NAADAC
Cultural Humility Part V
August 14, 2020

>> SAMSON TEKLEMARIAM: Hello everyone and welcome to today's webinar on substance abuse disorders and Latinx communities presented by Dr. Pierluigi Mancini. My name is Samson Teklemariam and on the director of training and professional development for NAADAC the association for addiction professionals but I will be the organizer for this training experience. The permanent homepage for NAADAC webinars is www.naadac.org/webinars. Make sure to bookmark the webinars to stay up-to-date in the latest in addiction education. Closed captioning is provided by CaptionAccess please check your Q&A in the chat box or the email to use closed captioning. Every NAADAC webinar has its own webpage that has everything you need to know about the webinar. Immediately following the web event you will find the online CE quiz link on the same website you used to register for the webinar. You will see a yellow arrow, yellow and red arrow pointing at it here. Everything you need to know will be permanently hosted at www.naadac.org/cultural-humility-Latinx -- communities-webinar.

You can use the large arrow anytime to minimize or maximize the control panel. If you have any questions for the presenter, type them into the questions box. We will gather your questions and give them to our presenter during the live Q&A. Any questions we do not get to, we will collect directly from the presenter and post the questions and answers on our website. Lastly under the questions tab you will see another tab that says handouts. You can download the PowerPoint slides from that handout tab and the user-friendly instructional guide mentioned earlier on how to access your CE quiz and immediately earn your CE certificate. Please use those instructions if this is your first time taking our CE quiz.

Let me introduce you to our presenter. Dr. Pierluigi Mancini has over 30 years of experience in culturally and linguistically appropriate health treatment prevention bid and he's a sought out speaker and consultant in mental health and addiction. His expertise is immigrant mental health and health disparities and found the George's only Latino behavioral health program in 1999 to serve the immigrant population by giving appropriate legalistic services in English, Spanish and Portuguese. His book Mental in the Trump Area: 10 Inspirational Stories about Immigrants Overcoming Depression is available on Amazon.com. NAADAC is delighted to provide this webinar.

Dr. Mancini, if you are ready I will hand this over to you.

>> PIERLUIGI MANCINI: Thank you so much, Samson, and thank you everyone that has made this broadcast possible. My name is Pierluigi Mancini and I've been an administrator and clinician for over 30 years working in the behavioral health field. The last 20 years, I have a

specialized in working with ethnic minorities and immigrants and working towards health equity and eliminating health disparities.

I am an immigrant with Italian and Colombian heritage and am also personally and long-term recovery from addiction since 1985 but it is an honor to be hurt with you today and I thank you for being part of this webinar. I want to start with a short video about what is typical.

[Video]

[Upbeat music]

>> PIERLUIGI MANCINI: Thank you so much, Samson, for playing that for us, I want to start this workshop by beginning to shatter some preconceived notions that we may have. Beginning to break some stereotypes that maybe are associated with Latinx communities as we dive into the conversation.

My goal for today is to be able to help you understand the makeup of the Latin X community, for some of you this may be a new term so let's talk about that. But I want to talk about the social determinants of health, how this affects our communities and affects equity and creates health disparities but maybe some of the ethical issues that arise when serving this population and then exploring implicit bias and the effects of service delivery. At the end, want to be able to provide you with some strategies and interventions and maybe discuss some solutions of what we can provide this community. So let's define this community. We hear the words Latina, Latino and Latinx, reality is Hispanics are not a unitary homogeneous culture.

Spanish may be the unifier among the community, the largest country in Latin America is Brazil and they speak Portuguese. When we identify community as Latino or Latinx it typically includes anyone that comes from countries that began in Mexico all the way down to Argentina.

But it also includes people that identify themselves as being Hispanic or being Latino. Even if they weren't born there but by heritage. There are many of these terms, Latino Americano or Latin American South American or central American people define themselves by their country of origin often so you may be defining a group in general as the Hispanic community or Latinx community but when you speak to individuals, chances are they will identify by their national Argent.

Many of a lot of challenges. We do have challenges with members of our community that have educational barriers. We do have many young people, the average age in their community is 26 years old. By 2030 it is estimated that Hispanics will be the largest community among the elderly. There are some misconceptions we will talk about language proficiency and workforce.

