

NAADAC

Cultural Humility Series, Part III: Social Class Bias and the
Negative Impact on Treatment Outcomes

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>> It is very near and dear to us and as a lot of folks on the call it is salient in society and important to us. Our own implicit bias. During the webinar we will create an awareness of what is social class and what is social class bias within United States would look at the effects that the social class has on individuals in mental health we hope to educate supervisors and clinicians and clinicians and training on the adverse effect of social class bias and what it has on the therapeutic relationship and to create a dialogue within our community, our clinical communities. And I will ask questions and I know you cannot respond to think about it to yourself and write it down as necessary. When is less than we had a conversation surrounding social class. Most of us reading animal farm in high school will might be the first my success we had on social class. We generally don't talk about it. It is one of the few biases that we openly embrace and ignore at the exact same time. It is fostered in our social structures and for example in our hierarchy of titles. The first generation versus multi-generation students. We can see it in business and banking in the neighborhoods in which we live, whether we live in food deserts or banking deserts. And also in an unpaid air quotes behind it, professional languages. How we speak to each other. This will get into cultural capital as a go along. SES, socioeconomic status is a full expression of who we are as a human being. Whether or not we think about it, hopefully at the end of the webinar you will see it and you will get it within yourself and it is how you dress. It is how we talk. It is our excesses to resources and COVID expose that in our society with the assumption that everybody has a job or the vast majority has a job that we can work from home. That we

have access high-speed Internet. With that, social class bias is undeniable reality and implicit overt rules. Think about is over rules we have for middle-class, mobile class and working class. Just some statistics I want to bring the mind considering how many individuals have negative impacts from the current virus. In 2017, 39.7 million Americans lived in poverty in of this, 18.5 million Americans are 45.6 of them reported deep poverty. That means living 50 percent below the poverty line which equates to US citizen living on two dollars a day for every person in their household. Of this, roughly 17 to 18 percent identified as a person of color. We will talk about that, that inner sexuality of marginalized communities today. Social class is gentle broken down into three levels. It is low SES, working-class, middle-class and upper-class. The general definitions or low SES are making roughly \$20,000 a year below and that is different than the federal poverty level. (Away from Microphone) Working-class is between 30 to 70 percent. (Away from Microphone) Middle-class encompasses lower and middle and upper middle class is \$40-\$150,000 for your and then upper-class is considered \$150,000 plus a year. Mind you, this does not take into account different regions of the United States and the different inherent cost-of-living concerns. So implications of social class is a symbol for some of the inherent aspect of being, you wake up with your race and gender and ethnicity in your social class each and every day and it's an inherent part of your neighborhood and it's an inherent part of your client neighborhood and it's an inherent part of you interact with and access to care, structures of power. And it is the most overlooked. I'm heavy-handed right now talking about that. I want to talk a

little bit and address cultural mismatch theory suggests that social class we have a tendency in our society and this is systemic. We are socialized to view certain individuals differently. We have a tendency to look at those with a high SES is be more welcoming, more kind and knowing a knowledgeable and it also presupposes that those that are poor have the opposite traits. Kind of like that so Kim while we talk about this. Middle-class generally evokes the idea of white picket fence. The abundant resources, low material constraints and the ability to go grocery shopping in the ability to buy healthy foods and the ability to exercise choice and control. Think about that. How much choice and control or how choice and control looks on each one of those levels of social class. How much choice and control of their lives today have a middle-class how much choice over their lives they have an upper-class how much choice and control they have. That takes me down to boundaries and social ramifications of members of each particular group and you can look at the movies of where the wealthy and the love interest Mary Stone out of the social class and how the family reacts. The movie presupposes it is a lower-class person that is raising up and becoming part of this. And I go back to the movie pretty woman years ago. We do not have anything in our society -- and she will rise up to meet Richard Gere's wealthy care to where he has versus Richard Gere being in touch with his humanity and seeing another human being as an equal. The screen froze. I do apologize. Manifestation of classism within the individual. As we have done a primer on social class, we have internalized classism, negative cognitive and emotional experience is related to fear of failure. If you remember in the movie and I

know I like pop culture. Jason Alexander, from Seinfeld he was afraid Richard Gere was going to be seen with this person. We can look in our current pop culture where Megan Markel married Prince Harry. Why was it a big to do? Because she was a commoner and so there is this fear of losing her place. We're always looking up at afraid to move down. There is a body of research that shows individuals once they move into an ever echelon class and I apologize. There's a bloom that just popped. Once they move up, there is this fear of going back to where they came from and it changes their overt behaviors. That is the upward classism or internalized classism and we have upward classism that we associate and this is also an implicit bias and can be overt. When we look at those that are wealthier than us or have more resources and would look at them as uppity and snobby. If you have teenagers run you probably say them saying the word booujee. Looking down and saying that this people down there deserve it and they're trashy and worthy and lazy. And then we have lateral classism where we look to the people around us and we try to maintain homeostasis and we will talk about keeping up with the Joneses. That is probably where it is mostly present in middle-class society is keeping up with those around us and were afraid of losing status, I go back to the movie Fun with Dick and Jane work the lawn gets repossessed. The female lead comes home and says yes take it, I ordered this different grass versus being honest and saying my husband just lost his job and the grass is being repossessed, as silly as it sounds. And so one of the things I want you to think about is how comfortable, as you read through this and obviously cannot interact right now, but how

comfortable are you sharing any of the following even with your friends. Your income. In the United States have a tendency to avoid speaking about income within companies and agencies. It is a secret. Why is it a secret? How comfortable are you sharing your debt? Talking about your student loan debt? What kind of beer do you drink? What kind of wine you drink? Are you behind on your bills, what your credit score is. As I tell my students, contain exactly how much are worth. It is called an x-ray table for life insurance or your FICA score for your credit. Think about that. How much that impacts us. Rest of us are proud of our FICA score and some of us are ashamed. Why? What does that say about us? What does that say about our clients? Have you ever been bankrupt, what is your ZIP Code? Each and every person on this phone call from this webinar today knows the ZIP Code they do not want to live in. They know the ZIP Code whether clients live. And what that ZIP Code entails. What is the school district? There was a lady who was sentenced to six years in jail for lying about her address to get her child into a better school. Taking that chance to get your -- your child access to schooling. Do you buy canned foods and raw foods. What brands are you wearing, look around your house? What brands are lying around your house with her its furnishings or clothing, these things all represent everything we do. The reason I bring this to a personal way as we do, because our clients are doing the exact same thing and as we set up our offices and as we dress for session, as we have them come to our place in our agencies, that is where the disconnect happens because our biases start to come through the way our client stress. Think of your biosocial intakes when you are doing objective

reporting on your -- clients dress and speech. And this takes us into a little more identity. I apologize. I jumped up one side. Just wrap this up and I will turn this over to Dr. Rivas. The identities we talked about whether we are low, working class, middle or upper class. We have a tendency to look at those wealthy -- (Away from Microphone) --. If you are lucky enough to come from a status place you look at yourself favorably in those underneath lower statuses unfavorably. There is a feeling of more power. There is also a demonstration of over precision. One thing about that is having excessive for the knowledge and knowing the truth in the absence of said knowledge or understanding of the truth. This is a pretty interesting concept and this will play into the were talking about diagnosis and prognosis, are lower SES clients because it often comes from the position of over precision.

