is particularly useful as a resource for information about health disparities and the best methods to address them.

International MultiCultural Institute

<http://www.imciglobal.org/>

The International MultiCultural Institute (iMCI) works with individuals, organizations, and communities to create a society that is

strengthened and empowered by its diversity. iMCI's initiatives aim to increase communication, understanding, and respect among people of diverse backgrounds and address systemic cultural issues facing our society. The Institute accomplishes this through its conferences, individualized organizational training and consulting interventions, publications, and leading-edge projects.

Office of Civil Rights

<http://www.hhs.gov/ocr/civilrights/resources/specialtopics/lep/>

The Office of Civil Rights of the U.S. Department of Health and Human Services investigates complaints, enforces rights, develops policies, and promulgates regulations to ensure compliance with nondiscrimination and health information privacy laws. The agency offers technical assistance and public education to ensure understanding of and compliance with these laws, including the provision of resources and tools to improve services for individuals with limited English proficiency.

Office of Minority Health Resource Center

<http://minorityhealth.hhs.gov/>

The Office of Minority Health (OMH) was established by the U.S. Department of Health and Human Services in 1985 to advise the Secretary and the Office of Public Health and Science on public health policies and programs affecting Native Americans, African Americans, Asian Americans, Latinos, and Native Hawaiians and other Pacific Islanders. The mission of OMH is to improve and protect the health of racial and ethnic minority populations through the development of policies and programs that will eliminate health disparities.

The OMH Resource Center (OMHRC) is a national resource and referral service for

minority health issues. It collects and distributes information on various health topics, including substance abuse, cancer, heart disease, violence, diabetes, HIV/AIDS, and infant mortality. OMHRC also facilitates information exchange on minority health issues, and offers customized database searches, publications, mailing lists, referrals, and the like regarding Native American, African American, Asian American, Pacific Islander, and Latino populations.

Substance Abuse and Mental Health Services Administration

<http://store.samhsa.gov/>

The Substance Abuse and Mental Health Services Administration (SAMHSA) is the Nation's one-stop resource for information about substance abuse and mental illness prevention and behavioral health treatment. The SAMHSA Store Web site provides information on behavioral health topics such as cultural competence, healthcare-related laws, and mental health and substance abuse.

Surgeon General's Report on Mental Health: Culture, Race, and Ethnicity

U.S. Department of Health and Human Services. *Mental Health: Culture, Race, and Ethnicity. A Supplement to Mental Health: A Report of the Surgeon General*. HHS Pub. No. SMA 01-3613. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, 2001.

This report highlights the roles that culture and society play in mental health, mental illness, and the types of mental health services people seek. The report finds that, although effective, well-documented treatments for mental illnesses are available, minorities are

less likely to receive quality care than the general population. It articulates the foundation for understanding relationships among culture, society, mental health, mental illness, and services, and also describes how these issues affect different racial and ethnic groups.

Stanford University Curriculum in Ethnogeriatrics

<http://www.stanford.edu/group/ethnoger/>

This online curriculum explores healthcare issues for older adults from a variety of cultural groups (with modules on African Americans, Latinos, Native Americans, and several Asian American populations).

African and Black American Resources

Congressional Black Caucus Foundation Health

<http://www.cbcbfinc.org/what-we-do/researchandpolicy.html>

Congressional Black Caucus Foundation Health's mission is to empower people of African descent to make better decisions about their health and that of their communities. The Web site provides information about public health issues, key legislation on public policy issues, health initiatives, and local events directly and indirectly relating to the health of people of African descent worldwide. It includes a section on substance abuse.

National Black Alcoholism and Addictions Council, Inc.

<http://www.nbacinc.org>

The National Black Alcoholism and Addictions Council, Inc. (NBAC) is a nonprofit, tax-exempt organization of Black individuals concerned about alcoholism and drug abuse.

NBAC educates the public about the prevention of alcohol and drug abuse and alcoholism and is committed to increasing services for persons who are dependent upon alcohol and their families, providing quality care and treatment, and developing research models designed for Blacks. NBAC helps Blacks concerned with or involved in the field of alcoholism and drug-related issues to exchange ideas, offer services, and facilitate substance abuse treatment programs for Black Americans.

