The Impact of Culture on Person/Family Centered Planning

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Introduction

To understand the impact of culture on person/family centered planning one must first understand three major terms, namely person/family centered planning, culture, and recovery. In person/family centered planning the consumer and provider together develops a plan outlining goals and interventions to assist the consumer's recovery. For this plan to be person or family centered the individual who is receiving services and/or his or her family must be active participants, direct the process, and be the final decision maker(s). The goal of person/family centered planning is to achieve outcomes identified and managed by the consumer and/or his or her family and facilitated by the provider. Research has shown that the best predictor of positive mental health outcomes is the consumer's perception that his or her needs are met. (Roth, 1999).

We define culture as a common heritage or set of beliefs, norms, and values. It refers to the shared, and largely learned, attributes of a group of people (DHHS, 2001). "Cultural Identity" refers to the culture with which someone identifies and to which he or she looks for standards of behavior (Cooper & Denner, 1998). In short, culture is the way in which persons see and identify themselves.

Recovery refers to the process through which people living with a disease or a disability are able to live, work, learn, and participate fully in their community. For some individuals, recovery is the ability to live a fulfilling and productive life despite a disability. For others, recovery implies the reduction or complete remission of symptoms

of a disease or disability. Science has shown that having hope plays an integral role in an individual's recovery. (President's New Freedom Commission on Mental Health, 2003) Recovery is about giving the overarching message that *with hope, the restoration of a meaningful life is possible*… Instead of focusing primarily on the relief from symptoms as the medical model dictates, recovery casts a much wider spotlight on restoration of self-esteem and identity and on attaining meaningful roles in society. (Deegan, 1997, 1988)

Person/family centered planning entails individuals and/or families actively participating in the treatment process. Providers must recognize and be able to work with them within the norms and values of their individual and collective cultures. *Culture influences outcomes* (Humphrey, 2003) which then impact the process of recovery for that consumer and/or his or her family. The individual's culture will impact the treatment goals, interventions, and processes used to achieve these goals. Providers and administrators should understand that culture and recovery are interwoven. Just as culture directs how individuals perceive and attend to illness and wellness, culture also influences perceptions of recovery. Culture permeates all aspects of an individual's life and providers must acknowledge this through the assessment, treatment, and service delivery processes. Administrators must ensure that person/family centered planning, concepts of recovery, and cultural competence are integrated throughout the treatment system.

Failure to incorporate person/family centered planning, the concepts of recovery, and cultural competence as the lynchpins of all mental health services will perpetuate a cycle

consisting of the provision of costly services over long periods of time. Such results are perceived as negative outcomes by consumers and funders alike.

Barriers – Perceived and Otherwise

By the year 2025, nonwhite racial and ethnic populations will comprise 40% of the population of the United States (Bureau of the Census, 2001). In spite of this, health disparities impacting people of color today are alarming and are apparent not only in publicly-funded services, but in the private sector as well. (Daniels & Adams, 2003)

Although the majority of providers are well intentioned and attempt to provide care in an ethical manner, they are limited. In other words, *they don't know what they don't know*. Systems (and the clinicians who work within them) traditionally operate from a paternalistic point of view, taking responsibility for people and their lives (Deegan, 1993) and teaching consumers to depend on these systems and their clinicians in a negative cycle that acts to impede rather than foster recovery.

The cycle is confounded by the need to provide services that are culturally appropriate. Although the provision of culturally competent/appropriate services and the recognition of cultural differences that would warrant such services is not evidence-based practice, it is believed that for any practice to be deemed *evidence-based,* it should be culturally appropriate/competent and should respond to the unique needs of the consumer and/or family receiving the services. (Stanhope, Solomon, Pernell-Arnold, Sands & Bourjolly, 2005)

For providers whose consumers are homogeneous and made up of the dominant culture, (i.e. people of European ancestry), there may be less of an issue of cultural appropriateness as the majority of the service delivery systems today were created to serve the dominant culture. If directors of programs were surveyed regarding their service delivery to groups of consumers of color/different races/different cultures as to whether or not their programs respond to the needs of those consumers, most of the time, they will answer in the affirmative. (Humphrey, 2003, 2004)

Cultural competency is an add-on that program administrators find difficult to define, hard to implement, and often impossible to obtain reimbursement for except in cases of programs that have been created to meet the needs of specific groups of consumers. Sadly, these are few and far between. The following are points that may assist in the identification of some of the barriers and suggestions for addressing them. This list is by no means exhaustive and the study of these factors should be on-going.