>> Dr. Rivas: Let's talk about poverty as a risk factor. If we look at intergenerational patterns and poverty, the risk factors continue. The risk factors are such academic failure, substance abuse, antisocial behavior, depression, teenage pregnancy and those are mediated by the social environments and family. Intergenerational family theories look at intergenerational patterns of behavior, communication including overt and covert communication patterns as being maintained by and within the system. Meaning the way we are clearly communicating in the way we are implying certain things as normative. Intergenerational patterns are a system that is maintain the system of behavior marked by conflict that remove the group further each generation. So specifically looking at families living in poverty, they are more likely to have social

interactions that are marked by high levels of conflict. In which the families use adverse of behavior to influence one another. When parents -- and I want to take a minute to look at the level of stress we are exposed to when we are struggling for resources. When we are trying to just manage our level of stress as a parent, it will influence how capable we are in managing her children stress. This puts parents and families living in poverty in a position where they may not always be able to manage those behaviors from the children and the conflict that may happen is exacerbated to their levels of stress. And it looks at Maslow's hierarchy of needs from her struggling for safety, shelter and food, it is tricky to think about how we would like to behave, how we would like to get our needs met in other ways because were trying to survive. So as these patterns of conflict are maintained within the system, children's behaviors are starting to shift into these acting out behaviors and residential treatments -- kids are really sending allowed message through their behaviors and this is influence within the system. In terms of cognitive abilities such as self-regulations. It also plays a key role in this intergenerational cycle of poverty and so as these families have children their kids they are sending to school as are worried about where their next meal will be, the kids are able to do these higher level tasks like learning about math and one plus one is a silly example when the word about making sure they eat are worried about where their food will come from or their parents stress levels. These are some -- housing for example. I will take of couple communities as we look at the divide and like Dr. Rivas was saying, we know based on where we live, or ZIP Code and communities, we know

where those neighborhoods are so to speak. The rich neighborhoods in the poor neighborhoods. Let's look at places like Aspen or Greenwich where the families or the employees that often work in those areas are unable to afford to live in those areas. So in some ways we are segregating in those behaviors within the communities ourself-sustaining. Neurological implications of poverty. If we look at neurological implications of poverty, I want to talk about, as I mentioned, stress so that HPA access, the hippocampus, pituitary and adrenal access complex. What we see with that is our reaction to stress. So in the areas of our neurological system involved in stress in our system is set to react to a threat. It does not clarify whether that threat is minor or major. It is still we have a stress response that exists nonetheless. So when we are exposed to stress, our amygdala is active because it has to react to distress. We see in the stress-strain is that the amygdala is highly active in the hippocampus is less active in the prefrontal cortex is less active. In looking at poverty, we are looking at a group of people in stress mode quite frequently. With that stress level, the adrenal response is a release of epinephrine and cortisol. We know that when we are in stress brain, we are not able to do higher level functioning because the system is set up for fight or flight and are sympathetic nervous system kicks in. In that space, we are limited in being able to sit down and do a task. Let's say that we have families and poverty that are constantly in this stress state and there is conflict that we mentioned in the kids are going to school. So the kids are going to school heightened by the conflict and heightened by the stress response in the amygdala is active in the prefrontal cortex is not as active. In children it

begins to develop in its developmental process is not complete until about 23 to 25. So that process is negatively impacted by the levels of stress. We have a group of people now segregated by communities that are under resourced when they go to school. These acting out behaviors we tend to see in children, they are in a different state of being due to stress and physiological reaction. So these neighborhoods tend to be under resourced with what the school should provide. In the level of need is greater. So those psychological implications of poverty, Ace score. I'm sure everyone is familiar with adverse childhood experiences. This is one of those -- that body of research looks at 10 factors that negatively impact individuals that they have been in childhood. It makes them more susceptible or more at risk later for substance use disorder or psychological disorders and physiological problems. When we are looking at poverty and knowing that a lot of risk factors are coming into play, one, the stress response; two, substance use if it is in the household, abuse, physical abuse, sexual abuse, this is a group at a higher risk. A higher ACE score. Going back to kids, as they are going to school, they are higher risk kids and the resources are less than or at minimum able to meet their needs. Source stress response, is on static -- allostatic load. The allostatic load is a level of stress. It is the wear and tear on the body that accumulates when we are exposed to repeated in chronic stress. In their poor health implications for that. Substance use, antisocial behavior. I want to talk about antisocial behavior gives prosocial behavior. As part of the school mechanism is teaching approach social behavior. Make new friends and keep the old. Think of all the songs we are growing out. It really

promoted prosocial behavior. The challenge now is we have communities where children are going to school that their negative behaviors and antisocial behaviors are reinforced incidentally subconsciously within the household. The resources are not there. Two the higher risk group, again, this impacts their education due to the levels of stress they are experiencing. In 2013, about 21 percent of school-age children are coming from families living in poverty. The percentage of school-age children living in poverty ranged across the United States from nine percent in New Hampshire to 33 percent in Mississippi, 30 percent of low SES students obtained admission to higher education. Of those on average, 50 percent will graduate. The cycle now continues in this class system to further the divide.

Last but not least, I want to talk a tiny bit before I passes back about funding of schools being tied to performance. If we look at a Google search like great schools comes up. And it is a way of identifying what schools perform better and it has a broken down by class and race and it has it broken down by performance and we know that lower SES communities are less funded and that is the area where more support is needed for equity and they are in the schools using the best resources they can to deal with the students who may have a higher ACE score and have acting out behaviors. Often those behaviors are misinterpreted and met with a more punitive response. And so now we have an understaffed and under resourced school unable to meet the needs of kids and promote incidentally or not purposefully, becoming a K-12 pipeline to prison to further exacerbate the divide. And toss it back to Anthony.

>> One of the things and I want to tie this together. When we are looking at neighborhoods we want to move in or schools want to place our children, we have this bias that we want the best and I put air quotes from that. We want the best for our children. What often does that mean? Think back for a second. Generally it means that we want our children to be around other children like us and not like us in the talk like us. We want our children to be in classrooms we deem safe. How do we deem the classroom safe? Think about all those questions. Because while we're doing it in our own life, we are also pushing that onto our clients. There is a whole body of literature and physicians do a great job of studying this. We have a tendency to give -- over diagnosed lower SES individuals and give them worse prognosis. The literature does not point to why we do this outside of we just other them. This goes back to and I will dovetail into this idea of ever precision or we know what is best. We'll talk about this in a minute and a later slide but think of all the self-care for the educators and the clinicians. That spouses tell you to do for self-care. What are those options I give you? Are they fit for the working poor or middle-class or are they fit for wealthy and upper-class?

This covert behavior of choosing schools and giving our clients self-care techniques coincides with overt behaviors, thus moving ourselves to different neighborhoods and placing her offices in different neighborhoods. How many of y'all sought out if you're in private practice, where your place of office. How many of you all looked at the neighborhood and said I don't what my officer because I wanted to be nice and a nice building I wanted to be safe? It comes with privilege. And it is not lost on our clients.