National Medical Association

<http://www.nmanet.org>

A professional and scientific organization representing the interests of more than 25,000 physicians and their patients, the National Medical Association (NMA) is the collective voice of African American physicians and a leading force for parity and justice in medicine and health. Established in 1895, NMA aims to prevent diseases, disabilities, and adverse health conditions that disproportionately or differentially affect African American and underserved populations; improve quality and availability of health care for poor and underserved populations; and increase representation and contributions of African Americans in medicine. NMA provides educational programs and opportunities for scholarly exchange, conducts outreach to promote improved public health, and establishes national health policy agendas in support of African American physicians and their patients.

Asian American, Native Hawaiian, and Other Pacific Islander Resources

Asian and Pacific Islander American Health Forum

<http://www.apiahf.org>

The Asian and Pacific Islander American Health Forum (APIAHF) is a national advocacy organization that promotes policy, program, and research efforts to improve the health of Asian and Pacific Islander Americans. APIAHF established the Asian and Pacific Islander Health Information Network (APIHIN) in 1995. APIHIN was developed as an integrated telecommunications infrastructure that gives Asians and Pacific Islanders access to health information and resources through local community access points and key provider intermediaries. The organization supports two mailing lists: API-HealthInfo, which concentrates on Asian and Pacific Islander American health, and API-SAMH, which deals with issues related to behavioral health of special interest to the Asian and Pacific Islander community.

National Asian American Pacific Islander Mental Health Association

<http://www.naapimha.org>

The National Asian American Pacific Islander Mental Health Association (NAAPIMHA) evolved from an Asian American Pacific Islander Mental Health Summit sponsored by SAMHSA. NAAPIMHA focuses on five interrelated areas: enhancing collection of appropriate and accurate data; identifying current best practices and service models; capacity building, including provision of technical assistance and training of service providers, both professional and paraprofessional; conducting research and evaluation; and working to engage consumers and families.

National Asian Pacific American Families Against Substance Abuse

<http://www.napafasa.org>

The National Asian Pacific American Families Against Substance Abuse is a nonprofit

membership organization that addresses the alcohol, tobacco, and drug issues of Asian American and Pacific Islander populations; it involves providers, families, and youth in reaching Asian American and Pacific Islander communities to promote health and social justice and reduce substance abuse and related problems.

Psychosocial Measures for Asian American Populations: Tools for Direct Practice and Research

<http://www.columbia.edu/cu/ssw/projects/pmap>

This Web site presents information on psychosocial measures (including some related to substance abuse) found to be reliable and valid with Asian Americans (in general group or for a specific subgroup).

The Vietnamese Community Health Promotion Project

<http://www.suckhoelavang.org/main.html>

This project's mission is to improve the health of Vietnamese Americans. A part of the University of California–San Francisco School of Medicine, the Web site provides information in Vietnamese and English, along with links to Vietnamese Web sites related to health issues.

Hispanic and Latino Resources

Hispanic/Latino Portal to Drug Abuse Prevention

<http://www.latino.prev.info>

The Indiana University Prevention Resource Center created this trilingual Web site to serve the growing Latino population and those who work with Latinos. Many Latinos face a language barrier, as do many prevention profes-

sionals trying to address their needs. This Web site helps bridge the communication barrier by offering information about and links to resources for substance abuse prevention, general health information, building cultural pride, and research tools, such as databases and bibliographies.

National Alliance for Hispanic Health

<http://www.hispanichealth.org>

The National Alliance for Hispanic Health is the nation's oldest and largest network of Hispanic health and human service providers. Alliance members deliver quality services to more than 12 million persons annually. As the nation's action forum for Hispanic health and well-being, the programs of the Alliance inform and mobilize consumers, support providers in the delivery of quality care, promote appropriate use of technology, improve the science base for accurate decisionmaking, and promote philanthropy.

