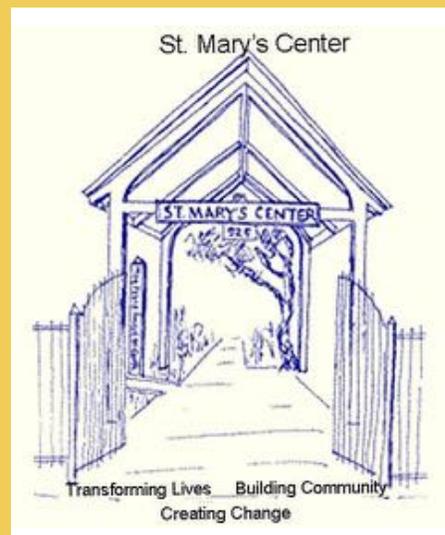


St. Mary's Center



Co-Occurring Healing



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Our Story

This project began with a belief that both the service provider and the client/consumer would benefit from a deeper look at the therapeutic implications of culture in a healing relationship with persons with co-occurring health issues. For the service provider, a respectful appreciation of the cultural values, mores, and strengths of a culture enables her or him to listen with a different ear. For the client/consumer, a connection or re-connection with cultural roots can deepen self-esteem and personal agency—enabling them to take a more active part in the healing relationship.

We began with healing circles as a way to surface African American cultural values and characteristics as seen by participants at St. Mary's Center. As participants engaged with the process they began to see themselves beyond their diagnoses and could speak of themselves from a more integral perspective.

With the surfaced characteristics in mind, staff assessed themselves and the agency through a questionnaire as well as an interview process led by the cultural mentor. Based on the staff assessments, four cultural competency trainings involved staff from all aspects of St. Mary's programs. A post-test indicated that staff had increased their cultural competency and, at the same time, they perceived an increased need for further work. Their recommendations included new ways of collaborating with Center participants, including a client advisory board, and continuation and development of culturally specific services.

Sincerely,
Sister Eva Lumas
Carol Johnson, Executive Director

See Me, Hear Me:

Empowering African American Seniors

and Their

Behavioral Health Care Providers to

Embrace the Healing Power of Culture

A Curriculum developed by

St. Mary's Center

Oakland, California

2013

St. Mary's Center wishes to express its deep gratitude to the twenty African American men and women elders whose insight, generosity, courage, hope and commitment to healing and wholeness helped to give this project life.

The seniors and staff of St. Mary's Center wish to express their gratitude to Alameda County Behavioral Health Care Services for the funding and continual encouragement in the development of this project. We also wish to thank the Oakland Health and Human Resource Education Center for encouraging us to follow our instincts and "let the process be the product" for this curriculum. Engaging in this project has served us well, and we are confident that this curriculum can inspire other behavioral health care providers who strive to companion, console, coach, and celebrate the African American community.

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Foreword

The learning question that prompted the development of this curriculum is both urgent and complex:

What are the cultural and spiritual nuances, beliefs, practices and norms specific to the African American community that should be incorporated into the planning, delivery, and outcomes of mental health and co-occurring conditions services for this community?

The urgency of the question is evidenced by the fact that low-income African Americans receive a disproportionately high amount of Alameda County's mental health services, but their treatment outcomes are inconsistent or disproportionately low.¹ The complexity of the question is evidenced by the fact that California mental health providers are still asking the question after investing more than twenty years toward promoting cultural competency in the delivery of behavioral health care and supportive services.² The question is important and, yes, it needs to be continually asked not only because the wellbeing of the African American community will be critically affected by the answer, but also because the question can never be fully answered—African Americans who utilize behavioral health care services and providers are still learning the full effects of ongoing cultural assaults, disruption, distortion and loss within the Black community. And, both groups are still learning the multiple and overlapping demands of meaningfully pursuing cultural competence on individual as well as organizational levels.

Contemporary literature points out that accomplishing these tasks is made all the more arduous by virtue of the fact that behavioral health care providers, agencies and systems do not share common understandings of the relationship between culture and wellness. They do not have shared understandings of how to

¹ Behavioral Health Care Services. African American Utilization Report. Alameda County, CA: Winter 2011. p. 7-8.

² Ibid. See also: California Institute for Mental Health. Many Voices, One Direction: Building A Common Agenda for Cultural Competence in Mental Health. Sacramento, CA: 2002. p. 7.

recognize, develop or assess the individual or organizational cultural competencies. And, they are often conflicted about the appropriateness of offering culturally-specific services in a health care venue with a multicultural client populace.³ Additionally, there is the fact that African American culture cannot be simply described because, like all cultures, it is not monolithic, static, completely conscious, completely known by any single person or group, or unaffected by the psycho-social ecology of place and time.⁴ The fact is that it takes a lot of time to discern the inner workings or core reality of a culture, any culture.

African American culture cannot be fully known by periodic excursions into “afro-tourisms” (occasionally engaging with African American cultural artifacts such as music, aesthetics, dance, food, aphorisms, etc.). It also cannot be fully known or appreciated by participating in seasonal celebrations (i.e., Kwanzaa, Martin Luther King, Jr. Holiday or Black History Month). Indeed, Africentric social scientists⁵ not only caution against applying a thin veneer of culture to “standardized” behavioral health care practices, they also site the need to make cultural healing (i.e., overcoming the effects of cultural assaults, disorientation and alienation) an essential component of the planning, delivery and outcomes of behavioral services offered African Americans.⁶

This document represents a two-year effort by seniors and staff at St. Mary’s Center SMC) to address the learning question as it relates to African American seniors with co-occurring health issues. We originally planned the project as a two-fold process: 1) A series of Healing Circles to invite a representative group of our

³ Lewin Group, Indicators of Cultural Competence in Health Care Delivery Organizations: An Organizational Cultural Competence Assessment Profile. (Washington, DC: 2002), p. 1.

⁴ See: Jacqueline P. Butler, “Of Kindred Minds: The Ties That Bind”, Center for Substance Abuse Prevention: Cultural Competency Series 1. (Rockville, MD: 1995), pp. 30-41.

⁵ This group of persons are referred to as “African American subject matter experts” in the Alameda County African American Utilization Report. op. cit. p 11.

⁶ See: Judson L. Hixson, “Developing Culturally Anchored Services: Confronting the Challenge of Intragroup Diversity”, Center for Substance Abuse Prevention: Cultural Competency Series 7. (Rockville, MD: 1998), pp. 9-45; Na’im Akbar. Chains and Images of Psychological Slavery. (Jersey City, NJ: 1984); Wade W. Nobles. Seeking the Sakhu. Third World Press. (Chicago, IL: 2006) pp.243-315

African American seniors to name their cultural and spiritual characteristics and suggest ways of incorporating them into the services we provide. 2) A four to six session staff enrichment/training process to familiarize the whole staff with the identified cultural and spiritual characteristics and to learn practical strategies for incorporating them into our varied programs and services. However, we quickly ran into a number of significant challenges that invited us to let the process of developing our project become the pivotal component of our learnings. In sum, ***we learned that we had to learn how to learn.***

Our process taught us the truth of the adage that “developing cultural competence is a journey, not a destination”. Every step of developing our teaching/-learning process not only led to new insights, but also required us to address a previously unanticipated or unarticulated question and/or concern. We quickly learned that achieving our learning objectives would require careful attention to multiple individual and organizational assumptions, understandings and practices that were taken for granted. We chose to let the learnings derived from engagement in the process teach us what we needed to do next. This open-ended method of discovery required us to continually tweak the content and/or methodologies we had earlier conceived. And, while we readily admit that we have much more to do to develop our individual and organizational cultural competencies, we proudly boast that our process has resulted in a firm foundation for future work.

Within the next twelve months staff have committed to the following actions

(1) Create a Senior Advisory Board to facilitate more collaboration among our seniors and staff regarding the planning and delivery of services

(2) Develop ongoing staff enrichment/training opportunities focused on African American culture, history, best practices for overcoming historic traumas

(3) Continue the healing circles with one set designed to help our African American seniors overcome the ill-effects of cultural alienation, and another set designed to promote intercultural awareness and sharing among the multicultural senior populace who regard St. Mary’s Center as one of their primary communities.

We assume that every behavioral health care group and venue will have to discern its own cultural competency needs, readiness, and practical possibilities for developing their cultural responsiveness to the African American community or any

other community they seek to engage. We hope this sharing of our teaching-learning process will motivate our colleagues to “stay the course” on the journey toward increased culturally.



Introduction

See Me, Hear Me: Empowering African American Seniors and Their Behavioral Health Care Providers to Embrace the Healing Power of Culture was developed as a multidimensional process to actively engage African American seniors in (1) naming the cultural and spiritual characteristics that should be incorporated into the behavioral health care services they receive, and (2) proposing how these characteristics should be incorporated. Together, this sequence of activities would nurture collaborative relationships between the seniors and staff, reconnect the seniors to their cultural core, and cultivate the cultural awareness and competence of the staff which would result in new/renewed individual and organizational understandings, programs and practice.

The curriculum presented represents a two year, four-part process of reflection, dialogue and program development on the part of the staff and a selected group of African American seniors at St. Mary's Center (SMC) in Oakland, California. The Center was founded in 1973 and, as a nonprofit corporation, and serves low-income and homeless elderly in West Oakland. SMC provides a welcoming setting and comprehensive services for people age 55 and older from all racial, cultural and religious backgrounds. Over 70% of the seniors who regularly engage in the onsite services are African American. SMC services include outreach, housing stabilization, health services, financial management and assistance, meals, art, a winter shelter, as well as substance abuse and mental health counseling and case management. Seniors are involved in neighborhood improvements and advocacy at the state, local and federal levels.

St. Mary's Center was poised to take on this process. SMC's mission is "to be a responsive community of healing, hope and justice, providing comprehensive services...(encouraging) clients to be self-reliant and engaged in achieving their personal goals in order to improve the health and well-being of our community."

This document presents a descriptive overview of the multiple and varied strategies, learning objectives, thematic content, methodologies, resources, outcomes and learnings for our project. We also offer some recommendations for others who may choose to embark along a similar learning path. ***See Me, Hear Me:***

Empowering African American Seniors and Their Behavioral Health Care Providers to Embrace the Healing Power of Culture is a multidimensional process with four distinct, but overlapping parts. **Part 1** consists of six (6) communal discernment meetings aimed at constructing a vision and cultivating agency-wide commitment for the innovations project. **Part 2** consists of a series of healing circles that invited African American seniors to name their cultural and/or spiritual characteristics and suggest ways of incorporating them into the practice of behavioral health care and related services (BHC/RS). **Part 3** was designed to engage the staff in a comprehensive assessment of their own cultural competency and the cultural competency of SMC as a behavioral health care agency. **Part 4** consists of four (4) staff enrichment/training sessions designed to foster attitudes, develop skills, and engage staff with implications of the outcomes from **Parts 2** and **3**.

Each of the parts are developed according to the primary purpose, a description of the method(s) used, outcomes, and recommendations.

PART 1

The process for developing intercultural competence aims at moving participants to a higher level of intercultural competence...An initial step in exploring the learning needs is to understand what type of change is envisioned, why, and by whom.

J. Gregersen-Hermans and M. D. Pusch

The Community Planning Meetings

It goes without saying that there has to be some way of assessing the interests of employees and other agency stakeholders to engage in a “culturally anchored” project that would somehow impact every employee and most, if not all of the services offered to the largest cultural community the agency serves: the African American community. The Executive Director articulated the strategic goal of these meetings by stating: “We want to strengthen our program at SMC to serve the greater needs of the African American community in our area. How can we better respond?” With that in mind, these planning meetings served to “test” the interests of employees and other stakeholders for initiating such a project, to outline the general contours of the project, and to identify some of its desired outcomes.

Descriptive Overview. At St. Mary’s Center six 90-minute planning meetings were conducted over a three (3) month period of time. The meetings were convened and chaired by SMC’s executive director, and the participants included both staff and African American seniors who regularly and actively participate in the agency’s varied programs and services. The actual number of meeting participants grew over time and they were personally invited by either the executive director or a member of the staff.