I have worked with the court mandated clients throughout my career and this is antidotal. But I've seen the differences in agencies where we had pro athletes, professional athletes come in one door and the rest the clients come in the other door. That really doesn't still divide and that is a divide we consciously and unconsciously promote. I will show you some slides. I will put them on the screen. And then I want you to study them and we have some questions afterward.

I think I zoomed past the question.

>> I can help. I will launch the pole for everyone. Here is the picture Anthony was referring to and of the GC that we will launch the pole on your screen. The question is, what are some traits associated with this group. There you go. You will see the pole pop up on the screen for the moment. If you do not see it, adjust the view on your screen and you may be able to adjuster from full view to window size view different views there. The question again is what are some traits associated with this group. We just voted on your screen. Thank you all for those who are participating in the pole. As a reminder, if you have questions for our presenters, send them in the questions box will be on the right-hand side of your screen in the go to webinar view pain and if you're having trouble viewing it, go ahead and maximize or minimize your screen defined the question box. You will see it there. It looks like close to half of you have voted. We will give you about five or 10 more seconds and then we will close the poll.

Perfect. Thank you so much everyone. We will go ahead and close it and I will share the results in turn this back over to the presenter.

>> Okay. When we are looking at this. These pictures. Obviously we were looking at the poll reply and we see that 22 percent said they eat healthy. Seven percent said they own their own home. Nine percent they have their own reliable transportation. Think about this. What led you to their decisions. That they are reliable and trustworthy, only finding only 49 percent said that. What biases came up for you during that time. The next screenshot, there we go. I want you to take a look at the families involved in this picture and I will hand over to Samson for another question on this one. Thanks thank you so much Dr. Rivas. You will see this pulling question pop up on your screen asking the same question. What are some traits associated with this group and you will see answer options a through E.? And I will give you a chance to answer this while you are answering that poll and participating, Doctor Anthony, if you can click the audio tab and select phone call option and connect using your phone. We are having your audio cut in and out. We discussed some feedback from the audience. Thank you so much. While Dr. Rivas is doing that, continue for spitting in the poll and looks like almost 40 percent of you have answered the question and thank you so much. Again, if you have trouble accessing the poll, minimizing and accessing the screen. Minimizing or maximizing the screen. Over half of you have voted in thank you so much. In about five more seconds here. Thank you. I will close the poll and share the results and I will turn this back over to Dr. Rivas.

>> I hope this is a better connection.

>> I can hear you loud and clear.

>> Fantastic. As you can see from this next poll, we saw

two things differ. We saw a downgrade of reliable and trustworthy in an upgrade that they own their home. Think about this to yourself, we saw four percent owned reliable transportation and think about all the associations you need to come up with this. What makes them reliable and trustworthy are less reliable and trustworthy than the previous group. What makes you think this group owns their own home. What are those associations because it is an implicit bias is coming to the surface? One thing I recommend and I will promote and it's at the end of the site to is taking the implicit bias test. There will be a link on it for this and see what your implicit biases are and most of us know how to take test an employee to take the test without using a clinical mind. Use the civilian mind the sits on the counter read the book and sits on the couch and watches T.V. or goes for a bike ride. Use that mind when you take the test to really identify where this internal messaging is coming from. I will move on to the next picture I want you to look at them and we are going to then ask you questions. Take a look at the folks on these pictures and we will be ready for the pole in a second.

>> Excellent. Thank you so much. We will launch this next pole. The question asked what are some traits associated with this group and you will see that question pop up in a moment with five answer options and similar to those before and select the option again you can change the view if you need to. Sometimes you have to switch it from full view to another view and it looks like we have some great responses coming in already. Thank you for sending the questions in and feel free to keep this coming and we will give you 10 more seconds. Perfect. Wow. Big numbers coming in. I'll

give you five more seconds and it looks like some people are just now accessing it.

>> Okay.

>> I wish I could see how the numbers change in last five seconds and I will close the pole and share the results and I will turn this back over to Dr. Rivas.

>> We can see jumps in they are well read, eating healthy and owning their own home and reliable transportation and then the trustworthy and reliable. Remember a few slides back when we're talking about that snobbishness and that boujee attitude. What biases are we having? I through this in there because I have been talking about downward bias but we also have upward bias. We have clients that come in that are working with court mandated offenders. I hate that term, that is what I was implicated with in my career. As someone who shows up and they have a DUI and driving a Mercedes and we have folks coming off the bus. Our biases work both ways and as you can see by the shift in the numbers, there is some that is just generic me healthy and reliable transportation and on their own homes for the reliable and trustworthy one is a fun one to look at.

>> This is one of those interesting things, Dr. Rivas. We really don't break the sound. We have watched between reality T.V. and what the media has told us and what we have experienced it may be the messages we got home have all shifted our worldview in such a way that we don't really look at it. We don't look at where we're coming from and really looking at our social class that we inherently have behaviors that reinforce it and it is one of those areas that we just won't talk about in society.

>> ES indefinitely. This is something as a society that as I

said before, it is one of the few biases that we actively ignore yet promote and it is an interesting facet of American society. We believe we are in this society when in fact we do have a class system that the structures are in place for. We will talk a little bit about systemic bias and implications. I want to think, write it down on a piece of paper next to you if you have one. I wanted to think about the first population that comes to your mind when you hear the prompt. I will read it and I will show it on the screen. For the next slide. Think about the first population that comes to your mind. Traits, quick things you think to yourself as a clinician when you're working in see this on paperwork or at intake, or the client tells you about this. Cocaine, crack, methamphetamine, heroin, crack a -- krokodil. If you do not know what krokodil is, it is made with diesel fuel and Sudafed and it's popular in Eastern Europe and the average lifespan of the person using it is about two years after they start injecting it. Medical marijuana, marijuana, illicit, prescription opioids and inhalants and benzodiazepines. Think what comes to your mind. What population comes to mind. What is the person look like when you hear this? Does a person who comes to you for substance use disorder primarily likes to use cocaine, powder cocaine. What are your thoughts. The person comes to you on crack, a person becomes he using methamphetamine, person for prescription opioids. I do recommend, there is a great show called chasing heroin and it talks about the prescription opioid concerns. But think about this. What if the biases that have popped up for you as we went through this? Next, I will hand this over to Sampson again for a poll question. I will turn the screen back over to you. You can go without

one.

>> Thank you, Dr. Rivas. Everyone, you will see this question pop up in a moment. The next question asked what SES is associated with the wine? What SES is associated with wine? If you're having trouble seeing the question, you may want to change the view but change it from full view to a different type of you and then it will appear and you also have the questions box on the right-hand side of the screen. After we close the poll we can use that? Any time to send in questions to your presenters and we will have a live Q&A to the end we will answer the questions we've already received an order in which we have received them and thank you so much for those who have answered the pole. I'll give you five more seconds. Thank you all so much and I will close the poll turn this back over to your presenters.