National Council of La Raza Institute for Hispanic Health

http://www.nclr.org/index.php/issues_and_programs/health_and_nutrition/hispanic_health

The Institute for Hispanic Health (IHH) works closely with National Council of La Raza affiliates, government partners, private funders, and Latino-serving organizations to deliver quality health interventions and improve access to and use of quality health promotion and disease prevention programs. IHH provides culturally responsive and linguistically appropriate technical assistance and science-based approaches that emphasize public health, rather than disease-specific, themes. Themes include behavior change communication, healthy lifestyle promotion, improving access to quality services, and

increasing the number and level of Latinos in health fields.

National Hispanic Medical Association

<http://www.nhmamd.org>

Established in 1994, the National Hispanic Medical Association (NHMA) is a nonprofit association representing 36,000 licensed Hispanic physicians in the United States. Its mission is to improve the health of Latinos and other underserved populations. NHMA provides policymakers and healthcare providers with expert information and support in strengthening health service delivery to Latino communities across the Nation. Its agenda includes expanding access to quality health care; increasing medical education, cultural competence, and research opportunities for Latinos; and developing policy and education to eliminate health disparities for Latinos.

Native American Resources

Centers for American Indian and Alaska Native Health

<http://www.ucdenver.edu/academics/colleges/PublicHealth/research/centers/CAIANH/Pages/caianh.aspx>

The Centers for American Indian and Alaska Native Health (CAIANH) at the University of Colorado, Denver promote the health and well-being of American Indians and Alaska Natives by pursuing research, training, continuing education, technical assistance, and information dissemination in a biopsychosocial framework that recognizes the unique cultural contexts of this special population. The site provides online access to the group's journal, *American Indian and Alaska Native Mental*

Health Research, as well as information about ongoing research projects.

Indian Health Service

<http://www.ihs.gov>

The Indian Health Service (IHS) is the principal federal healthcare provider and advocate for Native Americans; it ensures that comprehensive, culturally acceptable personal and public health services are available and accessible to Native peoples. Its Web site provides a tour of the IHS and its service areas, administrative reports, legislative news, IHS job opportunities, and healthcare resources targeted to this group.

National Indian Child Welfare Association

<http://www.nicwa.org>

The National Indian Child Welfare Association (NICWA), a comprehensive source of information on American Indian child welfare, works on behalf of Indian children and families to provide public policy, research, and advocacy; information and training on Indian child welfare; and community development services to Tribal governments and programs, State child welfare agencies, and other organizations, agencies, and professionals interested in Indian child welfare. NICWA addresses child abuse and neglect through training, research, public policy, and grassroots community development. NICWA also supports compliance with the Indian Child Welfare Act of 1978, which seeks to keep American Indian children with American Indian families.

One Sky Center

<http://www.oneskycenter.org>

One Sky Center aims to improve prevention and treatment of substance abuse for Native peoples by identifying, promoting, and disseminating effective, evidence-based, culturally

appropriate substance abuse prevention and treatment services and practices for application across diverse Tribal communities. It also provides training, technical assistance, and products to expand the capacity and quality of substance abuse prevention and treatment services for this population. SAMHSA created, designed, and funds One Sky Center to work with all federal and state agencies providing services to Native Americans.

SAMHSA's Tribal Training and Technical Assistance Center

<http://beta.samhsa.gov/tribal-ttac>

The Tribal Training and Technical Assistance (TTA) Center uses a culturally relevant, evidence-based, holistic approach to support Native communities in their self-determination efforts through infrastructure

development and capacity building, as well as program planning and implementation. The Center provides TTA on mental and substance use disorders, bullying and violence, suicide prevention, and the promotion of mental health. It offers TTA to federally recognized tribes, other American Indian and Alaska Native communities, SAMHSA Tribal grantees, and organizations serving Indian Country. The Web site provides resources across behavioral health topics relevant to Native peoples.

White Bison

<http://www.whitebison.org/>

This Web site offers resources related to the Wellbriety self-help movement for Native Americans, including a discussion board and access to the *Wellbriety* online magazine.