The meetings invited a critical and representative group of organizational stakeholders (administration, providers and client/consumers) to discern if and how the African American seniors served by SMC would benefit by addressing the Learning Question posed by the Alameda County Behavioral Health Care Innovations 2 grant project (INN 2):

What are the cultural and spiritual nuances, beliefs, practices and norms specific to the African American community that should be

incorporated into the planning, deliver, and outcomes of mental health and co-occurring services offered to this community?

Apropos to this, the community planning meetings are meant to achieve the following purposes:

- Review the overall purposes of the project being considered. It is useful to use the County's Winter 2011, *African American Utilization Report*.
- Discern if the agency's overall service capacity and effectiveness could be improved by creating a project that addressed the County's learning question
- Articulate a vision for the project in relationship to the agency's current organizational and programmatic values and goals
- Promote agency-wide "buy in" (commitment) for the project from staff and African American seniors
- Elicit ideas from both staff and seniors regarding the project's content and structural components in order to achieve the project's desired outcomes:
 1. *Learn the cultural and spiritual characteristics specific to the African American community.*
 2. *Learn how to incorporate these characteristics into the planning, delivery, and outcomes of behavioral health care services provided to African Americans with co-occurring conditions.*
- Initiate collaboration of staff and seniors with the cultural mentor that will resource, coordinate and facilitate the process that would eventually become the curriculum presented to the ACBHCS.

The table below outlines the participant attendance, agenda and desired outcomes of meetings. This detailed overview of the meetings is not intended to be prescriptive. Instead, it is meant to be instructive. The topics the group chooses to discuss, and the insights the group bring to those discussions gives glimpses into the assumptions, beliefs, goals the group begins with that can facilitate or challenge the organization's capacity to develop its overall cultural competence.

FIRST MEETING
Attendance: <ul style="list-style-type: none">• Top leadership of the organization• Senior management• Key program staff
Agenda Summary: <ol style="list-style-type: none">1. Discern need for increased and improved behavioral health care services for African American community2. Discern potential of project to enhance the agency's services to the greater needs of the African American community3. Identify additional participants for next meeting to invite ideas regarding project content and process, and promote agency-wide "buy in" among staff and seniors
Significant Outcomes would be: <ol style="list-style-type: none">1. To affirm that the project could enhance quality of the agency's and County's services for the African American community,2. To decide that the project will be a strengths-based and holistic process3. To identify names of staff and seniors to invite to next meeting

SECOND MEETING

Attendance:

- Top leadership of the organization
- Senior management representative(s)
- Client representatives
- Key program staff

Agenda Summary:

1. Review the purpose of the project
2. Affirm that the project could enhance services offered by the organization
3. Affirm that the project would have two primary components: healing circles to engage seniors and staff enrichment/training program
4. Brainstorm possible content for healing circles (e.g., build self-esteem) and staff enrichment/training (e.g., identify attitudes, assumptions, knowledge and behaviors that contribute to both positive and negative treatment outcomes among African Americans).
5. Identify additional participants for next meeting to broaden input regarding project content and structure, and promote agency-wide “buy in” among staff and seniors

Significant Outcomes would be:

1. To affirm that the project would complement and enhance services offered by the agency
2. To affirm that the project should be strengths-based and enhance collaboration between seniors/clients and staff.
3. To name some issues that contribute to poor treatment outcomes with African Americans, e.g., they have general distrust of health care system, they often feel warehoused, stereotyped or judged.
4. To name some practical ways that staff can show cultural sensitivity toward African Americans, e.g., make eye contact.
5. To identify staff and seniors/clients to invite to next meeting

THIRD MEETING
<p>Attendance:</p> <ul style="list-style-type: none"> • Top agency leadership • Senior management representative(s) • Client representatives • Key program staff
<p>Agenda Summary:</p> <ol style="list-style-type: none"> 1. Continue brainstorming possible content for healing circles (e.g., can contribute to empowering clients) and staff enrichment/training (e.g., varied power differentials that impacts mental health issues and treatment in African American community) 2. Identify additional participants for next meeting to broaden vision of project content and structure, and promote agency-wide “buy in”
<p>Significant Outcomes would be:</p> <ol style="list-style-type: none"> 1. Further clarification of content and structure of healing circles and staff enrichment/training processes 2. To identify staff and seniors/clients to invite to next meeting 3. Assignment: Come prepared to discuss possible content and structural components of staff enrichment/training program.
FOURTH MEETING
<p>Attendance:</p> <ul style="list-style-type: none"> • Top agency leadership • Senior management representative(s) • Client representatives • Key program staff
<p>Agenda Summary:</p> <ol style="list-style-type: none"> 1. Continue conversation regarding ways that agency can better demonstrate cultural responsiveness with African Americans we serve 2. Identify organizational values that should inform development of project/process
<p>Significant Outcomes would be:</p> <ol style="list-style-type: none"> 1. To affirm that overall project/process should be participatory/relational, holistic, and reality-based—be a collaborate effort, address larger needs of the community 2. To affirm need to provide wide spectrum of services and stay mindful of primary values and principles that guide our efforts, e.g., meeting people where they are

FIFTH MEETING
<p>Attendance:</p> <ul style="list-style-type: none"> • Top agency leadership • Senior management representative(s) • Client representatives • Key program staff
<p>Agenda Summary:</p> <ol style="list-style-type: none"> 1. Continue conversation regarding ways to develop agency’s cultural responsiveness to African Americans 2. Identify cultural mentor to facilitate development and implementation of project in collaboration with key stakeholders (seniors, staff, administration)
<p>Significant Outcomes would be:</p> <ol style="list-style-type: none"> 1. To collate lists that demonstrate agency’s cultural competence and areas in which agency perceives the need to grow 2. To identify hopes and concerns about the the project will pose to the “normative” programs and practices of the agency and individual providers
SIXTH MEETING
<p>Attendance:</p> <ul style="list-style-type: none"> • Top agency leadership • Senior management representative(s) • Client representatives • Key program staff • The Cultural Mentor
<p>Agenda Summary:</p> <ol style="list-style-type: none"> 1. Introduce Cultural Mentor (e.g., mentor shares assumptions, experience, knowledge, skills they bring to the task) 2. Clarify for cultural mentor the specific purposes of the project, the planning committee’s desired outcomes for the Healing Circles and the Staff Enrichment/Training Process
<p>Significant Outcomes would be:</p> <ol style="list-style-type: none"> 1. To clarify the cultural mentor’s role and responsibilities for resourcing, developing and facilitating the learning process 2. To strategize how the cultural mentor can learn the culture of the organization

Outcomes. Besides deciding to use Healing Circles to actively engage African American seniors in the process of achieving the first learning objective and to develop a staff enrichment/training process to achieve the second, these meetings served SMC very well. From an organizational standpoint the meetings provided a profile of the agency's cultural competence capacity in each of the seven performance areas that U.S. Department of Health and Human Services deems to be essential for providing culturally competent health care:⁷ From these first meetings an agency can expand buy-in for the process as well as assess initial areas of cultural competence. In the case of SMC we learned the following:

- *Organizational values:* Affirmed the agency's value for providing culturally competent care in order to meaningfully respond to the larger wellness issues of the community
- *Governance:* Demonstrated the administration's commitment to provide it
- *Planning/Monitoring and Evaluation:* Demonstrated the organization's willingness to create processes for proactively assess and cultivate its cultural competence
- *Communication:* Demonstrated the need for open communication and collaboration between the administration and providers, between the providers and seniors/clients, and among providers.
- *Staff Development:* Proposed a viable strategy for developing the staff's cultural competencies
- *Organizational Infrastructure:* Increased the organization's resources for developing the cultural responsiveness of providers and programs, i.e., hired a cultural consultant
- *Services/Interventions:* Agreed to establish a new programmatic venue to enhance the organization's overall commitment and capacity for delivering culturally competent services—the creation of African American the Healing Circles.

⁷ See: Lewin Group, An Organizational Cultural Competence Assessment Profile. (Washington, DC: 2002).

As previously stated, the meetings also gave some insight into the staff's and seniors/clients' current understandings of African American culture and spirituality, as well as how it should be incorporated into the services offered to that community:

- Identified African American cultural and spiritual characteristics important to this age group (55 and older):
 - Relational with strong value for kinship and community ties
 - Have empathy for others
 - Resilient
 - High-context—body language, tone of voice, facial expressions—all convey meaning
 - Value improvisation and spontaneity
 - Highly proficient verbal skills—often answer seemingly simple questions with elaborate stories (thinking that it all comes to bear on “the answer”)
 - Tend to be intuitive thinkers
 - Value the role of spirituality and faith.
- Identified a cogent list of culturally competency indicators for individuals and organizations working with African Americans:
 - Acknowledge that developing cultural competencies is a process—not a project
 - Remember that facilitating wellness has to include empowering African Americans (developing their sense of agency—their ability to be self-defining and determining
 - Ability to identify and use strengths and respect their ability to name needs and have them met)
 - Ability to help African Americans overcome intragroup stratifications (i.e., classism, internalized racism/self-hate, cultural alienation)
 - Skills to reconnect African Americans with values, behaviors and relationships that traditionally nurtured/sustained wellness
 - Keep services “real” (i.e., engage head, heart and spirit)

- Foster collaboration between staff and seniors to discern what wellness is and how to promote it
- Be open to innovations that may increase and/or improve programmatic outreach and effectiveness (i.e., seek out best practices to develop services for African Americans)
- Encourage peer group leadership
- Provide culturally resonant services, celebrations, and opportunities (e.g., educative outings like movies, exhibits; seasonal celebrations like MLK Holiday, Kwanzaa and Black History Month; “art and soul” events like music, dance, poetry writing/recitation, drumming, “mask”, painting and clay projects)
- Identified a practical list of attitudes and behaviors that give evidence of providers’ cultural responsiveness to the African American community:
 - Remember that a person is taking a risk/becoming vulnerable by coming for services—may feel, shame, guilt, stigma and distrust
 - Avoid making unfair comparisons with other ethno-cultural groups
 - Not projecting negative judgments onto all Black people because of troubling experience with one Black person
 - Whenever possible “be there” if invited to a party, communal celebration, church event
- Identified a list of practical methods for providers to invite and demonstrate respectful engagement with African American seniors:
 - Make eye contact, be welcoming (i.e., smile),
 - Be “homey”—have coffee and donuts in community drop in center
 - ,Keep environment safe—physically and psychologically (i.e., move volatile situation out public view/arena)
 - Ask open-ended questions and slow down—don’t “rush” people to get what you think is the important data (i.e., don’t assume you know what you need to know or what person need)
 - Respond to people with empathy (sometimes silence is interpreted as disinterest, not respect)

- Identified a set of values to guide the development of the INN 2 project:
 - It should be *relational* (includes meaningful interactions among staff, between staff and seniors)
 - *Holistic* (can respond to expected and unexpected, but real needs of seniors and staff)
 - *Reality-based* (acknowledge that no matter what we do, there will always be more to do, so focus on laying sound foundation for ongoing discernment of meaningful and practical outcomes.)
 - Will have to let the process teach us how we need to grow and what we do now to start moving in that direction
- Identified a list of pertinent topics for possible inclusion in the staff enrichment/training process:
 - Knowledge about African American culture, history, persistent micro and macro aggressions of daily life
 - Impact of historic trauma, power differentials, stratifications within the African American community (i.e., social class)
 - Differences between African American and African cultures
 - Ways to make agency truly multicultural
- Identified a sobering list of issues that often impede the effectiveness of behavioral health care services offered to African Americans:
 - They may have a general distrust of health care system
 - They often feel warehoused, stereotyped or judged; often find that “standardized” program models are not culturally responsive, or just put a “cultural veneer” on its standardized methods (i.e., “add in” a Black History Month program, but not attempt to make substantive changes in goals or methods)
 - The “system” assumes it knows what African Americans want/need, rather than asking and collaborating with them

- Many providers seem to fear African Americans (i.e., too quick to call the police or quick to diagnose rather than empathize with client responses)

Recommendations. Although organizations can use methods that are different from the Community Meeting model identified here, every effort to assess and develop the cultural competencies of an agency's program planning, delivery and outcomes should consider that:

1. Some form of "buy-in" to the process is necessary. This includes top leadership as well as a diversity of staff.
2. It is equally important to engage staff who represent each of the agency's varied programs. This diversity of staff serves to break down institutional hierarchies of organizational roles, education and experience, etc.
3. Active participation from the persons whom programs are intended to serve is a key component. They provide a broad base of insight and experience that the planning process would not otherwise have.
4. Reviewing a summary of current Cultural Competency Standards in the field early on in the process can help focus the group's ability to identify its current cultural competencies and learning needs.
5. Engaging a cultural mentor early on in the process can help organizations identify and explore a wider range of possibilities regarding individual and organizational cultural competencies than they may have been able to address on their own.
6. It is important to affirm the group's demonstrated cultural competencies and willingness to identify its learning needs. The collected data provides a snapshot of the group's perceived and/or actual cultural competencies which will influence the development of the healing circle and staff enrichment/training process.
7. The cultural mentor needs to know:
 - a. The group's desired outcomes for the project

- b. The time frame for developing and implementing the enrichment/training process⁸
- c. Which key persons within the organization (including seniors/clients, staff and administration) that he or she can regularly collaborate with to discern the cultural competence proficiencies and learning needs of the agency.⁹

⁸ See: J. Gregersen-Hermans and M. D. Pusch, "How to Design and Assess an Intercultural Learning Experience", in *Building Cultural Competence*. Kate Berardo and Darla Deardorff (eds). (Sterling, VA: Stylus publishing, 2012). pp. 23-52.