There are challenges we have one a comes to the demographic of the community that falls under Hispanic Latinos. The largest group by far, 65-68%, identify as Mexican Americans or are from a Mexican-American heritage, and then you have Puerto Ricans and Cubans and those are the three largest groups. It presents a challenge sometimes, especially during research and during data gathering because those are the top three groups that we usually ask about. But as you saw from the previous graph, there are 22 countries that Hispanics can come from.

We only seem to be collecting information from three of them. That can be problematic because there are many different variables and factors that have to do with substance use disorder and the reason people use or not use substances from those other countries. Need to learn about those. We also have in our community all the regular racial groups. So we have afrolatinos, Indolatinos, euro Latinos and Asian Latinos but so what is a Latina looks like? When we talk about implicit bias later on I will challenge you on that.

Because the reality is that because we have members of the Latino community that can come from anywhere in the world, chances are there is someone in Latin America that looks like you. We have blonde, blue-eyed, we have very dark skin, we have Asian Latinos. So there's a combination that we cannot just typically stereotype. We have African Latinos that came from Haiti, the Dominican Republic, Puerto Rico, Cuba just like Africans into the United States, to the Americas.

The European Latinos, many went to South America when -- after the war and during the war, they escaped and there are many Europeans that stayed and married and married indigenous and married white, black and Asian-- Africans and Europeans are assimilated within the indigenous population. Many Asians were also brought to the Americas as slaves to build railroads in Peru and other countries.

So it can look like anyone in the world. And in the United States we have the US-born Latinos and foreign-born Latinos. In the United States, we have 282 million US-born individuals and almost 45,000,000 foreign-born individuals.

In the foreign-born population, half of it comes from Latin America. The second largest group comes from Asia and that is a very large number of countries. In the third group is from Europe. But the largest group has the foreign population coming from Latin America.

Of the foreign-born population, 33% are foreign-born of the Latino population in the US, 33% are foreign-born. 67% were born here so we have many assumptions about all Latinos being foreigners, they all came from somewhere else. And we have remember that Latinos have been in the United States for over 500 years. 67% of Latinos in the US were born here. The vast majority of Latinos do not have any immigration issues. They have never had to go

through an immigration process. They are US citizens born here. You can we have an issue of English proficiency and we will talk more about English proficiency but I want you to recall this when you get to that point.

Among those with limited English proficiency -- and to clarify what that means -- when someone is learning a foreign language, there are different stages of proficiency. If any of you listening have had this experience, there are different stages of learning in other languages. And you may be able to have a conversational stage and understand very simple instructions. You may be able to ask one or two very simple questions. And then all the way to proficiency and studies show it can take 3-7 years to get to that point. In the meantime, we have 46% of the foreign-born population of the US that speaks English less than very well. That means they have limited English proficiency. So this is significant for us because if you do not speaking this very well that it is difficult for you to receive information and receive substance use disorder treatment and services in English. And linguistic barriers are one of the biggest barriers for that sector of the Latin X population that has limited English proficiency.

We have not found a way to break that barrier. It leaves a lot of people suffering, dying, because there is no access to treatment for them because of language.

Even those that speak English well or very well may have some difficulty because to speak at a level for you to be able to share your emotions and share your troubles, you need a level of proficiency to be able to manage that second language while you are in an emotional state. Example to be used here is you have ever been to a foreign country where they speak a language other than English, and you get hurt or get lost or pick pocketed and you need help, most of us the first thing we do is ask for someone who speaks English I need help. We revert back to our main language. It is natural and normal when we are in crisis or emotionally in crisis.

It is the same thing. When we have a behavioral health issue it is very difficult to try and find the right words in a second language while you are emotionally in crisis so let's keep this in mind as we discussed these issues.

We have to understand that we affect many barriers that exist are because people say well, these folks, they just work or they are neighbors and do not contribute to the tax base or to society. We need to break the stereotypes as well. So by occupation, as you can see, we have people working in management, people working in sales, service occupations. There is construction and transportation.