Appendix G—Glossary

Acculturation typically refers to the socialization process through which people from one culture adopt certain elements from the dominant culture in a society.

American Indian and Alaska Native people include those “having origins in any of the original peoples of North and South America (including Central America), and who maintain tribal affiliation or community attachment” (Grieco and Cassidy 2001, p. 2).

Asians are defined in the United States (U.S.) Census as “people having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent,” including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam (Grieco and Cassidy 2001, p. 2).

Biculturalism is “a well-developed capacity to function effectively within two distinct cultures based on the acquisition of the norms, values, and behavioral routines of the dominant culture” and one’s own culture (Castro and Garfinkle 2003, p. 1385).

Biracial individuals have two distinct racial heritages, either one from each parent or as a result of racial blending in an earlier generation (Root 1992).

Blacks/African Americans are, according to the U.S. Census Bureau (2000) definition,

people whose origins are “in any of the black racial groups of Africa” (p. A-3). The term includes descendants of African slaves brought to this country against their will and more recent immigrants from Africa, the Caribbean, and South or Central America (many individuals from these latter regions, if they come from Spanish-speaking cultural groups, identify or are identified primarily as Latino). The term Black is often used interchangeably with African American, although for some, the term African American is used specifically to describe those individuals whose families have been in this country since at least the 19th century and thus have developed distinctly African American cultural groups. Black can be a more inclusive term describing African Americans as well as for more recent immigrants with distinct cultural backgrounds.

Confianza means trust or confidence in the benevolence of the other person.

Conformity in Helms’s model of racial identity development refers to the tendency of members of a racial group to behave in congruence with the values, beliefs, and attitudes of their own culture to which they have been exclusively exposed.

Cultural competence is “a set of congruent behaviors, attitudes, and policies that . . . enable a system, agency, or group of professionals to work effectively in cross-cultural situations”

(Cross et al. 1989, p. 13). It refers to the ability to honor and respect the beliefs, languages, interpersonal styles, and behaviors of individuals and families receiving services, as well as staff members who are providing such services. “Cultural competence is a dynamic, ongoing developmental process that requires a long-term commitment and is achieved over time” (U.S. Department of Health and Human Services [HHS] 2003a, p. 12).

Cultural competence plans are strategic plans that outline a systematic organizational approach to providing culturally responsive services to individuals and to increasing cultural competence among staff at each level of the organization.

Cultural diffusion is the process of cultural intermingling.

Cultural humility “incorporates a lifelong commitment to self-evaluation and critique” (Tervalon and Murray-García 1998, p. 123) to redress the power imbalances in counselor–client relationships.

Cultural norms are the spoken or unspoken rules or standards for a cultural group that indicate whether a certain social event or behavior is considered appropriate or inappropriate.

Cultural proficiency involves a deep and rich knowledge of a culture—an insider’s view—that allows the counselor to accurately interpret the subtle meanings of cultural behavior (Kim et al. 1992).

Culture is the conceptual system that structures the way people view the world—it is the particular set of beliefs, norms, and values that influence ideas about the nature of relationships, the way people live their lives, and the way people organize their world.

Ethnicity refers to the social identity and mutual belongingness that defines a group of

people on the basis of common origins, shared beliefs, and shared standards of behavior (culture).

Ethnocentrism is “the tendency to view one’s own culture as best and to judge the behavior and beliefs of culturally different people by one’s own standards” (Kottak 1991, p. 47).

Health disparity is a particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion (HHS 2011a).

Hembrismo refers to female strength, endurance, courage, perseverance, and bravery (Falicov 1998).

Latinos are those who identify themselves in one of the specific Hispanic or Latino Census categories—Mexican, Puerto Rican, or Cuban—as well as those who indicate that they are “other Spanish, Hispanic, or Latino.” Origin can be viewed as the heritage, nationality, group, lineage, or country of birth of the person or the person’s parents or ancestors before their arrival in the United States.

Immersion–emersion is a stage in the identity development models of both Cross and Helms during which a transition takes place from satisfaction with the old self to commitment to personal change: from immersion in one’s old identity to emerging with a more mature view of one’s identity (Cross 1995b).