⁹ See: Cynthia A. Grace. "Practical Considerations for Program Professional and Evaluators Working With African-American Communities", *Center for Substance Abuse Prevention: Cultural Competency Series*, (Rockville, MD: 1995). p 69.

PART 2

Far too many Americans of African descent believe their history starts in America with bondage and struggles forward from there toward today's second-class citizenship. The cost of this obstructed view of ourselves, of our history, is incalculable. How can we be collectively successful if we have no idea or, worse, the wrong idea of who we were and, therefore, are?

Randall Robinson, *The Debt*

The Healing Circles

One of the hallmarks of African American culture is the importance of relationships—the tendency to seek, forge and honor interdependent and mutually supportive ties that confer identity, shape the priorities and guide the activities of each person so engaged.¹⁰ This African American trait resonates well with the four guiding principles of Healing Circles: (1) Every person wants to be connected to others in positive ways, (2) Everyone has values that indicate what a positive connection is, (3) Being connected and acting on our values is not always easy to do, and (4) Given a safe space, we can reconnect with our core values and nurture our desire to be positively connected.¹¹

These principles were well suited to the organizational values that guided this project (i.e., relational, holistic and reality-based). They resonated with the staff's desire for more collaborative approaches for developing and delivering services to the seniors/clients. And, they provided a very transparent approach for building self-knowledge, self-esteem, and agency among the seniors. The process also provided a practical venue for enabling the seniors and staff to consciously promote wellness apart from the confines of crisis intervention or other treatment modalities.

This project conducted three rounds of Healing Circles. Each round had distinct, but overlapping purposes. The first round served to identify African American cultural and spiritual characteristics. The second round engaged the

¹⁰ Jacqueline P. Butler, "Of Kindred Minds: The Ties That Bind", Center for Substance Abuse Prevention: Cultural Competence Series, (Rockville, MD: 1995) p. 46. See also: Wade W. Nobles, Seeking the Sakhu. (Chicago: IL: Third World Press, 2006). P. 17.

¹¹ K. Pranis, M. Wedge, B. Stuart. Peacemaking Circles: From Crime to Community. (St. Paul, MN: Living Justice Press, 2003) pp.9-10

seniors in the enrichment/training process of the staff. And, the third round of Healing Circles engaged the seniors in an art project designed to invite their development of a keepsake to honor the courage, wisdom, hope, risks, service and healing they had shared by engaging in the process.

The First Round Healing Circles

Descriptive Overview. This round of Healing Circles consisted of four sets of 90 minute gatherings conducted over six consecutive weeks for a total of 24 weeks. The gatherings were co-facilitated by a staff member and the cultural mentor. A third staff member served as a scribe capturing the “essence” of the seniors’ stories in a verbatim-like format on newsprint. Six (6) African American seniors were identified and personally invited to participate in each of the six week gatherings. The invitation emphasized that the seniors would be helping to improve the quality of behavioral health care provided to African American seniors at SMC and throughout the County. Each person agreed that his or her identity would not be disclosed, however he or she might be quoted. Each senior was told that they would receive a stipend of \$65.00 at the end of the six week process if they fully participated (attended and actively engaged) in the six week Healing Circle process, as well as a communal celebration to share outcomes engendered by the Healing Circle process.

The decision to restrict the number of seniors to six persons was consequent to the desire to optimize the time (90 minutes) while giving each senior a chance to speak, as well as sufficient time for group discussion that might be engendered by the personal sharing. Besides wanting a mix of women and men among the seniors selected to participate in the Healing Circles, five specific criteria guided staff decisions regarding which seniors to invite: (1) The persons had to be very familiar with the majority of SMC’s programs and services, i.e., they regularly participate in them, (2) The person had to have a demonstrated ability to engage in focused conversation, and express his or her ideas in a constructive manner, (3) The person would not be unduly reticent (fearful) of assessing the agency’s programs and services, i.e., afraid that there might be repercussions, and (4) The persons had to be available to participate in the whole process. In order to optimize the availability of the senior-participants, the staff decided to schedule the Healing Circles at a time and place that the seniors routinely gathered at SMC. It was also decided that light refreshments would be provided at each session.

For practical reasons, the format of the first session included a number of introductory elements. The last session focused on presenting a summary of

learnings, assessing the Healing Circle process in relationship to its primary purposes, and assessing the value of healing circles in general in the promotion of wellness among African Americans. Allowing for these necessary variances in content, each session included a Welcome/check-in (to acknowledge what may be pressing on the participants' minds and hearts while inviting each person's psyche into the room), an invitation to share insights and/or questions stirred by process, a facilitated conversation (all comments were recorded on newsprint), a review of the recorded comments to insure accuracy, and a brief check out (to learn how the engagement had impacted the seniors, i.e., what thoughts and feelings had been stirred).

The meeting space was always set up such seniors and staff sat together in a circle to minimize the power differential between the seniors and staff. A variety of methods were used to facilitate the conversations, however, the narrative interview method common to ethnographers was very effective for eliciting stories dense with meanings that can be quickly appreciated on a feeling level, if not totally understood on an intellectual level. In a group setting, this interview method tends to spawn other stories of equal intensity and depth.

It is important to note that the questions used to facilitate this process should be carefully chosen, but fluid enough to allow conversation to develop. As the seniors and facilitator(s) review the recorded comments for accuracy, it is possible to ask new questions. The review of comments enabled seniors and facilitators to explore the deeper meanings that were imbedded, if not explicitly named in the stories. The review also allowed the cultural mentor to correlate these meanings to specific African American cultural characteristics that the seniors and/or staff may not have been able to name on their own (See Outcomes, page 29)). It should also be noted that the seniors were asked to rate the cultural responsiveness of the agency by responding to a specific set of open ended questions (see Part 2, Appendix 1).

Purposes of the First Round Healing Circles. The sessions are designed to invite the seniors to:

- Identify specific cultural and spiritual characteristics that should be incorporated into the planning, delivery and outcomes of the behavioral health care services offered to African American seniors with co-occurring health issues.

- Describe how they know if and to what degree these characteristics are incorporated into the planning, delivery and outcomes of services
- Identify specific ways that providers could better incorporate these cultural and spiritual characteristics in their practice

The table below highlights the primary content and structural components of the sessions:

SESSION ONE
<ol style="list-style-type: none"> 1. Welcome and Introductions as needed 2. Check-In 3. Review purpose of the project: Improve the planning, delivery, outcomes of behavioral health care provided to African Americans with co-occurring conditions 4. Review the learning question that will frame goal of this First Round of Healing Circles: What African cultural and spiritual characteristics should be...? 5. Review the operational principles for Healing Circles and general format for each session 6. Review expectations, i.e., full participation and commitments, i.e., confidentiality. 7. Ask if any further clarifications are needed re: purpose, process, etc.; any concerns 8. Facilitated conversation, questions addressed to seniors: <ul style="list-style-type: none"> • Do you appreciate efforts of health care providers to be culturally sensitive? Why? • What kinds of behaviors demonstrate that the providers are/are trying to be culturally sensitive? 9. Review recorded comments for accuracy 10. Check-Out

SESSIONS TWO AND THREE

1. Welcome
2. Check-In
3. Invite comments or questions regarding conversation from previous session
4. Facilitated conversation—Continue conversation begun last session
5. Review recorded comments for accuracy
6. Check-Out

SESSION FOUR

1. Welcome
2. Check-In
3. Invite comments or questions regarding conversation from previous session
4. Facilitated conversation:
 - Review how the content of the narrative interviews is being interpreted and codified into specific cultural and/or spiritual characteristics (Part 2, Appendix 1)
 - Briefly discuss the meaning of these characteristics in relationship to wellness.
 - Briefly discuss these cultural characteristics in light of the larger African American cultural and spiritual inheritance (e.g., the seven principles of the Nguzo Saba. See: Part 2, Appendix 2)
5. Review recorded comments
6. Check-Out

SESSION FIVE

1. Welcome
2. Check-In
3. Invite comments or questions regarding conversation from previous session
4. Facilitated conversation: Rate and discuss the cultural responsiveness of the agency. See: Part 2, Appendix 3.
5. Review recorded comments for accuracy
6. Check-Out

SESSION SIX

1. Welcome
2. Check-In
3. Invite comments or questions regarding conversation from previous session
4. Summary and Evaluation includes:
 - A summary of learnings
 - Assessment of Healing Circle in relationship to desired outcomes
 - Assess value of Healing Circles in general as viable venue for promoting wellness among African Americans.
5. Review recorded comments for accuracy
6. Review next steps in the project – the Celebration to share outcomes and learning of the healing Circles, the staff enrichment/training sessions
7. Questions/Clarifications as needed
8. Check-Out

Outcomes. Although the structure of the Healing Circles is quite straightforward, we think it is important to include some narrative as to SMC's experience with the process. Toward that end we are including some of the tangible outcomes that came from our healing circles.

The success of the First Round Healing Circles is determined by discerning if they achieved their purposes. In the case of SMC, all three of the primary purposes were achieved:

- The seniors identified 13 cultural and/or spiritual characteristics that should be incorporated into the planning, delivery and outcomes of behavioral health care services provided to African American seniors:
 - *Relational*—belief that everyone and everything is integrally connected and the relationships should be honored
 - *Community-oriented*—a person's communal identity is integral to his or her sense of self and self-worth
 - *Person-centered*—appreciate spontaneity, improvisation, innovation, creative variance in expression
 - *Quick to perceive injustice/disharmony*—have strong intuitive sense of imbalance within relationships

- *Strong sense of the spiritual*—spirituality, faith are inseparably connected to life
- *High-context*—discern and express meaning through more than words, i.e., physical and emotional environment, body language, tone of voice, etc.
- *Sensitive to internal “cues”*—believe that feelings inform the process of reasoning, rather than compete with it
- *Oral-Aural*—respond well to verbal communication, more personal/engaging
- *Value efforts to build on transcendent characteristics of life*—“keep on keeping on”
- *Emphasize an optimal view of life*—“nothing we cannot do together”
- *Empowerment is central to wellness*—facilitate people’s ability to live purposeful/productive lives
- *Maintain, replicate and strengthen communal networks that historically fostered wellness/sense of well-being*—“I have the strength if you have the strength”
- *Strengthen understanding of group identity, strengths, potential and possibilities*—“I am because we are, we are because I am”

The seniors also identified indicators of cultural awareness by behavioral health care agencies and providers with descriptive examples that were analogous to those named by the staff in the planning meetings, for instance:

- The physical environment includes Black art and/or other Black aesthetics, i.e., statuary, music, etc.
- The staff are welcoming, i.e., cordial, make eye contact, seem interested (even pleased) that you are there, remember you when you come back
- Agency brochures include pictures of African Americans and range of services address health issues of particular concern to African Americans
- Staff take time to “catch up” with you and possibly share what they’ve been up to, rather than “getting down to the business” of “treatment”
- Staff shows empathy rather than judgment, treat you like a person, not a diagnosis

- The services should focus on building self-knowledge, self-esteem, agency, and collaboration between clients and providers

Using some of these same indicators, the seniors named ways that the overall services and individual providers of SMC demonstrate their desire to be culturally responsive. Of particular note are the following cultural competency indicators:

- Inclusion of Black art in the physical plant
- Welcoming atmosphere and informal “drop in” areas for socializing, recreation, etc.
- Regard SMC as one of their primary communities—deliberate efforts to turn “clients” into members of the family, and invite participation in the delivery of services (i.e., food program, hope and justice committee seniors advocacy program)
- If you don’t show up, staff will try to find you
- Staff “shows up” when possible if invited to family, church or community celebrations
- Seasonal cultural celebrations
- Effort on the part of staff to listen, collaborate on therapeutic goals and possible outcomes

The third purpose (identifying ways SMC providers could better incorporate African American culture and spirituality into their practice) was achieved with the seniors’ request that the African American Healing Circles continue beyond the timeframe of the INN 2 project because the process had:

- Meaningfully reconnected them with core cultural characteristics and strengths
- Increased their self-knowledge and self-esteem making them want to know more about themselves
- Nurtured their overall sense of wellness and well-being

However, it must also be acknowledged that no amount of encouragement or reassurance prompted the seniors to say anything critical about SMC’s existing programs. And, none of the seniors expressed willingness to participate in the staff enrichment/training process.