There is and even pie chart, that includes many other professions that do contribute to the tax base and provide individuals with opportunities so then the barriers can be scheduling or insurance or it could be some other type of area. But we need to get out of this mindset that

well, no, we don't have those services because nobody is going to come because they are always working.

Well, that is not true, there's a segment of the population that could be accessing those services if they were made available.

Let's discuss equity disparities and health literacy. Quality does not mean equity. Culturally competent behavioral health systems, that invest in culturally and linguistically appropriate services they have the power to reduce racial and ethnic health disparities. Equality means sameness. Equality means that everyone, if everyone gets the same thing everyone should get the same result. But that only works if everyone is at the same playing level.

As you see in the picture, in equality, everyone has a box. But not everyone can reach the Apple. So the sameness, everyone gives the box but not everyone starts at the same playing level. Equity is about fairness and equity is about meeting the individual at their level of need and making sure people get access to the same opportunities. Sometimes in our history, our various circumstances, policies, they create barriers to participation. And we need to make sure that we have equity before we can enjoy equality.

The picture on the right takes into account the height difference between the individuals. And if you want everyone to be able to reach the Apple we need to distribute different resources to those individuals. So they can start at the same level. So equity does not mean equality. We want equity. We don't want to give everyone the same thing because unless the playing field is even for everyone, that does not work. We need to look at those individuals.

So when we define health equity as is defined by healthy people 2020 it is the attainment of the highest level of health for all people. It is making sure that people get a fair chance to lead a healthy life.

No one should be denied the ability to access. Substance abuse disorder or substance use disorder treatment, because they were born poor or they were born in the wrong part of town where they were born in the rural area or they are still learning a new language. We should have treatment available when someone is ready to get better. When someone recognizes there is a problem when they have an intervention or they have an opportunity. We should be ready for that. So if that is equity than what is in equity? And would we define equity we talk about the differences in health, but I want to focus on those that are avoidable. That are unfair and that are unjust. Those are the ones affected by social, economic and environmental conditions or social conditions, these are the things that programs can control. Social inequities they occur when a person or group is treated unfairly because of their race, gender, class, sexual orientation. In the topic we are talking about today some other issues may include immigration status or limited English proficiency.

The economic inequity is when you have institutions like governments, churches or schools that create an unfair advantage so they create a policy or a rule that prevents people from accessing the services and we have to remember some of these rules and policies in the books are very old and part of the problem is sometimes they have not been revisited. It is up to us to bring attention to the matter so once you start recognizing and identifying some of these problems, it is up to us to raise a hand and say we need to revisit this. This is an old rule or old policy. Because it affects us at every level as an organization, as a field it affects us.

And then health inequity dictates how healthy you are. In Georgia, one county just lost their only hospital and they lost their only pharmacy two years ago, and there's about 8000 people in this county. So where you live, what kind of help opportunities are you going to have. Now there's no hospital or pharmacy for a thousand people. We have counties here in Georgia that don't have a single licensed clinician or certified addiction counselor, in an entire county.

So we have to be able to address inequities, especially the ones within our purview, our scope. And then there's the word disparity. Disparities are the difference in health outcomes. Among groups of people.

They are affected by health inequities and health behaviors. Health behaviors are influenced by health inequities. Things like smoking, poor nutrition, lack of exercise. Those are all behaviors that can lead to poor health. For Hispanic and Latino adults they are less likely to receive advice from a health provider to quit smoking than nonwhite Hispanic adults. The concepts of health outcomes and health access are inequitable. We need to attain the goal of health equity. And ensure that they work towards eliminating health disparities and can provide a foundation for us to move towards that goal.

And then what causes these health disparities and you may have heard this word social determinants of health. It is one of the biggest causes of health disparities so what are social determinants of health. It's those things that are indirectly related to your ability to get help so could be your inability to get resources to get your daily needs like local food markets or housing. Or education or job opportunities in your area.

I mentioned the hospital and pharmacy, those are social determinants of health which you have no access or it makes it more difficult to access hospital or pharmacy services and maybe there is no transportation or public safety. Language access and literacy. There are many things that surround your ability to actually get the help that you need.