>> We can see the association with wine. It is interesting. 52 percent, upper-class, 44 percent middle-class and four percent for lower working class. It is interesting because -- I will look into my fortune-telling mind and presume that most of us when we look at wine, we thought of a nice bottle of Chardonnay. If you live in one country, I'm in California. We're looking at some nice rabbit Ridge or something like that. And so we assume that middle and upper-class, big celebrations. Not associated with lower working class and I don't know how many have a similar high school experience or college experience that I had a friend who had but there is also mad dog 2020, being filled. Things like that. We make the association with wine it with the upper-class. And upper-class drink. We have another polling question and all passes back over and we will do the exact same thing.

>> The same question everyone. What SES is associated with prescription pills. For this one again you will see three answer options and it will pop up on your screen in a few seconds. There it is. What SES associated with prescription pills. You will see three options. A final reminder, we will have a live Q&A. Please keep sending your questions. Those who sent the men, we will ask your questions in the order in which they been received very thank you all for sending them in and thank you for participating in the poll. 30 to 40 percent have answered and will give you about five more seconds. That is great and thank you so much. I will close this and share the results and I will turn this back over to our presenter.

>> Dr. Rivas: Thank you. As you can see, now it is shifted and we are seeing middle-class and interesting enough, that does meet with the literature but it is also a bias. Why do we have the bias that prescription pills are middle-class. That that is what the middle class triggered choices. Is that because what were taught, what we see? As a seven literature, but also an interesting part in this webinar is looking with individuals working with opioids. You know many global and working-class individuals have started with their heroin use from prescription pills. I believe the less assisted I thought was 55 percent started with the prescription of the dentist. Opioids were known in the United States, locally is hillbilly heroin. It is interesting we were looking at it is middle-class. But it also affects low SES individuals but we view prescription as something to middle-class concern. And so that really drives how we treat people and how we acknowledge their addiction and how we acknowledge their disorders. I hope this is getting your

minds going, where you are looking at, oh my gosh, how do I view this and what lens am I looking at my clients through. I will transfer this over to the other Dr. Rivas and she is going to talk about implication and bias in legislation and dovetail it back into our bias. Dr. Rivas, that is an interesting poll because this is a well-informed group especially as it comes with the poll around the prescription pills. It's been in the media the last couple years. This administration is looking at our pill use and it's getting media attention and a different way than any other substances have before. It is interesting if we roll into drug legislation media and how we've been informed or how our biases have been shaped by our system, the systems in place. Looking at the implications of the bias of legislation, I want to go back a little bit in time to the Nixon administration. In this is a quote from Nixon's former domestic policy chief. He said the Nixon campaign in 1968 in the Nixon White House after that had two enemies: the antiwar left and black people. You understand what I'm saying? We knew we could not make it illegal to be either against the war or black, but by getting the public to assist the hippies of marijuana and Blacks with heroin and then by criminalizing both heavily, we could disrupt those communities. We can rest their leaders, read their homes, break up their meetings and vilify them night after night on the evening news. If we know we were lying about the drugs? Of course we did. This is the administration, during this time, that scheduling of drugs came about. If anyone many people on this meeting are familiar with the scheduling of drugs and have ever been perplexed about why we have certain substances in certain categories, it was informed by a vice and agenda to get everyone on the same page with

who are the better groups and who are not and so this is the intersection analogy of oppression and racism that have been formed these and created or contributed to the social classes and how we view them so I will go a little bit into the war on drugs. Now if we go forward for Nixon who wanted her talk theoretically about a war and created the scheduling, Reagan actually started a war on drugs and the Iran Contra scandal was one avenue in which we find funneled drugs into the community. Around the 80s there were activities brought in the crack and cocaine epidemic, brought it about. By funneling the substances through our communities, we began this process of further disenfranchising certain groups. And then on the media there was a representation of inner-city communities as criminals and drug addicts making Blacks synonymous -- making crack synonymous with black communities and cocaine synonymous with white communities and in 1986 the antidrug abuse act created mandatory minimums that exacerbated that, meaning that you would get mandatory minimum, meaning all judges had to use the same model and cannot make any deviation based on certain situations. This insured everyone had the same penalty and it separated coaccused from crack use and you would get a longer sentence, five-year mandatory minimum for crack and one-year mandatory minimum for cocaine. I want to fast-forward a tiny bit to the 90s. And OxyContin, and when the patent was created and fast-forward to the 2000's and going back to how informed this group is, we had the companies now take over -- I joke that it's the American cartel or we went from having -- going from crack to pills. In the Pfizer group and everyone is familiar with that what has recently come about, what we know

around the pill what Dr. Rivas was referring to going from pills to heroin, came about and it was targeted at a different group. So now companies were in on this and that targeted group was suburbs and rural. So where are we at one point -- Purdue Pharma, not Pfizer. I apologize. So now we have -- or what now has effectively been done is where the crack epidemic impacted largely black and brown communities, that were already struggling with poverty, then we fast-forward to rural communities that have been struggling with poverty and impacted that group at this point from going from pills to going into the heroin problem we have and it is an interesting thing going back to this administration and addressing the heroin or opioid epidemic, it is largely impacted white people. My point here is and before I go to you Dr. Rivas and I do want you to pipe in, now I forgot. Go for it. It will come back.

>> Dr. Rivas: I apologize clerks you are good.

>> I was going to support that. We look at the prescription pill, they become a problem when it infiltrated the middle-class. When it infiltrated white middle class. Primarily it was marketed in Appalachia and it was marketed in communities that had crushing injuries from coal mining and injuries from burns because prior to being prescribed -- and I am probably billing information already known -- but prior to being prescribed willy-nilly as it is now, it was designed for people at end of life. And they found there wasn't much money to be made in that incident prescribed it to poor people in the eastern seaboard and Appalachia region and they started to see more of the market. We did not pay attention to it, going back to her polling question -- infiltrated our neighborhoods and homes were now it became uncomfortable for the

middle class. Primarily most drug legislation in the United States has come out of some form of racism and it is affecting the white middle class and it was affecting her teenagers and impending air quotes around that and generally that is when the alarm bells sound.

>> I appreciate that. And it is interesting when we look at exactly what he said by class system. In terms of the poor groups, reviewing it more negatively as if they had some level of choice. And as it has impacted middle class and largely white middle-class, that is where it has found some way of wanting to intervene by the government. Anything else, Dr. Rivas.

>> No.

>> I'm trying to think of what my next point was and it will come to me I am sure. Let's go to the next one.

Implications. Some of these implications are understanding the larger systematic problem we have here. It is really tricky to look at these, any of these scenarios. One of the recommendations is really advocating for resources for quality, teaching and mentoring a new generation of therapists, understand the systemic nature. As her moving to a field of integrative practices, advocating for access to our clients because access to mental health treatment and access to physical to medical care and it's another thing that forces the class system. People middle class or upper class have access and can better access integrated care whereas lower working in poor communities are not able to access and have the same level of access. It is another thing that is interesting, we learn about mindfulness and wellness, a lot of what we tend to promote and being exposed to nature and some of the self-care we have are an accessible our

communities, going back to what I was talking about earlier for stress. When we are in a constant stress state, you cannot estimate in that state to meditate because it takes a different space in the brain. We have to have a step-down process to give them resources accessible and doable when we are working or they are working harder. Anthony or Dr. Rivas, the other Dr. Rivas, would you add anything to that.