Issues and Road Blocks to Consider

Training –

- Clinicians/providers of services lack a systematic definition of *cultural competence* and why it is important to understand consumers in this context.

- Clinicians/service providers lack a systematic definition of *recovery,* the difference between a *treatment plan* and a *recovery plan* and how to be a *recovery facilitator* rather than a *case manager.*

- Clinicians/service providers need information about where to get the right type of training for the consumers they serve.

- If clinicians/service providers do get training they rarely have "coaching" post-training to make certain this is integrated into the way they serve their consumers.

Health Disparities –

- Most disparities are based on the long history of racism and oppression in the United States.

- They may also be based on a perceived lack of resources, education, and ability to make good, healthy and safe decisions by the provider community.

- Additionally, there may be a very real (and valid) lack of trust for the system (i.e. Tuskegee Syphilis Experiment) by the consumer. (SGR, DHHS, 1999; Cooper-Patrick et al., 1999)

History of treatment of consumers of MH and Addictions Treatment –

- There are consequences for the consumer/person in recovery trying to control his or her destiny.

- Consumers have been disenfranchised for a long period of time. This disenfranchisement, standard practice in many settings, is viewed as the way to do business by both provider and consumer alike.

- Providers and administrators have not traditionally viewed *recovery* as possible.

- Consumers of Mental Health and Addictions Treatment have treatment done *to* them or *for* them, but seldom *with* them. They are rarely viewed as the experts in their own treatment.

- One size is supposed to fit all. If it does not, the consumer is labeled as resistant, in denial, a "frequent flyer" or "high utilizer" and is shunned both within and outside the service system.

- Consumers are often misdiagnosed as a result of spiritual beliefs and questions beyond the traditional "*are you hearing voices*?" are seldom asked.

- Race and ethnicity are relegated to a question or two and are seldom viewed as important aspects to consider when deciding upon a course of treatment for the consumer.

- Support networks, especially family, spiritual and social systems in consumer communities of color, often positive forces in the consumer's life, are frequently minimized or ignored altogether.

- The treatment delivery system does not empower the consumer to make decisions and choices about treatment for him/herself.

- Treatment delivery systems need information and they need to acknowledge that racism and oppression impacts communities of color and as such, the consumers of MH and Addictions Treatment. Treatment systems need to take a hard look at how they may be contributing to that oppression and how they might be viewed by the consumer as an extension of a system that has failed them.

- Stigma, how mental health and addiction may be viewed in the consumer's culture, and the language that is used both in and out of treatment play significant roles in keeping consumers and potential consumers of services feeling powerless, hopeless and/or from accessing services altogether. (SGR, DHHS, 1999; Sussman et al, 1987)

Program Assessment and Administration -

- Culture and the provision of culturally appropriate assessments, treatment and services are usually afterthoughts that may consist of a few signs in Spanish, some magazines in the waiting room and/or some pictures on the wall.

- Program services seldom have strategic plans for the delivery of services that are culturally relevant to the population they serve.

Financial Systems –

- Providers may believe that there is no way for culturally appropriate services to be paid for and that funding sources do not have standards by which to evaluate *alternative* or culturally-appropriate interventions.

- Providers do not speak the language of the payers and cannot describe their interventions in a way that will generate payment.

- There may be no one at the funding level holding service delivery systems accountable.

- Providers are not trained to negotiate payment for services that may be outside the norm of so-called traditional types of service.

Hope for the Future – Breaking Down the Barriers

Supporting the Consumers/People in Recovery -

- Consumers should see evidence at the outset that they are welcome by a treatment provider and that evidence should be more than just magazines and signs. As much as possible, the staff make-up should be representative of the consumer population.

- Consumers should be able to clearly identify the provider organization as recovery focused. They should be able to identify that the services understand their concept of illness and recovery and it is manifested at the outset of treatment through discussions with the consumer about recovery and wellness and not just about the illness.

- Consumers should have an active role in setting the agenda for treatment, should sit on advisory and executive boards and committees and should know that their voices will be heard.

- Consumers of services should expect that they will be treated in a holistic manner, that their cultures will be honored and respected, that the information they share will be incorporated into a recovery plan that they themselves author, and that they will be able to be open about themselves as cultural/spiritual beings. This connection should be recognized and used as a strength in the consumer's recovery process.

- Consumers should be taught to expect that they will be able to receive services that will respond to their cultural/spiritual needs and in the manner in which they understand illness and recovery. If this is not in programs created specifically around their understanding, then it should be through interventions designed for them within the context of the larger program structure.