Learnings. The most important learnings from the First Round Healing Circles have to be:

- The confirmation that, if invited, African American seniors with co-occurring health issues can and will:
 - Name cultural and spiritual characteristics that are important to them
 - Identify practical cultural competency indicators for behavioral health care organizations and individual providers
- The narrative interview process coupled with time for review and interpretation of the recorded comments served well to achieve the primary purposes
- The Healing Circle methodology provides a culturally resonate process to promote the overall sense of wellness and well-being among African Americans

With regard to these primary learnings, there were a number of related findings:

- The six-week timeframe was too short:
 - The seniors needed considerable explanation regarding the purposes and probable outcome of the project, i.e., they expressed the fear that project might just be an “experiment” that would not result in substantive change
 - Anticipate the need to deal with cultural alienation and distortions within the African American community when developing the list of possible questions to focus the narrative interview process, i.e., have to consider how the seniors may equate “Blackness” with criminality, violence, poverty, etc.
 - Need sufficient time to engage introverts and to meaningfully discover the meanings that may only be intuited or nuanced in the narrations of the stories
 - Have to have sufficient time to do summative evaluation of the process (the last session)
- By nature, the narrative interview process takes time for many reasons:
 - The stories cannot be rushed
 - It is often necessary to ask clarifying questions because the relationship of the story to the question that evoked it may not always be clear

- Persons listening to the story derive meanings that the story-teller had not previously considered, or did not intend
- The process spawns new stories that may lead the group in a new, but useful direction requiring more time to complete the process of inquiry
- The facilitator(s) have to have considerable cultural acumen to use the narrative interview process for discerning cultural and spiritual nuances, beliefs and values. This requirement is evidenced by the fact that:
 - The seniors often needed prodding to “unpack” the deeper meanings contained in their stories—it was not that they didn’t want to explicate the meanings, but they seemed to think that the meanings were clear “for those who have ears to hear”.
 - The seniors appreciated having the meanings of their stories positively aligned with culturally anchored research on the African American community, e.g., one senior said, “it’s nice to know that somebody thinks you are a person, not a problem!”
 - Efforts to name specific cultural and spiritual characteristics is a time-consuming process for most people who do not spend much time studying and/or reflecting on these human phenomena, i.e.:
 - ✓ The core realities of culture (i.e., values, assumptions, behavioral norms, worldviews, philosophies, etc.) are unconscious, therefore, people are often able to identify the explicit components of their culture (music, dance, food, aesthetics, language and aphorisms, etc.), but need considerably more time to articulate the implicit (core) realities that are reflected in the explicit components
 - ✓ No culture is monolithic or static, i.e., while there are definite commonalities that designate the members of a cultural group, there are numerous variances among the members, and cultures are always evolving to inform and sustain the members
 - ✓ Within the African American community, the impact of cultural disorientation, alienation and stratification adds another layer of difficulty for discerning core cultural characteristics in addition to the two dynamics mentioned above
- African American seniors with co-occurring health issues often think whether or not they have to suppress their cultural preferences and

mannerisms in order to get the services they need, i.e., they make a conscious effort to imitate the mannerisms, etiquette, formal/reserved interactive behavior and seemingly task-oriented modalities that prevail within “the health care “system”.

Recommendations. Specific recommendations are directly consequent to the learnings:

- An eight week process is more practical for achieving the purposes of this activity
- Senior participation can be facilitated by inviting persons who have a long history with the organization, scheduling at a time they are usually present, and extending the invitation within two weeks of beginning the process.
- It is essential that at least one of the Healing Circle facilitators has considerable cultural acumen in order to interpret and align the seniors’ stories with the well-documented and historically fruitful cultural inheritance of the African American community.
- Choose narrative interview question wisely, i.e., once asked seniors, “What comes to mind when you think of Black culture?” A senior responded, “Which Black culture do you want to know about? Homelessness, violence, addiction or prison?” That simple exchange led to a conversation about cultural alienation within the Black community and the effects of cultural aggressions toward the Black community.

Celebration of the First Round Healing Circle Outcomes

Descriptive Overview. This celebration was originally conceived as a way of bringing closure to the Healing Circle process—we did not anticipate the seniors’ desire to continue the process. We ultimately decided that having the event would be a beneficial way to:

- Reassure the seniors that they had indeed been “seen and heard” and to publically affirm their wisdom, courage and commitment
- Share the Round One Healing Circles outcomes with the larger SMC community and our collaborating agencies
- Bring everyone up-to-date on where we are in the INN 2 project.

The event was scheduled to occur within one month of the last six-week session. In order to facilitate participation, it was scheduled for the same time and place as the Healing Circles, and would end with a potluck lunch (prepared by the seniors and the staff). The seniors were encouraged to invite persons who would be supportive of their participation in the Circles (i.e., family, friends, pastors, etc.). Other invitees included staff from SMC, collaborating agencies, community partners and members of the ACBHCS Innovations project coordination team.

The table below highlights the substantive and structural content of the celebration.

St. Mary's Center HEALING CIRCLES CELEBRATION: "HEAR ME, SEE ME" October, 2012
<p>Welcome and Introduction of guests and seniors</p> <p>Overview of INN 2 Project: "Co-Occurring Healing Among African American Seniors"</p> <ul style="list-style-type: none"> • <u>Aim</u>: Improve the overall effectiveness of Behavioral Health Care Services (BHCS) provided to African American elders managing co-occurring health issues • <u>Desired Learning Outcomes</u>: <ol style="list-style-type: none"> 1. Identify cultural and spiritual characteristics that should be included in planning, delivery and outcomes of BHCS to African American seniors (ages 55 and older) 2. Develop a Training/Enrichment Curriculum for SMC, as well as other BHCS providers and volunteers that will enable them to better incorporate these cultural and spiritual characteristics in the services they provide to African American seniors <p>Overview of SMC Project to date:</p> <ul style="list-style-type: none"> • Community Planning Meetings • First Round Healing Circles followed by Celebration of Learnings • Initial Assessment of Staff and SMC • Staff Enrichment/Training Process • Post-assessment to compare • Project Review/Evaluation from varied community partners • Celebrations to share outcomes and Learnings of whole process <p>Highlight cultural and spiritual characteristics identified by seniors (and illustrate how they were derived from the narrative interview process), e.g., Seniors confirmed that African Americans are relational—seek connections. This cultural characteristic was derived from the following exchange:</p> <ul style="list-style-type: none"> • Question: What are some of the important things you want health care workers to know about working with African Americans? • Representative response: "The psychiatrist...is so busy seeing other people, he just does not listen...just prescribes pills; the medications have side effects...doctor doesn't answer my questions...I have to deal with the pharmacist, not the psychiatrist. I've learned to take care of myself. I just want to make a connection. <p>Comments, clarifications, sharing regarding Healing Circle experience and outcomes</p> <p>Recovery—Step 2 Dramatic Presentation: "Higher Power"</p> <p>Potluck Lunch</p>

Second Round Healing Circles

The second round of Healing Circles was initiated in response to the seniors' request that the African American Healing Circle process continue. These Healing Circles had one purpose:

Heal from the ill-effects of cultural alienation by creating a venue for African Americans to cultivate their self-knowledge, self-esteem and self-determination

Descriptive Overview. Each of the seniors who had participated in the First Round Healing Circles was personally invited (in person or by phone) to a meeting to discuss the possibility of continuing the African American Healing Circles. Ten seniors agreed to attend the meeting which was held at a time and place the seniors routinely frequented SMC.

Because the purpose of the Second Round Healing Circles was already known, the agenda of the meeting was to discuss the logistics and methodologies that would structure the gatherings. It was decided that this round of Circles would also be held once a week, at a time and place that the seniors regularly frequented SMC. The meeting room was to be set-up with chairs in a circle, and light refreshments would be provided. However, these gatherings would only be sixty (60) minutes long to accommodate existing program scheduling. And, there was no predetermined number of sessions.

The structure of these Circles differed from the First Round Healing Circles in several other significant ways: (1) The meetings were facilitated by the SMC cultural mentor, but the agenda was open-ended, i.e., the seniors were to decide one week to next what the topic or activity would frame the content of the following week, (2) A series of different timeframes were to be tried to determine what worked best (i.e., four week modules? every week?), (3) Participation was initially limited to African American seniors who regularly participated in the SMC community in order to establish the purpose and structural components, (4) Participants were allowed to come and go according to their interests and personal schedule, and (5) the actual format of the sessions was very informal, i.e., beyond a brief "check-in" no other structural components were proposed.

During week three, a group of six seniors and the facilitator went to see the movie, *42* (the story of Jackie Robinson's entry into major league baseball). While

debriefing the movie at the next week’s gathering, the group identified some of the macro and micro cultural aggressions that African Americans continually need to manage and/or overcome—even at St. Mary’s Center. In response, the facilitator used the opportunity to pose four questions to the seniors:

- What can you affirm about the cultural competency of staff and overall services at SMC?
- What does SMC already do, but you would like to see it further developed?
- What makes you want to ask “Why?” or “What if...?”, or makes you want to say. “that ain’t right!”?
- What would you like to see added to SMC already does?

The next three weeks were devoted to answering those questions. The table below is the actual summary that the seniors worked with the facilitator to develop. Once completed, the facilitator asked the seniors if they would make a panel presentation to the staff highlighting their answers to the four questions.

Outcomes. The Second Round Healing Circles produced two significant and unexpected outcomes:

- The seniors developed a list of affirmations, suggestions, questions and hopes regarding the cultural responsive of SMC services (See Table below)
- The seniors agreed to present their ideas to the staff during the enrichment/training process

We affirm:
<ul style="list-style-type: none"> • Feeling welcomed, known, like contributors, appreciated, overall friendly and respectful atmosphere, like a second family, look for you..., feel cared for • Ways that people and services encourage and empower us – make you feel “you can...” • Staff is accessible to help, present in lots of settings (here and other places at our invitation) • Staff listens and shares – makes you want to “bring your whole self” • Staff recognizes importance of spirituality • Advocacy and coaching with how to deal with larger health care system • Variety of services and information • Celebrations of culture, i.e., Kwanzaa, MLK, Black History Month

We suggest that you develop...
<ul style="list-style-type: none"> • Knowledge about Black History, culture, etc. so everyone (seniors, staff and larger community) will know more about who African Americans <i>are</i> and who we <i>can</i> be! – can nurture, share, learn from each other • How to better understand and balance activities developed for African Americans and multicultural community • How to deal with conflict as an opportunity to grow, not just a problem to avoid – keep talking to each other • Communication—the “what’s” and “why’s” • Awareness of how some Black/nonblack staff/volunteer attitudes, words, behaviors can feel offensive or arrogant, i.e., it “triggers” something...we both need to know what/why • See how we and staff can develop our ability to “work together”
We want to ask “WHY?”, “WHAT IF...” or say “THAT AIN’T RIGHT” when we...
<ul style="list-style-type: none"> • Don’t always feel we always know the what’s and why’s of policies, procedures (even if it was once explained) • Sometimes feel staff is too quick to “pull rank” and “close ranks” when conflict arises • Don’t always feel have a way of saying, “that ain’t right” or asking “what if...”
We hope that you add...
<ul style="list-style-type: none"> • Committee(s) to develop cultural celebrations – we know we have to do our part by showing up and participating • Ongoing Healing Circles – a way to keep raising our awareness about ourselves as African Americans, the relationship between culture and wellness, address Black health issues • Elder Advisory Board to: <ul style="list-style-type: none"> ▪ Identify needs, concerns, hopes, possibilities ▪ Make recommendations that inform policy and procedures – what if... ▪ Develop seniors’ sense of “ownership” – meaningful contributors to the good of the community ▪ Develop staff knowledge, attitudes, skills • Cultural Mentor to assist seniors and staff as: A resource, liaison, mediator, facilitator for growth/change

The fact that the Round Two Circles continued after the seniors’ presentation to the staff, provided an opportunity for two other significant outcomes:

- The seniors were becoming more aware that their sense of ownership and agency within the SMC was growing, and
- They were learning the potential of the Healing Circle process to foster that growth and reaffirmed their desire for the African American Healing Circles to continue

Learnings. The series of serendipitous events that produced these outcomes are worth noting as examples of letting the process lead to the next learning, as well as the value of informal activities. The first two weeks of Circles consisted of informal discussions about current events, this or that event in Black history, and possible topics for future gatherings. It was the discussion after seeing the movie *42* that the seniors engaged at a very different level. Watching someone else (Jackie Robinson's portrayal in the movie) suffer the effects of racism opened up a different kind of conversation.