>> I would add to that because one of the implications we had and I spoke of this and zoom, most of her recommendations from our clients come from a middle-class perspective and networks have been down. We tell them self-care and give them relaxation techniques, it is effectively that the ring them and it is Chris Harkey said it. New York City, working class family and he went to the camp. I went to a neighborhood that have more nature because he grew up in the city. If you want a Connecticut or Central Park, to some edge of the city, it looks like that. Things that help us. Out for the hustle bustle. Those are not always accessible to clients and what do we say when our clients are noncompliant, how do we chart that. They are noncompliant and they did not go out for their walk. Think about how many of you all working in the agency overbook yourself in five minutes to wolf down your food. We tell them to do that. No but if you're working three jobs, you're not going to take that leisurely time. And so these aspects that were telling things will help them, they oftentimes have the access to. So that further creates a divide.

>> It is interesting you mention the equity a few times and I think everyone has seen that picture of three different people looking over a fence and having different boxes and so I want to bring that up in this aspect that we have been under

resourcing certain groups where they many more to be at the same level. The last point I would like to make in terms of our family of origin, no matter where we collectively, everyone on this call, where we came from, we end up in a different class by nature of the profession we selected here, by nature of being at least a graduate-level in terms of a psychotherapist, therapist, counselor, anyone licensed has to be at least a masters level. The nature of our experiences in education we have shifted and some people likely feel that shifter have felt the shift. If I ask you to reflect on it. If you came from and remember having to come up with money that you had to come up with to join ACA to join NAADAC or as a student. He felt that challenge where it could have been a challenge more than someone else. He then entered the state of being in the profession even though financially it may elevate us like positions would but a friend this is different SES. Could you talk a little bit about that before we transition?

>> Coming from the family of origin whether it was working class or white collar blue-collar or gray color job or background, we automatically are elevated for the most part status wise because SES and all of this part out earlier because SES is a complicated scoring system. It not only looks at money but status job. If you are adjunct faculty with a PhD, technically you fit in the middle class because you have an advanced degree that you know monetarily if you're in adjunct faculty, you're not making middle-class money. But society pushes us into these roles. And that has an inherent effect on us and our family of origin and that counselor calls discord in our families to where we have moved into our reference group invokes remember from

sociology. That is a group we hope to change you. There's a fear of backsliding to our working-class roots. So what do we do? We adopt a mannerism of speech, the material possessions of our reference group and it really knocks us out of authenticity and congruent with who we are and can cause discord between us and our clients.

>> That is one of the things we really don't talk about. It is one of the things we don't talk about so thank you. Now back to you for unconscious bias.

>> As we've been talking about these biases, what you see on your screen right here is unconscious bias pathway and have the next slide

has a similar graphic. It starts with the cognitive categorization. How do we categorize the world? How we view the world and how we categorize people very that moves us into our stereotypes. One of the things I normally do and I'll stop here for a second. Everybody on this cause of bias. If you have a pulse, you have a bias. One thing is to face them head on and not ignore them. If you are a child of the 90s you remember the United colors of Benetton where they said I don't see color and I challenge that because if you don't see color, you don't see your clients, you don't see your friends, you don't see relatives, you don't see yourself. Because if we take one part of that person story way, we do not see the whole person. That is my soapbox. Categorization, we have this in our mind we say okay this person does this in here is the stereotype. It goes along with that. And we have a conscious bias that may be expressed but there is always this unconscious bias because if you do the whole, I don't see that then an unconscious bias garden will grow and keep growing and it

will negatively affect you. If we understand our conscious bias, we can say no. That is a presupposition based on false information. Because even if I was having experience with the person who had XYZ features, social class, whatever, that was one -- that was not in entirety of the population. But if we allowed the unconscious bias to grow, now we have overt behaviors and that does bleed into our prognosis, our diagnoses and that leads into whether or not we will treat them. And I don't think most people is called -- I am clinically licensed as an LLC in the MAT -- MST and go underground score remember professors and peers, I don't want to work with people's addictions. No I don't. Why? There is that overt bias and that overt behavior. What is wrong with somebody who has an addiction. They have an addiction and they came to you for treatment. There is nothing inherently worthless but we still have this behavior. And then we have the inadvertent behaviors where pulling away, if your clients are in the office and may be keeping your my stuff hidden, they will pick up on this and they will pick up on if you have two offices and if you're going to the worst off. We had a nice office in our neighborhood and my wife and I were going on vacation and we needed flu shots. The receptionist apologized to us when I came in because we only had an appointment at the other office. Guess where it was? Was it in the sick code or the effusive code. It was in the iffy ZIP Code. Only when in the receptionist was brisk and gave her my insurance card we realize we went to the other office. That is anecdotal and sure everybody on the call has had an experience like that and that was that overt behavior.

>> It is like our reaction just as a whole to see homeless

persons on the street. Do we make eye contact and would talk to them?

>> That is an excellent point. In Denver, they were in a study and found they surveyed homeless people in Denver that had signs and were asking for money and one of the questions was what he want most from people to pass you by. The vast majority was in the 70 percent indicated look me in the eye and smile and knowledge of my humanity. That was a schematic person they found. Acknowledge my humanity. The next slide is the implicit bias pathway. Provided we all have implicit bias. I will bring us a bill a bit but I will throw it out now. Your choice of what insurances you take. You avoid Medicaid and I will put air quotes around it, because it's hard to get reimbursed sometimes when you're working with third-party payers. The stick to private pay, cash pay. You stick to the big insurance companies. That is already starting to bias. In Colorado Springs there is a six month wait for psychiatric care for med monitoring and for prescribers, a six month wait. At that point we can choose path ARB and we have judgment and decisions about patient care and pathway be we can mutate and trust with our patients. We understand the reports. I use some antidotal. I'd fallen down the stairs and we have moved from Denver to a small mountain town. If anyone knows Monument, Colorado. We lived on the Whitmore side. I'm being facetious when I said that the people who know the area, that is a big to do. I told urgent care with my daughter. The physician nothing is broken or strained asked me what kind of payments I want. That is bias. And I had rapport and the child went to school with my child and we had rapport and he knew what I did and the professor,

addiction counselor and asked me what kind of payments I want and I said I will take ibuprofen. And there is a bias. Nor was he going to have a negative outcome. If we can't trust her patients and understanding not put this bias on them, we can engage them and get them to adhere to treatment and treatment protocols and we have to treatment outcomes. We will put constraints on them that will either push for noncompliance or make compliance really difficult to abide by.

>> Create an interesting point with the physician bias and it has been evidenced through overprescribing white populations in terms of the opioid epidemic which is what you're talking about. In terms of pills they have ever prescribed white groups and ever prescribed minority groups so that inherent belief that it can relate to their pain and cannot relate to the other groups really exacerbated the problem and said that it's a good caution for us in the counseling and psychotherapy field and being mindful of what we talked about today is how the biases by class play out because often we are looking and we are a bit more aware of recent culture where we may not be as aware of our class groups.

