CoLab
Community & Behavioral Health Policy

Additional Questions & Answers from "Integrating Race and Culture in Evidence-Based Practices" Webinar

Questions

1. *Will we have access to this Power Point?*
    a. Yes, please visit this link

2. *Are CEUs available?*
    a. We do not provide CEUs for our webinars at this time, but we will explore it for the future.

3. *Can you please share some thoughts about how to obtain financial and professional support for identifying, implementing, and testing culturally grounded interventions?*
    a. A number of private foundations are interested in supporting grassroots intervention development and testing. We recommend looking at the following organizations:
    b. Premera: https://www.premera.com/visitor/community-support/grants-sponsorships
    c. Group Health Foundation: https://grouphealthfoundation.org/grantmaking/community-learning-grants/
    d. William T Grant Reducing Inequality: http://wtgrantfoundation.org/grants/research-grants-reducing-inequality

4. *What does "BIPOC" stand for?*
    a. The term "BIPOC" stands for Black, Indigenous, and People of Color. BIPOC centers the violence and discrimination experienced by Black and Indigenous peoples and also acknowledges that not all people of color have the same experience. For more information on the term's history, its meaning, and more context on how to use it, please visit the following website: https://www.nytimes.com/article/what-is-bipoc.html

5. *Is it better to complete screening tools with clients or have them do it on their own?*
    a. The answer is somewhat complex and "it depends"-- there are some real concrete reasons we need to do tools with clients as they need clarification on the questions, the meaning behind the questions, etc. If we have them do it on their own and we are confident they can do so independently then having them do it independently can be useful as well- it boils down to our clinical judgement, relationship with the client, what we know about them and their skill set.

6. *Question for Deekon Jones: I was just checking out your website. I'm in Spokane too and want to refer youth to your program. Are the services are paid for by their insurance?*
    a. Deekon: yes, we are accepting insurances

7. *Difference between accommodation (making the EBP culturally relevant) and adaptation (changing core aspects of the model)? Due to EBP's being made by mostly white folks and this societal pressure that they're "right" can make it difficult to question the order and process of an EBP in order be able to be flexible. How can we trust that our flexibility will work?*

   a. Accommodation and adaptation are some of the terms used in the science of treatment modification. This science is largely focused on providing guidance to systems for how to monitor quality across multiple sites of practice. At the clinical level, the adequate delivery of treatment will always be a decision the clinician needs to make as they consider how to balance individual client needs and evidence-based treatment. The clinician will be in a better position to make this decision the more they familiarize themselves with the rationale for and skills needed to delivery evidence-based clinical elements (e.g., parent training, graduate exposure) and client-directed care (e.g., provide choices, listen to the client about what is and is not working, use measurement to assess whether the plan is working). We encourage clinicians to seek out as much education as they can on these issues and learn from their own experience.

8. *We don't have a lot of efficacy for BIPOC clients. I believe CBT often forgets the holistic approach especially the spiritual aspect. I have found that most of my BIPOC clients have a huge spiritual component.*
   a. Our treatment science is currently limited by the dominance of a white, institutional viewpoint. Science on treatment approaches that are culturally-grounded in other traditions are available and increasing in visibility. At the same time, we want to reinforce our support of clinician and client-level decision-making in determining whether available evidence-based practices will be meaningful and effective for the client. We encourage the use of routine client feedback about whether clients are experiencing improvement in their treatment goals regardless of what practices are used, and in providing clients options when developing treatment plans.

9. *It's interesting that there are measurable differences within Asian and Latinx populations (regional etc) but it wasn't mentioned within the black community. Is that because we conceptualize blacks as one homogenous group, or some other reason?*
   a. No, there is significant heterogeneity in the African American and Black community as well. The African-American diaspora for example refers to communities of people outside of the U.S. and there's significant diversity here as well.

10. *In some cases with clients, work with insurance companies specify the necessity of using EBPs in treatment even though at times they are not culturally appropriate. Do you have advice on how to justify adjusting an EBP so as to both appease the insurance company and tailor treatment towards our clients' needs?*
   a. The Washington State Health Care Authority (HCA) directs insurance companies serving Medicaid clients to report the use of evidence-based practices as one of a number of ways to ensure the most vulnerable populations in our state are receiving high quality services. HCA requires the reporting of EBP's, but does not specify that any client is required to have an EBP. The requirements for treatment include an evaluation and treatment plan and it is expected that EBP's for the presenting condition are presented as an option for the client, but there is no requirement for any specific client to have a specific EBP. At the same time, the standard used for reporting these practices (The Reporting Guides) is clear that clinicians are expected and encouraged to tailor the delivery of evidence-based practices to fit client needs. If a clinician feels that the elements described in the Reporting Guides for any single session was sufficiently addressed, regardless of how it was framed for the client, then that session can be reported as an evidence-based practice. The most recent update to the Reporting Guides added Motivational Interviewing and Measurement-Based Care to every treatment approach as an

allowable clinical element. This means, for example, that as long as clinicians are capturing standardized information about client recovery in session, they can and should be reporting the use of an evidence-based practice for that session.