Training –

- Clinicians should understand and incorporate into practice the U.S. Department of Health and Human Services Office of Minority Health's National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health Care.

- Clinicians should understand the need to respect and be open to the ways of other races or cultures even if they differ significantly from their own. (A level of comfort with one's own worldview helps to promote the acceptance of another's.)

- Clinicians should understand that performance evaluations are tied to delivery of culturally appropriate services just as for other indicators and the indicators should be equally weighted.

- Clinicians must receive training on how to conduct person centered planning such as "*Facilitating Consumer Recovery through Best Practices: Clinical and Consumer Training on the Emerging Best Practices Model by Developing a Recovery Management Plan.*" This training integrates person center planning, recovery, and cultural competence.

- Clinicians must overcome the need to do *for* and *to* consumers who come for services and should acknowledge the consumer as the expert in his or her own recovery process. Especially when it comes to culture and the provision of services that are appropriate and competent, the clinician should be the *learner* in the process.

Program Administration -

- Administrators/Directors of programs should insure that CLAS Standards are part of every staff member's orientation and that the guidelines are incorporated into their employee's performance evaluations in a meaningful manner.

- Administrators, directors and managers should be familiar with CLAS Standards and Guidelines and should be well trained in them so that they might in turn adequately train their staff and provide on-going coaching until the provision of culturally appropriate services becomes integrated into staff practice.

- Administrators, directors and managers should create performance evaluations that reflect the program's commitment to the provision of services that are culturally appropriate and should hold staff accountable to these standards.

- Administrators, directors and managers should ensure that assessment tools, programs and treatment modalities that are used by their organizations include culturalogical questions, components and treatment best practices related to issues of race and culture. Assessments tools should include questions related to spirituality. Rich clinical information is often lost because such questions go unasked. Once the assessments tools, components and modalities are developed, clinicians should be trained on how to ask the questions and how to implement the modalities. Adequate coaching should be part of this training.

- Administrators, directors and managers should design interventions based on the population who come to them seeking assistance. If knowledge of what types of interventions might be desirable to the consumers is needed, *ask the consumers*!

<u>Policy Makers/Funders</u> -

- Creating *Centers of Excellence* for programs that excel in the area of the provision of culturally appropriate services to consumers is a value-added strategy to encourage programs to respond to this need. Programs who earn this designation are held up as models to others and provide powerful examples of how to provide culturally- appropriate services.

- In conjunction with the consumers themselves, create outcome measures for culturally appropriate services then tie funding to outcomes – no outcomes, no funding.

- Train monitors of programs at the funding level with the same type of training in the provision of culturally-appropriate services that the providers receive. In this way, when they evaluate programs they are able to do so in an informed manner. Make the demonstration that programs are providing culturally appropriate services just as important as any other indicator.

- Make the creation of a strategic plan for provision of culturally-appropriate services a mandate for both initial and continued funding. Use that plan when monitoring for compliance.

Conclusion

The field of behavioral health has grown and developed over the years and these

changes have impacted the manner in which services are provided. In some ways, the

growth has been slow (i.e. closing of some state hospitals, restraint and seclusion

policies, etc.) but there have also been much-needed advancements.   Work being

done in states such as Ohio, Connecticut, Michigan and others regarding the creation

of systems of care that are recovery-oriented creates hope for consumers, programs

and policy-makers alike. As these advancements continue, the quality of

life/recovery may be improved for consumers, outcomes will be improved for

programs, and consumers will spend less time in treatment saving scarce resources.

While all of this work has been encouraging, further steps need to be taken. As stated previously, one size *does not* and *should not* fit all. While some ethnocentrists might prefer to think of the U.S. in terms of what is referred to as a *melting pot,* there are those who choose not to be part of that and who find comfort in cultural ways that may be quite outside of the pot. Treatment systems created around the *melting pot* premise negate consumer/family individuality and that which makes them special and unique. Consumers come to treatment with narratives and wonderfully rich stories of family and home and often those stories detail for providers who the person is as a cultural/spiritual being. Sometimes, the stories speak of rich heritages and traditions that allow the consumer to feel connected to something larger than him/her. Sometimes, the stories are painful and narrate internalized racism and long histories of oppression. If providers do not recognize these stories as tools to use when assisting the consumer on his or her recovery road, they are missing a great deal. Person Centered Planning gives us that opportunity, the skill and the knowledge necessary to gather and utilize this richness to assist people in their recovery.

If we want people to tell us stories about their lives, why don't we just ask them? (Davidson, 2003, pg. 64)

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