Indigenous peoples are those people native to a particular country or region. In the case of the United States and its territories, this

includes Native Hawaiians, Alaska Natives, Pacific Islanders, and American Indians.

Institutional racism generally “refers to the policies, practices, and norms that incidentally but inevitably perpetuate inequality,” resulting in “significant economic, legal, political and social restrictions” (Thompson and Neville 1999, p. 167).

Language is a culture’s communication system and the vehicle through which aspects of race, ethnicity, and culture are communicated.

Machismo is the traditional sense of responsibility Latino men feel for the welfare and protection of their families.

Marianismo is the traditional belief that Latinas should be self-sacrificing, endure suffering for the sake of their families, and defer to their husbands in all matters. The Virgin Mary is held up as the model to which all women should aspire.

Motivational interviewing is a counseling style characterized by the strategic therapeutic activities of expressing empathy, developing discrepancy, avoiding argument, rolling with resistance, and supporting self-efficacy. In motivational interviewing, the counselor’s major tool is reflective listening.

Multiracial individuals are any racially mixed people and include biracial people, as well as those with more than two distinct racial heritages (Root 1992).

Native Hawaiians and other Pacific Islanders include those with “origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands” (Grieco and Cassidy 2001, p. 2). Other Pacific Islanders include Tahitians; Northern Mariana Islanders; Palauans; Fijians; and cultural groups like Melanesians, Micronesians, or Polynesians.

Nguzo saba are the seven African American principles celebrated during Kwanzaa:

- *Umoja* is unity with family, community, nation, and race.
- *Kujichagulia* means self-determination to define collective selves, create for collective selves, and speak for collective selves.
- *Ujima* refers to collective responsibility to build and maintain community and solve problems together.
- *Ujamaa* refers to cooperative economics to build and maintain businesses and to profit from them together.
- *Nia* is a sense of purpose to collectively build and develop community to restore people to their traditional greatness.
- *Kuumba* is creativity to always do as much as possible to leave the community more beautiful and beneficial than it was.
- *Imani* refers to belief in the community’s parents, teachers, and leaders and in the righteousness and victory of the struggle.

Organizational cultural competence and responsiveness refers to a set of congruent behaviors, attitudes, and policies that enable a system, agency, or group of professionals to work effectively in cross-cultural situations (Cross et al. 1989). It is a dynamic, ongoing process.

Orgullo means pride and dignity.

Personalismo is the use of positive personal qualities to accomplish a task.

Race is a social construct that describes people with shared physical characteristics.

Racism is an attitude or belief that people with certain shared physical characteristics are better than others.

Reculturation occurs when individuals return to their countries of origin after a prolonged period in other countries and readapt to the dominant culture.

Respeto can be translated as respect but also includes elements of both emotional dependence and dutifulness (Barón 2000).

Selective perception is, in Helms's model of racial identity development, the tendency of people early in the process to observe their environment in ways that generally confirm their pre-existing beliefs.

Simpatía is an approach to social interaction that avoids conflict and confrontation. One who is *simpático* is agreeable and strives to maintain harmony within the group.

Syncretism is the result of combining differing systems, such as traditional and introduced cultural traits.

Transculturation is the acceptance of a part or a trait of one culture into another culture.

White privilege is a form of ethnocentrism and refers to a position of entitlement based on a presumed culturally superior status.

Whites/Caucasians are people "having origins in any of the original peoples of Europe, the Middle East, or North Africa." This category includes people who indicate their race as White or report entries "such as Irish, German, Italian, Lebanese, Near Easterner, Arab, or Polish" (Grieco and Cassidy 2001, p. 2).

Appendix H—Resource Panel

Note: Information given indicates each participant’s affiliation during the time the panel was convened and may no longer reflect the individual’s current affiliation.

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Appendix K—Acknowledgments

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SAMHSA TIPs and Publications Based on TIPs

What Is a TIP?