Early in the process seniors were asked to participate in a panel presentation to the staff at one of the training sessions. Although they had been reticent to do this several months earlier, the seniors now accepted the invitation. The process of developing confidence through the earlier Healing Circles together with the discussion after *42* and the cultural mentor's framing of questions seems to have brought them to a level of comfort for addressing the staff in the panel presentation.

Recommendations. The movement that happened within the senior group in the Second Healing Circle would suggest that sufficient time is needed to develop safety in the group and sufficient time to share in depth—especially when using the narrative process which we found so helpful.

In addition, the more ownership of the Healing Circle process that participants have (e.g. developing topics or issues and encouraging conversation among the group and not only directed at the facilitator) the stronger the group and potential for fostering personal growth.

Shared activities should be considered as provide fertile ground for insights and growth in addition to formal group settings.

Third Round Healing Circles

This last round of Healing Circles was designed to give the seniors an opportunity to:

- Give creative expression to the varied insights, emotional stirrings, self-understandings, etc. they developed by participating in the INN 2 project
- Create a keepsake to honor the courage, wisdom, hope, risks, service and healing they had shared by engaging in the project

The purposes of this last round of Circles could be carried out in a variety of ways. You might use drawing, painting, dance, etc.—depending on your clients and the resources available. St. Mary's Center had the help of a professional sculptor which gave the project a very "hands on" quality.

Descriptive Overview. Each of the seniors who participated in the First Round and Second Round Healing Circles were personally invited (in person or by phone) to participate in a clay project facilitated by a professional sculptor, Zahava Sherez. The project was conducted in two-hour sessions held over the course of six to eight consecutive weeks (depending on how much time it took to complete and fire the sculptures). All of the materials were provided at no cost, and participants did not have to have any previous experience working with clay.

The seniors agreed that their sculptures together with a statement of its meaning would be displayed at the Center. Because the project offered SMC still another way of discerning and reinforcing the positive outcomes of the Healing Circle process, the seniors were offered a stipend of \$65 dollars for fully participating in the project (i.e., attending and fully engaging in the process).

At the first gathering, the SMC art therapist and the cultural mentor led a brief discussion about the primary purposes of the Third Round Healing Circles, the participants would decide what insight, feeling or memories, etc. they wanted to hold onto. The sculptor would then engage each participant in an informal, but instructive conversation about what the desired clay object was meant to express. Based on that conversation, the sculptor would guide each person's effort to memorialize their reflection in clay.

Prior to the last session, the participants were given a list of questions to frame the explanatory statement that would be exhibited with their sculptures (See: Part 2, Appendix 4). The questions would also frame the intragroup sharing during

the last session when each participant would display and share what his or her sculpture represented by stating: 1) what insight, feeling, hope, memory, belief or value they wanted to memorialize, and 2) How their sculpture's subject matter, color, etching, symbols, words, etc. expressed that concept. The agency art therapist and the cultural mentor decided to participate in the process to companion and encourage the seniors.

Outcomes. As you will see in the pictorial vignettes below, the insights, feelings, etc. that the seniors enshrined in clay range from playful childhood memories, to self-discovery, to professions of faith, to declarations of love, to honoring ancestral legacies marked by achievement and betrayal, to self-acceptance. This project served to remind the seniors and all who viewed their work that words are not always able to give full expression to the primary relationships, deeply held values, iconic beliefs or treasured memories that express who we really are!



“I was inspired by my brother to make the Flintstone house; he made one. I remember hanging out with my brother and watching the Flintstones. Fred (Flintstone) was a motivator, always working, and open to new adventures...I am now staying on top of things, doing the right things, and feeling good about myself...Working with clay made me feel good; it seemed to take away pain in my mind and body...Making the Flintstone house, and remembering good times of my childhood made me feel good and freer.”

“Playing the guitar is a challenge and a joy for me...I started out preferring to play in one key. I learned that what I can do with one key, I can do with all. I can now play any key that I want. That ability connects with spirituality; my ability to play a broader range of what I hear. When I play the guitar or work with the clay...I am...expressing the spirit...I...am...free to...develop a God-given gift.”





“This altar expresses the Love I have for Jesus Christ...God holds me and everybody; knowing that gives me Peace...At first I hated the thought of doing art... I was quick to say *no* to the clay project; I’ve never worked with clay before. Then once I began, it felt good to have my hands on the clay. It seemed like God had hold of the whole thing in my hands. I was surprised to discover I can create something...I now know that I can do more than I think. I have learned that I can do anything if I put my heart into it.”

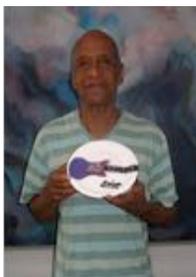
“All my children’s names are on the heart. I am bonding with Family; we are loving, understanding one another. I have wisdom and understanding about who I am today. I am a child of God; we are all children of God...God’s spirit lives within...each person. When I worked with clay I felt my entire spirit. What I hoped for and felt became visible. I respected myself and the importance of being in control of my life. I’m now able to express myself and am not so afraid of the results. I don’t need other people’s approval and I can repel negativity. I’m open to positive energy and love. My heart is open with people and I feel a lot of Peace.”





“A pyramid reminds me of African American history...Throughout civilization each culture has strived to develop its essence...Culture has been oppressed by invading forces, oppression has affected African people; a lot of blood has been shed. The knife with blood is for strife in the African continent. The golden handle is for the influence of a higher power. I felt spiritual moments playing with the clay...I didn't know what it would be and took pleasure in its coming to be what it is...I keep open to life and its ongoing experience. It's a gift to BE...It's a great joy to be in the flow...with love for my brothers and sisters and doing good for all.”

“How many times can I break a commandment and be forgiven by God?...God...forgives us no matter how many times we do wrong. If God forgives, I have to forgive myself and others. I try to live by the commandments, but sometimes I get caught in the turmoil...of life. Just like Moses on his mission...I too have a sense of mission in life, and at times I feel overwhelmed...Today I...remove myself from destructive situations and no longer try to save the world. I have faith in God and myself...As I touched the clay...it felt loving to create without...conditions...I received caring... support and suggestions. This enabled me to enter a sacred space, and to feel free.”



Part 2, Appendix 1

Example of ways that senior responses to narrative interviews could be interpreted and correlated to documented African American Cultural and/or Spiritual Characteristics

Each cultural characteristic is followed by a brief definition/explanation. The numbers indicate the number of times the characteristic was at least implied in one of the senior narratives. The quotes offer an example of the narrative content correlated to the cultural characteristic.

HEALING CIRCLES:

Confirmed that African American seniors are:

- Relational – believe everyone and everything is integrally connected and the relationships should be honored (102)
 “They (health care professionals) should share some things about themselves, i.e., interests and personality—share your person, not just your profession.”
- Community-oriented – a person’s communal identity is integral to his or her sense of self and self-worth (99)
 “SMC is one of my primary communities...I am known,...feel nurtured, comfortable, supported, loved, appreciated, a contributor to...the community, feeds my spiritual hunger...a help to stay clean.”
- Person-centered – see ME, hear ME; appreciate novelty, innovation, spontaneity, improvisation, creative variance in expression (74)
 “One MD “processed” me, but showed no genuine concern for me as a person – was impersonal, rushed. Another MD really “saw” and “treated” me – the internal upheaval, poor physical and spiritual conditions, vulnerability, fear, embarrassment.”
- Quick to perceive injustice/disharmony—have strong intuitive sense of imbalance within relationships (58)
 “Because of my past history: provider did not attend to me, created uncomfortable environment. Being honest [about my past] created a problem for the doctor. I was stereotyped.”
- Strong sense of the spiritual—believes spirituality and faith are inseparably connected to life and overall sense of well-being (35)
 “I’d rather see a sermon lived than preached from a pulpit.”

Part 2, Appendix 2

A Summary List of Some Significant African American Cultural Characteristics

The cultural characteristics identified by the seniors are part of a more extensive list discussed in more depth in Jacqueline P. Butler, "Of Kindred Minds: The Ties That Bind", Center for Substance Abuse Prevention: Cultural Competence Series, (Rockville, MD: 1995) p. 46. A printer friendly version of this article is also available on line from the Management Services for Health website (erc.msh.org/mainpage.cfm?file=5.5.1hm&module=provider&language=English).

- *Relational*—belief that everyone and everything is integrally connected and the relationships should be honored
- *Community-oriented*—a person's communal identity is integral to his or her sense of self and self-worth
- *Person-centered*—appreciate spontaneity, improvisation, innovation, creative variance in expression
- *Quick to perceive injustice/disharmony*—have strong intuitive sense of imbalance within relationships
- *Strong sense of the spiritual*—spirituality, faith are inseparably connected to life
- *High-context*—discern and express meaning through more than words, i.e., physical and emotional environment, body language, tone of voice, etc.
- *Sensitive to internal "cues"*—believe that feelings inform the process of reasoning, rather than compete with it
- *Oral-Aural*—respond well to verbal communication, more personal/engaging
- *Value efforts to build on transcendent characteristics of life*—"keep on keeping on"
- *Emphasize an optimal view of life*—"nothing we cannot do together"
- *Empowerment is central to wellness*—facilitate people's ability to live purposeful/productive lives
- *Maintain, replicate and strengthen communal networks that historically fostered wellness/sense of well-being*—"I have the strength if you have the strength"
- *Strengthen understanding of group identity, strengths, potential and possibilities*—"I am because we are, we are because I am"

Another cogent list of values that sustain African American culture is the Nguzo Saba (the seven principles). See: Maulana Karenga, "The Nguzo Saba (the seven principles): Their Meaning and Message", In M. K. Asante & A. S. Abarry (eds). African Intellectual Heritage: A Book of Sources (pp 543-554). (Philadelphia, PA: Temple University Press, 1996):

- *Unity* – striving for unity in family, community, and race
- *Self-determination* – defining, naming, speaking and creating for oneself

- *Collective work and responsibility* – building and maintaining community and solving problems together
- *Cooperative economics* – building and maintaining the economic base of the community
- *Purpose* – restoring people to their full statured
- *Creativity* – developing the beauty and potential of self and community
- *Faith* – believing in the righteousness of the Black struggle for justice

Part 2, Appendix 3

Question that framed the Seniors' rating of SMC's Cultural Competence

Responses were recorded

Rating of SMC Cultural Competencies

- How often do you come to the center in a week? Approximately how much time do you spend at the Center?
- What activities do you regularly participate in? Why, i.e., why do the activities appeal to you?
- Are there activities that you choose not to participate in? Which ones? Why?
- Would you describe the people at the center (e.g., peers, staff, volunteers) to be one of your primary communities? If so, why or why not?
- Can you name/describe specific programs and practices at the center that demonstrate knowledge and respect for African American culture and/or spirituality?
- Are there ways you would like to see the agency develop its cultural awareness and responsiveness?
- Are there other centers/programs that you regularly participate in? Which ones? How and why, i.e., what do they offer you?
- Are there any communal and/or health care experiences at SMC that you do not find anywhere else?
- Has your participation in SMC's community, programs, etc. helped you to feel more "connected" with yourself? The African American community? The broader community?
- Are there services/programs that you wish SMC offered? What? Why?