Environmental risk factors, institutional risk factors, Provider factors and consumer factors. All of those issues can cause health disparities.

We talk about some of these as we move on but provider factors can be attitudes. What is the attitude of the workforce in a certain program when working with people from other countries or towards having to hire interpreters? Maybe have a negative attitude is going to show and people are not going to be able to receive the best treatment they can. Then health literacy. So when we talk about health literacy we talk about the degree to which individuals have the capacity to obtain, process and understand. So I will say that again. Obtain, process, and understand basic health information.

So when you tell someone what the prescribed treatment program will be, they may hear you, they may nod their head that they heard you, does not mean they understood it in Latin X communities it is common to nod their head out of respect, it means they are hearing you but not necessarily understanding what you said.

When I started this agency in Georgia, a few months into it we began to see individuals with co-occurring disorders. So we had our psychiatrist on staff and bilingual psychiatrist, and a bilingual nurse. Pharmaceuticals back then would give samples and so the psychiatrist had access to some samples, to psychotropic medications and would give some of our clients some of the samples.

The first week the receptionist came and told us, Dr. Mancini the clients are throwing the samples in the trashcan in the lobby. So the receptionist would bring back the samples from the trashcan unopened and we would ask the client about this when they came back later. Their response was that they did not understand what that was.

That since what they were there for was not a physical problem they did not need to take a pill. So they had no knowledge, they nodded and accepted the sample from the doctor, and we assumed they were going to take the medication but they did not understand, they did not process what the doctor had told me. We had to add as part of the nursing assessment a medication part that is part of the nursing assessment we had a medication assessment and the nurse would have a consultation with them with a brochure explaining the medication and what the side effects were in their own language and the Dr. spoke to them in their own language as well -- but we needed to make sure we installed that step before we gave them the medication because they were not obtaining or processing or understanding the information being given to them.

So we need to make sure they understand that they have the capacity to obtain, process and understand the information we are trying to give them. It is the same thing with substance use disorder treatment. Whatever the treatment plan is, we need to ensure they can obtain, process and understand.

We also want to make sure you are clear about cultural literacy. Cultural literacy is the ability to converse fluently solutions and informal content and idioms that constitute the dominant culture. It could be when you first meet an individual from another country, being able to be familiar or be able to share some whether familiarity whether does their country or religion -- it could be some slang, because in Spanish there's many different ways of saying things depending on the country of origin bid

So being able to understand -- because part of the cultural explanation of the problem may include some language you are not familiar with. So both individual and provider need to be able to develop this cultural literacy. It stresses the knowledge of those pieces of information that the individuals will assume the provider already possesses.

There's an example I like to use about cultural literacy that a doctor enters the room with a smile on his face and congratulates a young, unmarried Ethiopian woman on her pregnancy. But he does not realize that he is placing her in danger because in Ethiopian culture, being pregnant while not married and bringing shame to the family so that sometimes the woman attempts suicide for

In this case, the woman may not have been clinically suicidal but there is a chance she can become suicidal because the news the Dr. gave her. And the Dr. thought he was giving her good news.

So in this example it would have been the doctor's knowledge and is literacy about her culture, knowing if she was Ethiopian but whether she was married or not before he came in with the news that what brought her there today was in fact that she was pregnant.

Without health and cultural literacy, we are not going to be able to serve those individuals that are most in need. As reality makes it almost impossible to get healthcare print so we have a chaotic situation that individuals cannot help that they need.

Now, I want to present an overview of culture. Our culture influences our health beliefs both directly and indirectly. Directly, each culture holds certain beliefs about how illnesses are defined, how they are caused and how substance use behaviors help or hurt problems. Whenever you get the cold or the flu you have your own family traditions.

In my family, it is chicken soup and Vic's Vapor Rub. So we have to be able to understand the individuals we are serving and culturally how they identify the issues. Culture also influences how we manage the symptoms, how we cope and our ability and willingness to even seek help. So not only don't even see us but how do they even know that we are there? Let's look at a video on cultural identity.