Treatment Improvement Protocols (TIPs) are the products of a systematic and innovative process that brings together clinicians, researchers, program managers, policymakers, and other federal and non-federal experts to reach consensus on state-of-the-art treatment practices. TIPs are developed under the Substance Abuse and Mental Health Services Administration's (SAMHSA's) Knowledge Application Program (KAP) to improve the treatment capabilities of the Nation's alcohol and drug abuse treatment service system.

What Is a Quick Guide?

A Quick Guide clearly and concisely presents the primary information from a TIP in a pocket-sized booklet. Each Quick Guide is divided into sections to help readers quickly locate relevant material. Some contain glossaries of terms or lists of resources. Page numbers from the original TIP are referenced so providers can refer back to the source document for more information.

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Also based on TIPs, KAP Keys are handy, durable tools. Keys may include assessment or screening instruments, checklists, and summaries of treatment phases. Printed on coated paper, each KAP Keys set is fastened together with a key ring and can be kept within a treatment provider's reach and consulted frequently. The Keys allow you, the busy clinician or program administrator, to locate information easily and to use this information to enhance treatment services.

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| TIP 2 Pregnant, Substance-Using Women—
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Linking Substance Abuse Treatment and Domestic Violence Services: A Guide for Treatment Providers
Linking Substance Abuse Treatment and Domestic Violence Services: A Guide for Administrators
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- TIP 26 Substance Abuse Among Older Adults**
Substance Abuse Among Older Adults: A Guide for Treatment Providers
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- TIP 27 Comprehensive Case Management for Substance Abuse Treatment**
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- TIP 28 Naltrexone and Alcoholism Treatment**—*Replaced by TIP 49*
- TIP 29 Substance Use Disorder Treatment for People With Physical and Cognitive Disabilities**
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- TIP 30 Continuity of Offender Treatment for Substance Use Disorders From Institution to Community**
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- TIP 31 Screening and Assessing Adolescents for Substance Use Disorders**
See companion products for TIP 32.
- TIP 32 Treatment of Adolescents With Substance Use Disorders**
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- TIP 33 Treatment for Stimulant Use Disorders**
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- TIP 34 Brief Interventions and Brief Therapies for Substance Abuse**
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- TIP 35 Enhancing Motivation for Change in Substance Abuse Treatment**
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- TIP 36 Substance Abuse Treatment for Persons With Child Abuse and Neglect Issues**
Quick Guide for Clinicians
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Helping Yourself Heal: A Recovering Woman's Guide to Coping With Childhood Abuse Issues
Also available in Spanish
Helping Yourself Heal: A Recovering Man's Guide to Coping With the Effects of Childhood Abuse
Also available in Spanish

- TIP 37 Substance Abuse Treatment for Persons With HIV/AIDS**
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 Drugs, Alcohol, and HIV/AIDS: A Consumer Guide
 Also available in Spanish
 Drugs, Alcohol, and HIV/AIDS: A Consumer Guide for African Americans
- TIP 38 Integrating Substance Abuse Treatment and Vocational Services**
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- TIP 39 Substance Abuse Treatment and Family Therapy**
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- TIP 43 Medication-Assisted Treatment for Opioid Addiction in Opioid Treatment Programs**
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- TIP 44 Substance Abuse Treatment for Adults in the Criminal Justice System**
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- TIP 46 Substance Abuse: Administrative Issues in Outpatient Treatment**
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- TIP 53 Addressing Viral Hepatitis in People With Substance Use Disorders**
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- TIP 54 Managing Chronic Pain in Adults With or in Recovery From Substance Use Disorders**
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 You Can Manage Your Chronic Pain To Live a Good Life: A Guide for People in Recovery From Mental Illness or Addiction
- TIP 55 Behavioral Health Services for People Who Are Homeless**
- TIP 56 Addressing the Specific Behavioral Health Needs of Men**
- TIP 57 Trauma-Informed Care in Behavioral Health Services**
- TIP 58 Addressing Fetal Alcohol Spectrum Disorders (FASD)**
- TIP 59 Improving Cultural Competence**