>> Exactly. A bit of hair on the sides the restart program. The restart program is a DUI program in Colorado. If individuals are selected. I have worked with this program for a short time and I think it does great things so I'm not disparaging this program by any means. I just want to show sometimes the clients have restraints ready for selected he had to spend 50 days in jail with group therapy winter selected and what RESTART does is allow the felony, for DUIs, you get a felony DUI. It allows you for the felony to be

removed or moved to a misdemeanor to winter selected he had 260 days in jail and there's group therapy and treatment and wants you are placed on IOP. For the folks who do IOP that can be 20 hours of the services for week. Group therapy breathalyzers and I'll stop there because one of the program requirements, their harsh ramifications because they want to ensure that people succeed so it is waited both ways. You want to succeed in order to succeed there has to be some severe ramifications. If you miss a group, you spend 24 hours in jail and you miss therapy session you spend 24 hours in jail and if you miss a UA it is counted as a positive UA. Let that sit there for a second. Now you're paying for random UAs and may be a scam system in your paying for interlock on the vehicle if you own a vehicle that you cannot drive in your supposed to maintain insurance on the vehicle you cannot drive because you lost your license for year. Now you must be employed full-time and meet these requirements. If you live in an area with snow, and buses do not run on schedule. If you live in Colorado you know it's 40 to 50 degrees in the morning and could have six inches by rush-hour traffic and so the reason I bring this up is because this comes from a sense of that people have resources and while middle class and upper middle class have resources where they have relatives or they can pay for an Uber to transfer them back and forth and they also have jobs where they can take vacation or PTO where they have supervisors that allow them to take time off, many of the clients are from low SES for the ride the bus and the working jobs where they cannot just leave. I have some clients lose their job, I've seen clients come to class or 20 minutes late because the system had a breast for down or

got stuck in the snow. So these are the things we provide treatment but we don't provide resources to help our clients become successful in treatment. And think about it. The chart client that does not comply with treatment. We call them resistance and we view them negatively. Do we take the time to say they are related group because they live in our way in the red for buses to get a group? Do we take the time to think about how we can help them find this resources or do we even provide them resources like that in our agencies? An agency is where we have provided bus tokens but that is also counterintuitive because that is having faith the buses run on time. Things to think about when you look in the clients is out because they really don't want to be there or because actual life got in the way. And think about how you delineate between the client and which clients get grace which clients don't. I put the restart program and is the only program of work with. Where everybody was working together to help clients data jail. I want to put that caveat out there. There's a great post article on the magistrate for the Denver drug court where he came from a background of addiction. He substitutes-- substance abuse disorder and he was addicted to heroin and it's a beautiful rags to riches story, if you are interested in reading up on that. So think about those resources and think about how they impact our clients. Access to healthcare, we talked a little bit about that a minute ago and we're getting close to our time here shortly so I just want to press upon this and bias impacts her access to healthcare. Clients access the services and are they able to seek treatment, is it is an agency, is it that your private practice are you taking third-party billing, is her Medicaid and are you referring them out

doing pro bono work. Everybody has a right to make money in the practice. But that is also coming with implicit bias.

Are you purposely putting your offices and neighborhoods where you know you when I get certain clients?

Assessments. We know our assessment often times in a vast majority are normed on white males. Does it take into account reading level, English as a second language?

When we look at our clients being hospitalized, are they been hospitalized because of the severity of their diagnosis?

Or are we looking at the severity based upon our bias. Our treatment outcomes. And I know everybody in this webinar is ethical. Pay attention to the bias. Are you saying to yourself this person is not going to succeed and they're not going to show up to group? I've done this for 20 years and under this Congress will not show up. Think about that.

What does that bias look like for your particular population?

According to SAMHSA 47.6 million adults were diagnosed with a mental disorder. Often times representing a lot of people like to put their best foot forward and work a little more open to talk about mental health in our society of substance abuse. Our clients come to us and they probably burned bridges with their families, they been called offender and been through the system and they have stereotypes in whatever language hits them. How open are they to be truthful with you from a place of not being judged? I encourage you to work with clients on that. Of those 47.6 million or 9.2 million co-occurring, 51 percent received treatment for their co-occurring disorders, 40 percent did not. The question is, what of the 48 percent not receive it? Did they not have access or feel comfortable? Anecdotally from my experience, I have found clients -- I come from a client

centered background. I have a client tell me this is the first time I've not been judged and it was not just by me, it was by coworkers in the agency and I was like this is the first time I've not felt judged by something or somebody is like oh I'm just this or that. I think we could do better I think we can reorient attention to biases and access to care, we can increase that number ELISA for the opportunity for clients to seek treatment and seek treatment or they do not feel judged. In the last part and I will pass over currently in the United States we are going through unprecedented times and unemployment and currently 20 million+ unemployed individuals in United States and people losing healthcare in their jobs in high stress populations. We've seen it through NAADAC and SAMHSA, being locked down is not doing positive things for substance use in our country. We are seeing rates of substance use increase in people, as I tell my students from what nobody starts kindergarten and says when I'm growing up I want to drink my life away and destroy my career and alienate my family. I've not seen one person that sat around in kindergarten and so that or said I want to slam heroin when I get older. Human beings like to escape reality. These drugs to escape the panic, and I think most folks -- we escape trauma, drugs to numb the hurt and the fear. Coming from that lens versus this moral model choice I think is another way of understanding bias. I do this when I asked my students, what is your approach, is it psychological model, disease model, public health model, is it moral, spiritual, bio psychosocial model, what is your approach to working with your client. I encourage you to look at that and understand how you are approaching your clients. What model you are using. Now I am biased and I

like the biopsychosocial model because it takes all the things into consideration, learned behavior, trauma, psychological distress and their biological markers. It is important to understand that our clients are not inherently trying to engage in treatment, they are not actively trying to thwart you are willfully thwart you. A lot of these behaviors they are exhibiting our inherent rules associated with their social class in the world in which they live in an a lot of your reactions come from implicit bias that we have toward that social class and understanding that our middle-class reaction to certain things and most of the folks on this call, someone tells you to do some for treatment, you are probably compliant. But we know even medical compliance hypertension, asthma, roughly around what relapse rates look like for clients but we excuse it because I don't want to take my high blood pressure pill today versus our client that becomes willful. I wanted to throw that out because I do think we'll see some folks that traditionally were middle-class during this time that will fall into lower SES and I am curious on how that will impact our treatment of them in their treatment or their compliance with treatment going forward and I will pass it over to the other Dr. Rivas to take us home.

>> This is interesting times so what we have hope to do over the course of the last hour and a half is create a little awareness of bias and how that has been integrated into a systemic system approaches or systemic challenge I guess that we have all participated in whether we knowingly or not. How can we move forward and I think right now we are in historic times with unemployment, challenges that will come down with the recession and depression and a reaction to COVID and potential administrative changes? This is

historic so this is a pivotal time for advocacy and advocate for resources. And in terms of structures needed for kids, screening for ACE and supporting families and children and getting them resources they need, for schools, using trauma informed curriculum and permitting prosocial behavior, providing resources families need to effectively parent so this figure right here, the proposed model and looking at impacting poverty and adulthood, the ways we can intervene will be through evidence-based family and school intervention programs and getting mental health in the schools and having this relationships. So policies and changing and advocating for policies right now. This is the time to advocate for policies that help create and support family economic well-being can help support individual well-being so we can eliminate or reduce the impact of family poverty adverse experiences and behavioral emotional problems where we can support. It will be through intervention programs looking at family systems and individuals. Dr. Rivas, would you add anything else in conclusion?