Part 2, Appendix 4

AFRICAN AMERICAN HEALING CIRCLES – CLAY CREATIVE ARTS PROJECT

Name _____

Describe your sculpture.

What does this sculpture represent to you?

What does the sculpture say about who you are now?

How does the sculpture express what you value in the way you live life?

When working with the clay what feelings came up? Did you experience any surprises, challenges, and discoveries and what did the clay teach you?

Did something get freed up in yourself as you worked with the clay?

Did you learn something about yourself in this creative group process that you would like to share with others and the community? If so, describe.

PART 3

Organizations need to establish an environment in which providers view feedback as a necessary tool for improved performance.

CIMH Center for Multicultural Development, 2002

The Staff Assessment Interviews

The staff assessment process was designed to engage the staff in a comprehensive assessment of their own cultural competency and the cultural competency of SMC as a behavioral health care agency providing services to African American seniors with co-occurring health issues. Due to the wide-scope of our inquiry and the specificity of the African American populace this project seeks to serve, it was necessary for us to develop our own assessment methods. To this end, we researched the cultural competence standards advocated by the National Association of Social Workers, the State and National Offices of Minority Health, the National Center for Cultural Competence, the Association of Black Psychiatrists, and the Center for Substance Abuse Prevention. We consulted with the Institute for the Advanced Study of Black Family Life and Culture. We also reviewed a short, but cogent list of contemporary literature and published assessment instruments pertaining to culturally competent health care practices.¹²

This information research/consultative process led us to two resources (one that generated qualitative data and one that generated quantitative data) that we could easily adapt to determine what the staff understood about the meaning of cultural competence on an individual and organizational level.¹³ However, we

¹² A variety of assessment instruments are available online and readily adaptable, i.e., “Improving Patient Care: Cultural Competence” (www.aafp.org/fpm/2000/1000/p58.html). There is also descriptive summaries of popular assessment tools. See: “Cultural Competence Assessment Tools”, Center of Excellence for Cultural Competence (www.nyspi.org/culturalcompetence/what/pdf/NYSPI-CECC_CulturalCompetenceAssessment.pdf), “Introduction to the Assessment of Multicultural Competence” Center for Multicultural and Diversity Studies—Assessment Tools, (<http://ego.thechicagoschool.edu/s/843/index.aspx?pgi=1184&gid=3>).

¹³ For the qualitative data we modified the process outlined in “What Is Intercultural Competence?”, International Extension Curriculum, Purdue University

needed to supplement these two resources with a survey instrument we created in order to explicitly address the INN 2 Learning Questions, i.e., what the staff knew of African American cultural and spiritual characteristics, and how the staff tried to incorporate these characteristics into the planning, delivery and outcomes of services provided to the African American community. Each of these assessment tools leaned itself to a pretest-posttest format which allowed us to discern how the staff's understandings, knowledge and/or practice had grown or changed as a result of their participating in the enrichment/training process.

Descriptive Overview. At one of the monthly All-Staff Meetings, the cultural mentor provided an update on the overall progress of the project and asked each of SMC's four program groups to identify a date within the coming month when they could participate in a 90-minute assessment interview during one of their regular program staff meetings. It was explained that the overall purpose of the assessment process was to enable SMC's staff "to do a good job even better" by:

- Identifying the individual and organizational cultural competencies that already exist at SMC
- Identifying ways the staff would like to see SMC develop as a culturally competent behavioral health care agency
- Identifying ways in which the staff can further enhance the services they provide to the African American community.
- Identify pertinent criteria the staff can use to plan and provide for the ongoing development of SMC's cultural competence on individual and organizational levels.

It was also explained that the content of the assessment instruments would be informed by insights from the research/consultation process and the cultural mentor's observations of ways that staff typically discuss and/or demonstrate their understanding of cultural competence. This being said, it was also stated that the assessment process was intended to be both instructive and evaluative—meaning that the assessment data would not only determine the topics and learning

(www.2.ces.purdue.edu/iec/default.htm). For the quantitative data we modified the survey instrument, "Intercultural Knowledge and Competence Value Rubric", Association of American Universities and Colleges. (www.aacu.org/value/rubrics/pdf/InterculturalKnowledge.pdf).

strategies of the forthcoming staff enrichment/training process, but it would also inform the agency's ongoing efforts to develop its cultural competency at both the individual and organizational levels. In sum, the staff was assured that the assessment data would serve to make the staff members themselves more conscious and deliberate about the way they discuss and demonstrate their understanding of African American culture and spirituality, as well as how to incorporate them into the behavioral health care services provided to the African American community.

The purpose of the interviews. The staff interview process was designed to achieve several purposes: (1) To determine if the staff could name African American cultural and spiritual characteristics, (2) To determine if and how they try to incorporate these characteristics into the planning, delivery and projected outcomes of the services they provide to African American seniors, (3) To reveal the conceptual framework that undergirds the staff perceptions of their own and SMC's cultural competence, (4) To determine if there are discrepancies between the staff's perceived and actual cultural competencies in relationship to the African American community, (5) To facilitate the staff's understanding of the varied indicators one might use to assess his or her own cultural competence, and (6) To further inform considerations for content to be included in the staff enrichment/training process.

The following process was used to administer the staff assessment with each of the four agency program groups:

The Staff Assessment Interview 90 minutes
<p>Introduction to the process (5 min):</p> <ul style="list-style-type: none"> • A Welcome and thanks for participation • Reminder that the assessment data will be used to determine topics and learning strategies for the forthcoming staff enrichment/training process, as well as the agency's ongoing efforts to develop its cultural competency at the individual and organizational levels <p>Brief Overview of the 4-part Assessment Process (15 min):</p> <ul style="list-style-type: none"> • Each person will be asked to do the following: <ol style="list-style-type: none"> 1. State their understanding of cultural competence on both individual and organizational level by completing each of the following sentences: <ol style="list-style-type: none"> a. A culturally competent behavioral health care provider... b. A culturally competent behavioral health care agency...

2. Complete a two-part survey designed to elucidate the staff's current understandings and efforts to incorporate African American cultural and spiritual characteristics in the services provided to that community.
 3. Rate the agency as a culturally competent behavioral health care agency and state the reasons for the rating ascribed.
 4. Engage in a dialogical process to debrief the assessment process including a discussion of any questions, concerns, suggestions regarding the assessment process.
- Answer questions as needed.

Distribute a blank, lined sheet of 8-1/2 x 11" paper (and a pen if needed) to each participant and ask that they complete the following sentences in 20 minutes time with as long or as short an answer as they care to give:

- A culturally competent behavioral health care provider...
- A culturally competent behavioral health care agency...

Offer a 2 minute notice before collecting the participant responses after the allotted time..

Distribute the survey instrument (See: Part 3, Appendix) noting that there are questions on both sides of the page. Then, instruct the participants how they are to complete the group ?designating blocks at the top of side one, so that the responses of each program group can be identified while the identity of the individual respondents can remain anonymous. Once completed instruct the group that they have 20 minutes to complete the survey, and ask them to begin.

Offer a 2 minute notice before collecting the participant responses after the allotted time..

Distribute another blank, lined sheet of 8-1/2 x 11" paper to each participant. Ask each participant to rate SMC as a culturally competent behavioral health care agency on a scale of 1 to 5 (with 1 being the lowest rating and 5 being the highest). Then, ask the participants to write the agency's name on the top of the page followed by a number rating. Finally, ask the participants to explain the numeric rating by stating what organizational characteristics (i.e., programs, policies, etc.) demonstrate SMC's cultural competence, and how they believe the agency needs to grow (15 min).

Offer a 2 minute notice before collecting the participant responses after the allotted time..

Engage participants in a dialogical process to debrief the assessment process and record the answers (20 min). For example: Did you find any of the assessment tasks difficult to do? If so, why? Did any of the survey questions surprise you? Intimidate you? Had you been asked any of these questions before? If so, which ones? Were you particularly glad to be asked any of the questions and/or to complete any of the assessment tasks? Are there other insights/questions/concerns that need to be considered regarding the agency's cultural competence on the individual or organizational level?

Outcomes: Data from the assessment interview process confirmed the complexity of developing the cultural competence of individuals and organizations. For instance, the staff (both clinicians/therapists and persons offering supportive wellness services) readily identified culturally responsive attitudes that inform their practice, i.e., respect, empathy, non-judgmentalism, hospitality, etc., but 75% of them could not name a specific African American characteristic that they try to incorporate into their practice. Similarly, the staff gave their agency a median rating of 4.5 as a culturally competent organization and explained the rating by citing the multiple ways that the organization demonstrates respect, empathy, ready access to all services, and the celebration of cultural events i.e., Kwanzaa and Black History Month. At the same time, the staff acknowledged their individual and organizational need for ongoing training, specifically the need for more knowledge about African American culture and spirituality as well as specific skills for incorporating them into the individual and group services provided.

The dialogical debriefing during the last 20 minutes of the assessment process can be as instructive as the written data regarding the staff's understanding of the demands of cultural competence. For instance, the survey questions themselves may have led staff to a more critical reflection on their individual and organizational cultural competence capabilities. This discovery may lead staff to identify possible outcomes for the forthcoming enrichment/training process that they had not previously considered. The benefit of this is that the staff's actual learning needs become more clear and focused for the staff themselves and for the trainer/facilitator who will have to design a process that meets the staff where they are while challenging them to keep growing.

Recommendations. Specific recommendations are directly consequent to the outcomes:

- Try to anticipate the variety of feelings staff may bring to the assessment process, and reassure them that the purpose of the process is to discern how to facilitate their movement along the cultural competence continuum.
- Be sure to use a variety of assessment tools and methodologies, e.g., qualitative and quantitative, written and verbal. The variety can expose perceptions that may have gone unnoticed using only one assessment tool, e.g., some staff may assign a high rating to their cultural competency

- knowledge and skills, but they may not be able to name a specific cultural characteristic they try to incorporate into their practice.
- Try to get an initial impression about the staff's level of cultural competence, as well as the kind of support they will need to handle the ambiguities of exposing their cultural competence strengths and learning needs.
 - Identity two or three staff members who would be willing to work with the cultural mentor to frame the specific topics to be addressed in the forthcoming staff enrichment/training program based on the data generated by the assessment. Particular attention should be given to identifying and alleviating unrealistic expectations for the enrichment/training process.

Part 3, Appendix

Staff Self-Assessment:	Date _____
Program Group: _____	Time _____

1. What brought you to St. Mary's Center?
2. How long have you been part of this community, i.e., how many months or years? _____
3. Did you know that the client population was predominately African American before coming? (yes/no)
4. Did you have any concerns regarding your ability to serve African American seniors? (yes/no)
 - Why/why not?
5. What experiential or educational background do you have for serving African Americans in the Behavioral Health Care System (BHCS)?
6. Can you identify an incident that made you think your cultural values and/or worldview were different from that of the African Americans you serve at SMC? (yes/no)
 - If yes, how have you attempted to resolve that realization?
 - Who/what assisted you to find resolution?
7. Do you believe that including African American culture and spirituality in the planning, delivery and desired outcomes of behavioral health care services provided to African American seniors can improve the actual outcomes of BHCS in that community? (yes/no)
 - Why or why not?
8. How have you tried to incorporate characteristics of African American culture and spirituality into the services you provide to African American seniors?
9. Do you believe that intercultural competence can enhance a behavioral health care provider's own cultural and spiritual development? (yes/no)
 - If no, why not?
 - If yes, describe one significant way that your engagement with African American seniors has changed your cultural and/or spiritual beliefs, values, practices.

PART 4

Do not fall into the trap of thinking, good counseling is good counseling". Know that...clinical competence . The latter...does not acknowledge... differences sufficiently to be helpful. To assume universality of application to all groups is to make an unwarranted inferential leap.