11. *I am curious if you know of any pathway currently moving toward evidence-based modalities using Indigenous Research Methods which are specifically interested in using storytelling, multiple truths, circular and holistic practices and world view embedded within research practices.*
    a. At the University of Washington, the Indigenous Wellness Research Institute is engaged in a number of projects that reflect these methods. At a state policy-level, most of the funding for children's mental health services is distributed directly through Federal or local funds and the state does not monitor whether mental health services align with the definition of evidence-based applied to Medicaid services.

12. *Since engagement is such an essential component when working with BIPOC families, how can we navigate how impersonal telehealth can be when we are trying to engage our clients and families especially when there are language barriers?*
    a. Please refer to our previous "Evidence-Base Practices and Telehealth for Youth" webinar for more information on this: https://youtu.be/Xw1U2KYPHyg We welcome any feedback on what else we can do to help answer this question; please email uwcolab@uw.edu for feedback or other questions.

13. *I'm thinking about the lack of efficacious treatments for comorbid disorders for BIPOC. How would you approach this? Meaning, what would you prioritize in treatment/where would you begin?*
    a. The research literature suggests that comorbid substance use and mental health issues are most effectively treated with integrated treatment plans rather than trying to treat one in isolation of the other. A possibly useful place to start is familiarizing yourself with these approaches to integrated treatment and the applying your own lens as a clinician to ensure implementation is client-centered and racially-conscious. We recommend looking at:
        i. Motivational Enhancement Therapy for SUD and depression: https://www.drugabuse.gov/publications/principles-drug-addiction-treatment-research-based-guide-third-edition/evidence-based-approaches-to-drug-addiction-treatment/behavioral-therapies/motivational-enhancement-therapy
    b. TARGET for SUD and trauma and anxiety: https://www.nctsn.org/interventions/trauma-affect-regulation-guide-education-and-therapy

14. *Any suggestions on how to foster the client's ability to self-advocate for not wanting EBTs during treatment plan creation?*
    a. We believe it is very important to be using client-centered practice in care, which involves giving clients authentic choices and transparent information. Shared-decision making guides can provide useful tips for how to present healthcare options with your clients. https://www.ahrq.gov/health-literacy/professional-training/shared-decision/tool/resource-8.html

15. *Question for Seema Mhatre: With regards to screening tools, would it be considered ethical to modify the screening questions in a way that would be more culturally appropriate and less harmful?*

   a. Seema: From what I understand, tools that are "validated" are not able to be modified without affecting the validity. I do think that when screens are administered in-person (not just given to a parent to complete on their own), there is more opportunity to create verbal understanding of a question. I think this might help mitigate some of the cultural blind spots that some tools have.

16. *Question for Deekon Jones: Do you have any recommendations for how to get involved in this work (any orgs or tips for launching a similar program)?*
    a. Deekon: I spoke with the individual asking about how to get involved in the process. I'll be hiring in the King County area when the Manual is complete, and training can be dialed in.

17. *Question for Deekon Jones: Are there music therapy groups for BIPOC kids/teens in King County?*
    a. Deekon: I'm not sure about other programs in the King County area, but I'm hopeful that this summer, New Developed Nations will be there and available to serve!
    b. In addition to Deekon's program (https://newdevelopednations.com/), here are some other resources, organizations, and individuals that were also shared during the webinar:
        i. Tribal Youth Resource Center: https://www.tribalyouthprogram.org/about-us/staff/
        ii. Indigenous Wellness Research Institute: http://iwri.org/
        iii. Dr. Edgar Tyson Hip Hop Therapy: https://www.hiphoptherapy.com/about-us
        iv. Ian Levy Hip Hop based counseling framework: https://ianplevy.com/

18. *Question for Seema Mhatre: Are there assessments that ARE racially/culturally aware that we should use instead of the ones that we see a lot, based on dominant white culture and used on white groups? I would love to get suggestions on racially/culturally aware assessments.*
    a. Seema: Our team has been looking into this. No tool will be perfect, but some are better than others. One tool we use at Odessa Brown Children's Clinic is called the Karitane Parenting Confidence Scale. It is only validated for parents of babies aged 0-12 months old, so it is kind of specific. But I like the way the questions are phrased and the multiple-choice answers. The tool itself is validated and is easily scored, but regardless of the score, the tool lends itself to allowing the clinician to build relationship with a parent. If a parent answers just one question slightly less than typical, it provides an opening for a clinician to explore more about how the parent is doing in that area. We, at OBCC, are also working with researcher from UW, Kendra Liljenquist. She is trying to develop a developmental screening tool (using what exists today) that does take into account: culture, language, reading level, environment and access to technology. I am very happy to be working with her because it feels like she is doing groundbreaking work. You may want to reach out to Kendra to hear directly from her about her work.

19. *Define "white culture"*
    a. White culture often incorporates perfectionism, quantity over quality, individualism, written ability, and that there is only one right way (Jones & Okun, 2001). For more information on what white culture is, click the following links:
        i. Characteristics of White Supremacy Culture: https://www.showingupforracialjustice.org/white-supremacy-culture-characteristics.html
    b. Seattle.gov has a worksheet to help discern white culture: https://www.seattle.gov/documents/Departments/RSJI/GRE/whiteculturehandout.pdf