>> No. Just understanding, affording her clients and population of resources access to care, coming from a place of nonjudgment, understanding our own biases and advocating for clients and the people we treat in order to have equity in access to care. I think it will be one of the big charges for our field and for students coming to this field to ensure we do have equity in access to care and that we are the most culturally competent practitioners out there when we are working with our clients. That is my big component is understanding that a lot of behaviors come from social class and there is an intersection -- a intersectionality with

marginal or generational poverty that come from that. Thank goodness we have moved on from making it illegal to be a person of color, but what we have done a switch that up and said over not racist anymore, we just treat you differently because you're poor. What neighborhoods have higher police interactions, what neighborhoods have higher or less access to banks. Those are marginalized communities, people of color and so we just switch one to the other and that is I think one thing I wanted to add.

>> Integrating care, affecting the system and changing a lot of pieces interacting and maintaining the status quo.

>> How many services for families. For children and individuals are placed in communities where the need is real. The site that just came up, we don't have time to do this but I like each one of you and it will be in the resources to take time to access this game. The point is to make it through three frames as far as you can and see where you are at. Play with your friends and family and you have to make difficult choices on this and it helps us understand if you didn't come from a low SES family or currently not in the position of worrying financially government what it looks like worrying financially and how you make decisions. Of those decisions based on planning for thought, are they based upon emotional, are they based upon survival at that time.
Dr. Rivas?

>> Next should be resources and then we will move to questions.

>> With this, here are some resources that encourage everybody to access. Poor kids, PBS frontline is a film and there is a follow-up as well and it examines poverty from the lens of children, from different parts of the United States and

it is a great film to watch. Obviously inform care through SAMHSA is another great one. We know if someone has PTSD how they are responding and we give them breaks because we know the diagnosis but there are similarities between living in poverty and having a trauma brain from poverty that we don't give grace to. And that is a great resource. Implicit association or implicit and bias test is another great example to access we can examine a multitude of implicit biases you may have and you may be surprised to do have a few take a look at the civilian mind and don't take a look at the clinical mine, take a look at your civilian mind and be honest with yourself. I need to find a better word for this. You know that yucky feeling in the pit of her stomach, allow that to sit there while you take this test. Allow it because then you can have a conversation about your implicit biases. Our wellness stress scale, look at the different levels and what they place on people. Your stress reaction inventory and I think most people are familiar with the stress reaction inventory in the ACE resiliency skills. We do know children at home with families. While there is environmental stressors and the last one looking at the Columbia suicide severity rating scale. It has some good questions. Dr. Rivas, anything to add?

>> No. I am right there with you and we are good on time. Any questions? Comments?

>> Thank you so much. Doctor Anthony Rivas and Doctor Bitá Rivas. Before going to the questions, we had one that can for multiple people and I don't know if you want to navigate your slides, but I was a good handful of people asked if you can repeat the cutoff levels in dollars for each of the classes. I feel like this was in the late 20s of the slides or

thirtyish but they were wondering if you could repeat the cutoff levels in dollars for each of the classes.

>> Dr. Rivas: Let me navigate back and that will be an earlier slide. One of the first lines versus going back about five. It is slide number three and I can read it out loud. Mind you, generally the cutoff levels in these shift. Sociologists and statisticians, there is little disagreement. Generally, sociologically, these are pretty decent standards. When we look at low SES it is generally 20,000 below per year and that is based on an individual or a couple, not a family. The federal poverty level starts to change his numbers. In the bay area of the poverty level is six figures if you live in the bay area for a family of four. Up at that caveat out there. Then working class is generally 30,000 to 40,000 a year roughly. Middle-class is the one that has the greatest range and that is \$40-\$150,000 per couple. When we are looking at that, low middle class, middle middle-class and upper-middle-class in an upper class is considered 150,000 and above for a couple. Based upon regional differences as I said I was brought up in the bay area. In the Bay Area, couple making \$110,000 selectively when I get to a whole lot in San Francisco. The regional differences occur but this is a pretty decent standard to get the area to hone in on the area of social class for that. Other qualifiers that tie into social class are educational attainment, whether you have white-collar, great color or blue-collar job. Blue-collar jobs are jobs that require the training whatsoever are minimal training and gray collar jobs are some that require some training but no licensors specific in the white-collar are obviously jobs that require higher education licensure's and some certifications. That ties into it with my anecdote. If

you're an adjunct faculty making \$3000 is six different institutions, he fit in the middle class but momentarily you're probably working class from one monetarily you're working class.

>> Your speaking to the contract employee versus an employee.

>> Thank you so much. Our next question for the first question comes from Cynthia. Cynthia asked, are there any reliable studies on the upper class to identify intergenerational trauma and brain development under stress? She also asked him how do we get accurate info was so many fears of disclosure to this group?

>> Could you repeat that? I apologize.

>> It is a loaded-- a lot of info. Are there any reliable studies of the upper-middle-class to identify intergenerational trauma and brain development under stress? She is also asking how are we getting accurate research info with fears of disclosure.

>> And Rivas, I can speak a tiny bit to intergenerational trauma. There is some research looking at intergenerational promise. If you look at the survivors of the Holocaust, that is one of the groups we have been able to track over time to trauma response and later generations based on the trauma their family members had experienced and how the systems of behaviors are passed down intergenerational. There is research there around intergenerational trauma. The second party here and the question is looking at, broken down by class system and Rivas, do you know information about the.

>> Dr. Anthony Rivas: I was going to address that. The studies I have and I have a couple in front of me, they look at

the intergenerational trauma and address cursorily the social class component of the individual usually for demographic data and they look more at the transmission of the trauma across generations and so it doesn't speak hi to it SES intergenerational trauma, it speaks to an overarching generational trauma with some allusion to the different classes through the different classes that were polled.

>> So this is an area we are interested because it is a new area of interest where there is not as much support in terms of the data collection. In terms of ACE and early childhood expenses, there is data to support the outcomes in higher ACE scores.

>> Definitely. One of the things we know is that the higher ACE score comes from having lower resources, but we don't want to bias against the wealthy because although they have more resources, there may be more hidden in her family violence, substance use that people are afraid to tell their clinicians were too exposed to the outside world from fear of losing their status.

>> You bring up a good point in that. The instances of ACE transcend class meaning anyone is susceptible to domestic violence and sexual abuse. What we are suggesting is that when you're in the lower class and you are involved in the criminal justice system, by looking at this year amount of people put in prison with drug charges, we are treating drug charges not as a mental health or physical health problem, but as a pattern of choice in putting people in jail. In that respect, when you have money to get out of some of these litigious areas and you have the resources to get out on bail and the resources to fight these charges, that is where we can see a difference anecdotally between the wealthy and

the poor when it comes to challenging the legitimacy of the charge against you. You want to add anything?

>> Yes, I do. And that is one of the things with the ACE score. When you have an opportunity to avoid being arrested or having his encounters, it generally reduces your stress response when you have the opportunity to get treatment versus incarceration looking it does take some of those stress results but you can't discount the negative consequences of substance use that are still existent in those higher SES areas.