Derald Wing Sue, Multicultural Social Work Practice, 2006

The Staff Enrichment/Training Process

The actual content and methodologies chosen for the staff enrichment/training process were based on four primary considerations: (1) the cultural competency standards of the social work profession, (2) the cultural competency recommendations of renowned Africentric social work theorists and practitioners, (3) the staff's perceived learning needs, and (4) the seniors' hopes for developing the agency's overall cultural competence. We quickly dismissed the notion that developing the cultural competence of our providers would result from attending a few workshops and mastering a definitive list of do's and don'ts. Each step of our process reinforced our understanding that the primary outcome of our training process had to be a commitment to ongoing learning.¹⁴ Apropos to that commitment, we had to start somewhere. We started by listening to our seniors to our colleagues, to our experience, and to our mission to create a shared vision of where we are on the cultural competency continuum and how to keep moving, intentionally and effectively, along that path.

¹⁴ Melanie Tervalon and Jann Murray-Garcia, "Cultural Humility Versus Cultural Competence: A Critical Distinction in Defining Physician Training Outcomes in Multicultural Education", *Journal of Health Care for the Poor and Underserved*. (Vol. 9, No. 2, 1998) pp. 117-125

SESSION ONE

Cultural Competence: More Than Meets the Eye

Time: 2-1/2 hours

Target Audience: All staff (adults)

Materials needed:

- Banner(s) – Cultural characteristics identified by seniors (can be posted, but should be covered until referred in the session)
- Banner(s) – Outcomes of survey from Staff Assessment Interviews
- Pins or tape to post banner(s) on wall
- Large (4"x6") post-its (at least two post-its for each of the participants)
- Marking pens (if not 1 for every participant, enough that no more than two participants share one)
- Handout: "The Three Primary Focus Areas for Assessing and Developing A Person's Cultural Competence" (Part 4, Appendix 1)
- Evaluation form (Part 4, Appendix 2)
- Self-Assessment data from survey administered during Staff Assessment Interviews

Room Set-up:

- Banners posted on wall, but covered until referred to in the session
- 2 Designated wall spaces for posting post-its
- Tables and chairs or desks

Learning Objectives:

1. To familiarize staff with contemporary understandings of cultural competency in behavioral health care
2. To assist staff to further assess their cultural competence in light of:
 - Survey data from Staff Assessment Interviews
 - Cultural and spiritual characteristics identified by African American seniors in Healing Circles
3. To increase staff awareness of NASW Cultural Competency Standards

WELCOME – OVERVIEW:

- Remind the participants of the desired outcomes of AC INN2 Grant Project:
 1. Identify cultural and spiritual characteristics that should be incorporated into planning, delivery and outcomes of services provided to African American seniors with co-occurring health issues
 2. Propose practical strategies for becoming more intentional and skilled at incorporating them into planning, delivery and outcomes of services
- State where the staff/agency is in the INN 2 project process, i.e., what's been done/have yet to do, i.e.:
 1. Planning Meetings
 2. Healing Circles
 3. Staff Enrichment/Training Process (this is the first session)
- State learning objectives for this session (see above)

INTRODUCTORY EXERCISE:

- **Ask participants** to quietly reflect for a few moments on the nature of the work they perform in service to the African American community. (20-30 seconds of silence)
- **Ask participants** to name one primary principle (can be a value, assumption, belief, etc.) that informs/guides their work with African American seniors (*e.g., a healthy cultural identity is an essential psychic anchor*). Write the principle on a post-it, put the post-it on wall in designated space. (3-4 minutes)
- **In light of the principle named, ask participants** to name one concrete outcome (i.e., a practice, service, organizational tweak) they hope this Staff Enrichment/Training Process will explore for ongoing development and implementation at the agency (*e.g., ways to foster ongoing knowledge, understanding, affirmation and incorporation of culture in the varied services we provide as individuals and as a group*). Write the desired outcome on post-it. Put the post-it on wall in designated space. (5-6 minutes)
- **Discuss the content of the post-its in light of following talking points:**
 1. It is not uncommon to find that there are a wide variety of guiding principles and perceived learning needs operating among a group of persons who work together. The variances not only reflect the differences

of culture, experience, training, etc. of individual staff members, they also expose the assumptions that each person has made about the nature and goals of individual and collective tasks charged to the group.

2. Even if the enrichment/training process could achieve all of participants' desired outcomes, it would not necessarily lead to cultural competence. Indeed, no one-time enrichment/training process can automatically produce cultural competence—there is no static list of cultural assumptions, no unvarying knowledge base, and no fixed skill set to be mastered—there is always more to know about one's own culture and the culture of another, about how to forge intercultural relationships that are mutually enriching. (Pedersen, 2006, Deardorff, 2012, NCCC, 2004)
3. What an Enrichment/Training Process can do is assist individual behavioral health care providers and organizations to assess and nurture their cultural competence. It can encourage and assist them to develop a critical consciousness that recognizes and respects the integral relationship between culture and wellness. (Lum, 2004, p. 21, 93-95)
4. Apropos to this, we need to know what we mean as individuals and a group when we say "cultural competence".

FOUNDATIONAL UNDERSTANDINGS FOR DEVELOPING CULTURAL COMPETENCE

- **Distribute and discuss the handout (Part 4, Appendix 1)**
- **Refer participants back to post-its**
 1. Ask them to compare the principles that inform their practice and the attitudes that foster cultural competence and write them on the handout (e.g., if they wrote "respect" as a guiding principle, put a check next to "respect"). Point out that these attitudes provide an important incentive for acquiring knowledge and skills.
 2. Refer the participants to what they wrote as desired outcomes for the Enrichment/Training Process and ask them to categorize their responses as an attitude, knowledge, or a skill. Point out that developing cultural competence will require that specific learning objectives are ascribed to each outcome. This is necessary in order to ascertain what a person actually needs or wants to know.

- **Review the survey outcomes from the Staff Assessment Interviews**
 1. Highlight ways that survey responses coincide with attitudes listed on the handout. Give feedback about staff attitudes from perspective of seniors (i.e., data collected from Healing Circles assessment of agency).
 2. Point out the percentage of staff that named an African American cultural or spiritual characteristic that they routinely try to incorporate into their practice. Note that it is possible to have requisite attitudes for cultural competence without having much specific knowledge or specialized skills, but the increase in knowledge and skill can make an individual even more effective. The Alameda County 2011 African American Utilization Report indicates the need to increase the effectiveness of services provided to the African American community. The NASW advocates for increased culturally congruent knowledge, skills and services as a viable way to achieve it. (P.12)
- **Review African American Cultural Characteristics identified by seniors in Round One Healing Circles in light of following talking points:**
 1. This importance of these cultural characteristics is not that they are the definitive of African American characteristics, there are many more. Their importance has to do with the fact that seniors served at this agency named these characteristics as critical indicators of cultural responsiveness in behavioral health care. Thus, they should be carefully considered when proposing strategies to develop individual and organizational cultural competence of the agency.
 2. Careful consideration of the characteristics should include insight and assistance from persons, organizations, program models and literature that can facilitate the ability of individuals and the organization to move beyond their current understandings, skill sets, and comfort zones—“to learn new patterns of behavior and effectively applying them.”. (See: NASW, p. 12)

EVALUATION (Part 4, Appendix 2)

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Part 4, Appendix 1

Foundational Understanding for Developing Cultural Competence: COMING TO TERMS

Culture

Culture is a comprehensive and purposeful network of core values, beliefs, philosophies, aesthetics, ethics, worldviews, behavioral norms and patterns, ways of knowing and judging, customs, rituals, spirituality/sense of the sacred, taboos, communication patterns, collective memories and striving that make a people “a people”. Culture informs and organizes the feelings, beliefs, values, behaviors of the group, but may be expressed individually in a variety of ways. *(A composite of popular definitions)*

Competence

Competence implies having the capacity to function effectively as an individual and/or organization within the cultural context of beliefs, behaviors, and needs presented by the group. *(NASW, 2001, p. 10, see also OMH website).*

Cultural Competence

Cultural competence refers to the ability of individuals and/or organizations to respond respectfully and effectively to cultural groups by integrating cultural knowledge into specific attitudes, policies, and practices appropriate to the cultural identity and self-identified needs presented by these cultural groups. *(See: NASW, 2001, pp. 7-8, 12)*

Cultural competency training for behavioral health care providers generally focuses on the importance of cultivating the attitudes, knowledge and skills—for example:

- **Attitudes** of respect, openness, curiosity, discovery, empathy, adaptability, receptiveness, and humility *(NASW, 2001, # 2, p. 17)*
- **Knowledge** of one’s own cultural assumptions, values, preferences, biases, etc., as well as specific and significant knowledge about the history, culture, strengths, vulnerabilities, potential and needs of the persons they serve. *(NASW, 2001, # 3, p. 18)*
- The **skills** associated with cultural competence are also two-directional, i.e., behavioral health care providers need to be wary of thinking that they know what a person needs. Instead, they must acquire a wide range of approaches and techniques to be able to engage clients in discerning appropriate assessment, planning, delivery and goals for service in ways that reflect and respect the client’s cultural insight, natural support systems and empowerment needs. *(NASW 2001, # 4, p. 19-20)*

The NASW explains the complexity of developing cultural competence by saying, “Cultural competence is never fully realized, achieved, or completed, but rather cultural competence is a lifelong process for (behavioral health care and related service providers) who will always encounter diverse clients and new situations in their practice.” *(p.11)*

Part 4, Appendix 2

Evaluation

SEE ME, HEAR ME: Enrichment Session 1

How would rate your experience of this session (1 = the lowest rating, 5 = the highest).

Circle a number: 1 2 3 4 5 Please state your reason for this rating.

What do you most want to remember from today's session that can increase your cultural competence?

Please write at least one new insight/awareness that you would like the whole staff to remember while developing overall cultural competence of the agency.

SESSION TWO

Knowing Cultural Competence When You See It

Time: 2-1/2 hours

Target Audience: All staff (adults)

Materials Needed:

- Banner(s) with definition of culture, competence and cultural competence (Part 4, Appendix 1)
- Handout: “Definitions of a Culturally Competent Behavioral Health Care Agency” (Part 4, Appendix 3)
- Banner(s) with “Seven Agency Cultural Competence Indicators”—can be posted, but should be covered until referred to in the session. (Part 4, Appendix 4)
- *Optional:* Handout or banner with staff rating of agency’s cultural competence and summary statements that explain rating (constructed from data generated during assessment interviews). Banner can be posted, but should be covered until referred to in the session.
- Pins or tape to post banner(s) on wall
- Small group assignments (pre-assign participants to groups with no more than 6 people in a group and try to diversify the group membership by race, culture, job, age, gender, etc.)
- Pre-determine where each group will meet
- Newsprint (enough for each small group to have one or two pages)
- Marking pens (at least one for each small group)
- Loose-leaf sheets of 8-1/2x11” paper
- Evaluation Form

Room Set-up:

- Banners posted on wall, covered or uncovered as indicated above
- Designated wall space for newsprint with small group reports
- Tables with six chairs around each one

Learning Objectives:

1. To familiarize staff with contemporary standards and indicators for culturally competent organizations
2. To increase staff awareness of the ways that individual and organization cultural competence impact each other.
3. To assist staff to further assess the cultural competence their agency in light of contemporary standards.

WELCOME – OVERVIEW:

- **Review definitions from Session One** to remind participants of training program's overall goals
- *Optional if time permits:* Highlight participant statements of what they wanted whole staff to remember as develop cultural competence of the agency
- **State learning objectives** for this session (see above)

INTRODUCTORY EXERCISE:

- **Introduce the activity** by explaining that:
 1. The overall effectiveness of an individual provider's cultural competence does not happen in a vacuum—it happens in a communal/organizational context.
 2. It is extremely difficult to sustain the cultural competence of individual providers when the agency/organization that employs them does not engage in ongoing efforts to add to their knowledge base of culturally competent principles, policies and practices (Cross –in Sue, 241; see Sue, p. 30).
 3. Developing such organizational capacities does not just happen—staff (including service providers and administrators), governing bodies, representative members of the client populace and other stakeholders have to keep working at it together in respectful, mindful and purposeful ways. (Lewin Report)
 4. Remind participants that they each person wrote a description of a culturally competent organization during the Staff Assessment Interviews. State that the definitions have been recorded onto the handout to be used in a moment in a small group activity. Remind participants that the

statements were submitted anonymously; and reassure them that it is not necessary for anyone to self-disclose. The point of collecting and printing the definitions was to have a practical way to keep each person mindful of his or her understanding of a culturally competent organization.