>> And then there is little research on higher conflict lower SES households and so there is some research to support there's a little more conflict just as a pattern of behavior.

Thank you. Any other questions?

>> Hopefully we been able to fully answer all parts of the question.

>> The next question comes from Kimberly from Springfield. Kimberly asks how does the session change if the therapist has an awareness of the implicit bias?

>> That is a good question.

>> It is a great question and accustomed to much like any time you're aware of a bias we have in session, we constantly are taking her reaction to the client and we are checking our own buses called. You're checking your own temperature and so you're paying attention, you're constantly assessing where is my reaction coming from. Is it objective or is it subjective? And that is like any other bias. It is being aware of it and not ignoring it and I think that has been implicated in our society. We have a pull your bootstraps society and work hard if you want to succeed and that is not entirely the case. The people who would look at is

not succeeding, we view them negatively. Always check in your temperature and single cases coming from objective clinical place or is it subjective based on this person.

Sometimes it's changing the language in. We meet our clients where they're at. Are they \$10 clinical words or do we adjust our verbalization to adequately address where clients are at and make sure they understand it? Are we going to use assessment reasoning assessments been able to adequately explain our clients what is happening? That is how it will change. Bringing the initial awareness. It is our countertransference occurring because of this. As her transference. We set up our offices want to make sure. We'll want to pay attention to that as well. One of those things is, if you're working with the indigent population, the show up in \$2000 suits or do you dress appropriately and it's always paying attention to that. Rivas, did you have anything to add?

>> I apologize. I am muted at the same time you're finishing your thought. In supporting this idea of taking our stuff, it is in knowing and acknowledging our worldview and our status as a clinician. An understanding the worldview of our client in such a way that we don't make a heavier diagnosis or let someone off assuming. I don't want to say let someone off but assumed the conflict happening for the liver as he is client would not be happening with a higher SES client. A lot of it is being aware of where we are coming from so to speak and being aware of the systemic problems that may have changed the influence the worldview or experiences of our client.

>> Exactly. I will put a little anecdotes he can think about it in your head. A scenario. Driving down the street and

you're hit by a car and rear-ended. The car is about 35 resulting tape on the window. As a person have insurance. None scenario hit at the same stop sign, brand-new Mercedes 500 does a person have insurance. It is sheer fact Levi said most people in the rest Russ Beckett doesn't have insurance. That is bias. Don't assume the present with the Mercedes has everything figured out.

>> Tammy from Princeton asked, how can class bias awareness tactfully be presented in office settings and so I feel like this question is more about peer to peer or colleague to colleague we have a lot like this. How can class bias awareness tactfully be presented or addressed in office settings.

>> Is an excellent question. The one answer that while it mandates my head.

>> Dr. Anthony Rivas: One of the first things we can do with our peers and being clinicians, we have to be staffing tests conversations are no longer clients but our peers in one of the things. Had he take implicit bias. Call amount this is something. I'm sure people have heard this term hooped the ride. That is classist. If we notice her peers are saying things like this just like at these racist language in and have a conversation and say have you thought about how that impacts our clients and figure notice on a real thing will a second implicit bias test at Harvard and let's look at some journals and talk about how this could impact your clients how do you think your client fields when they committed so starting that tough conversation and I know I'm opening myself up to a world of email hurt but there's questions I'm a hoarder when it comes to this. If you want to point me in a direction should be an email and I'll send it out as quickly as

I can. Opening up the conversation with her coworkers and yes, we have talked about race and gender and sexism and ageism one want to keep those conversations going and what and the other piece is really starting that place in the workplace and maybe talk a clinical directors and talking to HR about adding that component into diversity training is a good way to start.

>> I think I would add on that. And what you're hoping is to create agents of change. These historic times. One thing I would want to communicate is not that we do more pro bono work, we have every right to be paid for expertise. I think systemically we need to advocate for the importance of mental health and substance use services and integration of the services into existing medical services and advocating for a discussion around that has been put in place their various legislation entered media and culture and family systems. We have all bought into the structures that you are rich because you deserve it and you work hard and you are poor because you made bad choices. I think for me it is becoming an advocate to challenge these ideas systemically. Is it really true and can we start to have these conversations these are historic times where we are at a precipice of challenging a lot of ideas so this is the time to begin these conversations and how to get about that? This is the challenge right now.

>> Thank you both. I want to screws and one more but only one minute for the answer. This last question, and everyone thank you for your questions. We will collect or questions and add them to a Q&A document and send them to Doctor Anthony and Doctor Bitá Rivas and try to get them on our website within a couple weeks he can document the

questions you ask in the answers that they have. The last one and just about one minute, Marianne from Arizona asked what signs are there for becoming aware of how culturally humble one is or is not?

>> Our association is with it. Just to a quick temperature gauge of the reactions to your client and how you were looking at them they committed and judgment made upon their dress, verbalization and being aware. Today I challenge everybody, go away from the call safely and social distance -- social distancing and pay attention to your newfound biases. Pay attention to what you just heard and pay attention to your reaction. That is the first step. Peeling it back and goat this is another layer. I was ignoring it and I didn't realize it had it. I think that is the first step. Watch a show and ask yourself is this trash T.V.. What makes it trash T.V. and what makes it good to be and pick up the magazine. Why is it. That is the first step. I hope answer the question quickly.

>> Thank you. Doctor Anthony and Bitá Rivas, thank you for this excellent presentation. Audience, your questions were incredible and it is hard to not get to the rest of them. We will send them to the prisoners and we will work with them to get some answers on the website at a later date. Speaking of the website. Every NAADAC webinar has its own webpage to house everything you need to know about that particular webinar so immediately following the live event you will find the online CE Chris link on the exact same website used to register. So everything you need to know will be permanently hosted right here www.naadac.org/cultural-humility-social-class-bias-webinar. Pay close attention to the side and we want to make sure

you know how to access the new online CE the quiz and certificates. When you get to the website you will see the instructions link and it is in the handouts tab of the go to webinar control panel and you will see the online CE quiz link active in just a moment. Here is a schedule of upcoming webinars. Please tune in if you can because there are some interesting topics with great presenters. As you can see, this Friday, July 17 our cultural humility series continues with Doctor Janice Stevenson who has consulted on Oprah and many different networks and she has been consulted in legal cases with substitute treatment providers and those were in foster care settings. A great presenter to cite today and she will be talking about awareness and some of the questions you all had. The new who you are and for whom you provide services. Lots of great other presentations coming up and you can bookmark this page

www.naadac.org/cultural-humility-webinars. He can visit us anytime on a website or email CE at NAADAC.org.

Tremendous benefits. 145+ free educational webinars for NAADAC members. Face-to-face webinars and seminars and workshops and once we have lifted social distancing, our virtual annual conference will be coming up soon and so many more. Please note that a short survey will pop up at the end. Please take time to share your feedback with us and in the notes for the presenter. Thank you again for participating in this webinar and thank you Doctor Anthony and Bitia Rivas for your valuable expertise and leadership in continued support in the field. I encourage you to take some time to browse our website and learn how NAADAC helps others. Stay connected on LinkedIn, Facebook and Twitter. Be well.

>> Thank you so much.

>> Thank you so much.