- **Distribute the handout**, “Definitions of a Culturally Competent Behavioral Health Care Agency” (Part 4, Appendix 2)
 1. Point out that the left column contains the actual definitions the staff wrote and the right column contains definitions from varied sources advocating organizational cultural competence.
 2. Ask participants to quickly browse the left column of the handout and make a mental note of the definition that he or she wrote.
 3. Direct participants to silently read the varied definitions in the right column and make note of (i.e., underline) concepts that strike them either because it affirmed their thinking, offered a new insight that appeals to them, sparks their imagination, etc. (10 minutes)
 4. After 10 minutes, ask if anyone would like to share how the definitions in the right column may affirm or stretch their understanding of cultural competence.

FORGING A COMMON VISION

- **Remind participants** that developing a culturally competent organization requires stakeholders to keep working at it together in respectful, mindful and purposeful manner.
- **Invite participants into small groups** by announcing who will be in each group and where each group will meet.
- **Describe the small group task:**
 1. Write a 30-word, group definition of a culturally competent behavioral health care agency. The definition is to be written on newsprint and posted on the wall within 30 minutes.
 2. Every person in the group has to contribute to the definition by either offering a key idea/concept that will be included or by offering an affirmation of someone else’s idea. However, the affirmation has to be than saying, “I like that” or “good idea”. The affirmation has to reveal the

person's thinking, for instance, "I like that idea because it expresses the need to translate values into actions."

3. Tell the groups that they can decide among themselves how to initiate and complete the task. Ask them to begin.
 4. After 25 minutes, ask the groups to finish their task, decide who will read their definition to the other groups, and post their definitions on the wall.
 5. After all definitions are posted invite individual groups to report to the other groups. Affirm each group presentation, but wait until all groups have reported to comment on the varied definitions. (May type and keep group reports for reference in future enrichment/trainings).
- **Debrief the activity in the following manner:**
 1. Ask if any groups found it difficult to restrict the definition to thirty words? Did any have difficulty finding thirty words to put in the definition?
 2. Ask the participants to identify similarities and differences among the definitions. For instance, some may include more abstract concepts (e.g., respect, honor, support) and focus more on articulating an organizational vision. Other definitions may emphasize staff skill sets (i.e., active listening, culturally-sensitive assessment) or program goals (i.e., foster self-esteem and healthy relationships).
 3. Identify group definitions that may include language from the popularized definitions in the right column of the handout (in particular, did any group use ideas from the definition that specifically addressed effective behavioral care in the African American community)?
 4. Ask how the groups choose the words/terms to be included in the statement, i.e., was each group member asked to state the concepts he or she wanted included in the group definition then try to craft a statement that included something from everyone? Did the group simply decide to include recurring words or phrases into the definition?
 5. Did anyone feel the need to make assumptions or compromises in order to complete the task in the allotted time, i.e., to assume that people using the same words meant the same thing, or that different words, e.g., "multiculturalism" and "interculturalism" could be used interchangeably?

6. Did everyone think he or she had a contribution to make to the definition? If so, what attitudes and/or behaviors invited your participation? If not, why not? Did everyone think it was okay to question someone else's idea? If so, what attitudes and/or behaviors let you know it was okay? What may have led someone to believe it was not okay?
7. Highlight some of the group dynamics that commonly impede a group's ability to forge a common vision of cultural competence for their agency, i.e.,
 - Group members may defer to people of color—this absolves certain individuals from developing requisite attitudes, knowledge and skills; it puts inordinate stress on staff of color as they have to avoid being the “token” voice and presence of cultural competence; it also assumes that staff of color has the requisite attitudes, knowledge and skill to help train their co-workers. (Cross in Sue, p. 240)
 - Group members may defer to persons who have attained high levels of formal education, many years of work experience as a behavioral health care provider, or many years of working in the African American community. None of these realities necessarily make a culturally competent behavioral health care provider—their education occurred in an institution with its own cultural purview, and longevity alone will not produce increased skill in the profession or increased knowledge about African American people.
8. Highlight some of the organizational issues that commonly impede a group's ability to develop the cultural competence of their agency, i.e.,
 - It is possible for an agency to be nondiscriminatory without being culturally competent, i.e., may have people of color on staff and a multicultural client populace, but the staff has no “specific cultural knowledge” of the client populace and there is no “variety or adaptations of services to better meet the needs of culturally diverse populations.” (Cross in Sue, pp. 239-241)
 - It is possible for an agency to be unaware of the overall effectiveness of its cultural competence because the routine assumptions, goals and strategies that inform the agency's services remain unchallenged or stakeholders may be satisfied with the agency's efforts to be culturally competent. (Cross in Sue, p. 240)

GUIDELINES FOR TURNING THE VISION INTO A REALITY

- Terry L. Cross, et al. (1989) developed a well-renowned schema to help persons and organizations assess and develop their cultural competence. The schema consist of a six-stage continuum that range from cultural destructiveness (stage 1) to cultural proficiency (stage 6). Refer to banner.
 1. *Cultural destructiveness*. This first level of cultural incompetence is characterized by blatant efforts toward forced assimilation, i.e., attempts to ignore, demean and/or suppress the values, worldview, beliefs, preferences, normative behaviors, customs, ambitions and self-interests of any culture that differs from the dominant culture.
 2. *Cultural Incapacity*. This stage may be unintentionally culturally destructive, more often simply lacks the capacity (location, inadequate staffing, unchallenged biases in program development and treatment goals, etc.) to effectively respond to the needs of people of color.
 3. *Cultural blindness*. In an effort to be equally respectful and responsive to a multicultural client populace, agencies at this stage may not give sufficient consideration to the ways that some of the services provided to African Americans might have fuller effect if they were more culture specific (i.e., helped them to overcome historic trauma and cultural alienation, helped them to reconnect with core cultural values and reconstruct traditional support networks). By assuming that the helping goals, methods and desired outcomes of the dominant culture are universally applicable, the services offered by these agencies may not be culturally destructive, but they do not tap into or strengthen the nurturing cultural elements known to foster a sense of well-being among African Americans. (See: Lum, 93-95, Gilbert, et al.)
 4. *Cultural precompetence*. Agencies at this stage have made some effort to respect and honor cultural diverse, i.e., mission statement may include a reference to multiculturalism, staff may reflect client populace, environment may include culturally resonate aesthetics, may host seasonal celebrations important to the cultural communities served, and may make earnest efforts to engage cross-culturally in ways that demonstrate openness, acceptance and respect for cultural difference.

But, these agencies may not have congruent mechanisms for assessing, monitoring or developing its cultural competent goals or learning needs.

5. *Cultural competence*. At this fifth stage, agencies have developed an infrastructure to ensure ongoing self-assessment regarding culture, careful attention to managing the dynamics of difference, continuous development of cultural knowledge and resources that can adapt and/or create services to better meet the expressed needs of culturally diverse populations.
 6. *Cultural proficiency*. Cultural theorists and researchers believe that this stage of cultural competence is actually rare. At this stage, agencies are not only hiring staff who specialize in culturally competent practices, but they are developing programs based on culture, conducting research on these programs and disseminating the results. Persons from every level of the agency (board members, administrators, providers and clients) regularly participate in evaluation of the agency's cultural competencies.
- Once Becoming culturally competent requires individuals and agencies to know what stage they are in along the continuum, and how best to move toward the next stage. A 2002 publication developed by the Lewin Group for the U.S. Department of Health and Human Services is helpful in this regard. "An Organizational Cultural Competence Assessment Profile" (OCCAP) identifies specific criteria for each of 7 organizational performance areas (organizational values, governance, planning/monitoring/evaluation, communication, staff development, organizational infrastructure, and services/interventions).
 1. Review banner "Indicators of Culturally Competent Agencies" (Part 4, Appendix 4) and highlight that the profile seeks to identify concrete values, policies, structures and practices that "should be evident or manifest in a culturally competent organization." (Lewin, p. 3) Point out that while the profile can be used in whole or in part, a full application of the instrument would produce the most beneficial results because it would provide a comprehensive way to "define expectations and standards and assess the extent to which these are met." (Lewin, p. 3).

2. Ask participants to identify cultural competency indicators that are already evident in their agency. Then, make note of recommended cultural competency indicators that need fuller development.
- In light of this discussion, review the rating participants gave to their agency as a culturally competent behavioral health care agency. Without asking them to rate the agency again, ask if they might have rated the agency differently had they been aware of the cultural competence continuum or the Organizational Cultural Competence Assessment Profile.
 - Remind the participants that developing cultural competence is an ongoing process and congratulate them for engaging in an enrichment/training process that can help to keep them moving further along the continuum.

EVALUATION (Part 4, Appendix 5)

REFERENCES

California Institute for Mental Health. "What is Cultural Competence?"

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Part 4, Appendix 3

DEFINITIONS OF AN (INTER)CULTURALLY COMPETENT AGENCY

Definitions written by Staff during Assessment Interviews:	Popularized Definitions in Pertinent Health Care Literature:
<p>An interculturally competent organization...</p> <p><i>Record the staff definitions written during the assessment interviews. Might be helpful if the varied comments are numbered and you may have to edit in order to accommodate the limited space.</i></p>	<ul style="list-style-type: none"> • Cultural/Intercultural competence is the overall capacity of individual(s) and/or organization(s) to use academic, experiential, and interpersonal skills to increase their understanding and appreciation of cultural differences and similarities within, among, and between groups. It encompasses an individual's and/or organizations desire, willingness, and ability to improve systems by drawing on diverse values, traditions, and customs. <i>(National Center for Cultural Competence)</i> • Cultural competence requires that organizations: <ul style="list-style-type: none"> —Have a defined set of values and principles, and demonstrate behaviors, attitudes, policies, and structures that enable them to work effectively cross-culturally. —Have the capacity to (1) value diversity, (2) conduct self-assessment, (3) manage the dynamics of difference, (4) acquire and institutionalize cultural knowledge, and (5) adapt to diversity and the cultural contexts of communities they serve. —Incorporate the above in all aspects of policy-making, administration, practice, staff development and service delivery, systematically involve consumers, families and communities. <p>Cultural competence is a developmental process...organizations are at various levels of awareness, knowledge and skills along the cultural competence continuum. <i>(National Center for Cultural Competence, 1998, modified from Cross et al.)</i></p>

Definitions written by Staff during Assessment Interviews:	Common Definitions in Pertinent Health Care Literature:
<p>An interculturally competent organization...</p>	<ul style="list-style-type: none"> • Cultural competence is defined as the ability of systems to provide care (that)...<i>meets the...'</i> social (and) cultural...<i>needs (of diverse groups)</i>...and involves competence or abilities in three areas: 1) multicultural knowledge, 2) awareness, and 3) skills. <ul style="list-style-type: none"> The <u>first</u>, <i>multicultural knowledge</i>...providers should have specific knowledge about...the cultures of the groups they serve. <u>Second</u>, providers should be aware of their own cultural heritage; the ways in which their cultural values, practices, beliefs, (etc.) differ from those of others;...and may affect the therapeutic encounter. <u>Finally</u>, providers must possess a range of therapeutic and communication skills to be...able to alter their (interactive) approach based on cultural differences. (<i>California Institute for Mental Health</i>) • The effectiveness of behavioral health care with African Americans can often be linked to (the ability of) a system of care...to empower persons as well as help them overcome problems. Empowerment seeks to foster a person's general resourcefulness to sustain an overall sense of well-being. Within the African American community, empowerment requires behavioral health approaches to include <i>protective factors</i> and a <i>strengths perspective</i>. <ul style="list-style-type: none"> <i>Protective factors</i>...mediate or buffer negative situational factors. The <i>strengths perspective</i> posits that behavioral health care...must develop the capacity to meaningfully tap into and cultivate the reservoir of African American cultural, physical, emotional, cognitive, interpersonal, social, and spiritual resources and competencies; and, regard these reservoirs as essential sources of knowledge, healing and resilience. (<i>Adapted from CSAP, Cultural Competence Series, Vol. 7</i>).