[Video]

>> Identity is fluent, depending on the situation we are in, the company we keep we can view ourselves differently from one year to the next part how we define ourselves is a complex process that functions on a subconscious level mostly but despite the fact that every person self-concept is unique we use similar processes to get there.

The idea of self as a psychological construct we create to help understand ourselves and our world better and one of the ways we make sense of the world and derive meaning from life is to the cultures we associate with and therefore a good portion of our sense of self comes from the culture we identify with the most.

Three aspects of culture in psychology I found to be critical Identify oneself at cultural identity, social identity, and the in and out groups generated identity refers to the way individuals understand themselves underrecognized by others. This personal identity, referring to the qualities and attributes distinguishing oneself from another. Collective identity referring to the recognition we belong to social categories such as your job, religion, culture etc. And relational identities which refers to the qualities of ourselves in relation to others.

Cultural identity is a sense of belonging to a group that shares a certain way of interpreting the world certain rules that help its members survive and thrive in life. Simply put it is that we refer to ourselves when we say I am a… Blank an individual can identify with numerous cultures at the same time and it is this mix of beliefs, views and personal views, prejudices and buys that help to form our cultural identity.

Social identity theory was developed to help understand aims to minimize differences. Social identity can develop in groups in situations such as taking a group of strangers and splitting them in heaven: one group A the other group B or as complex. Or as simple as wearing a T-shirt of your favorite band leading to in group versus out group, in group is has a history of shared experiences. Basically it is people of something in common and can relate to each other because of the commonality. Out groups are the individuals who lack these qualities but in groups have a tendency to discriminate in favor of their own groups. They sound like they're on the same lines but differences exist within the same levels of different peoples would take this for example.

The following clips contain scenes of gang violence.

Okay so topographic --but using film West side story of both gangs in the movie can fit into similar cultural groups. Part of New York culture and gang culture bad if all similar sets of rules for deriving meaning for life on the streets and for surviving in the big city. They can claim a similar cultural identity but the difference comes from what they named their social identities

to be, the characters form two rival groups competing for turf, the sharks and Jets, this comes from different ethnic back onto the movie but because they didn't buy separately they created two vastly different in groups discriminating against each other although a violent ends. Even within the social groups there are smaller in groups such as the women identifying separately from the man and down to are the two main characters of the rival gangs discriminate against own social groups in favor of each other ultimately establishing their individual identities separate from others. Identity is fluid composed of interconnected factors that change on a regular basis.

Despite the myriad components comprising the Gestalt cultural identities, social identity and established in groups will always play a major part of defining who you are.

>> PIERLUIGI MANCINI: Thank you again for helping us with the video. I want you to have an opportunity to see that as we move forward because we certain preconceived notions and I want to make sure throughout this workshop you start identifying how we sometimes come up with these preconceived notions.

So one of the challenges that culture is really not talked about, a lot of it is taken for granted. Just like the air we breathe grade it is not discussed but widely shared. People have little practice in discussing how culture affects our behavior and we are not well prepared to explain our culture to others. In this cartoon, there are assumptions about diversity and asking people where they are from because of how they look. In this case it's from Los Angeles and we need to make sure we understand that one of the things about culture that I like to challenge people is if we ask someone to tell me about the culture, about France for example, people will be quick to come up with a few things. They will say cheese or wine for the Louvre or art bad

But how many times are we prepared to answer the question if someone asks us to tell them about our own individual culture? Many of us have done that homework? So culture is the integrated pattern of human behavior, so our thoughts, communication, actions and typically defined as the quality of learned behaviors so everything we are exposed to from the time we were born and that will be significant when we talk about implicit bias. It provides us with our identity, beliefs, values and behavior as part of our natural process but it is also important to understand what it is not. It is not somebody's personality, so if we see someone from a certain culture acting a certain way, that does not define the culture that defines that person.

Culture is not static. It is not the language they speak. It is not an ethnic or racial group and it is not based on geography. It is deeply rooted in personal, we perceive things in different ways depending on who we are and how safe we feel, where we come from and past experiences.

Culture includes our environment, thoughts, values, beliefs, it is dynamic and always changing.

When I was young I took a girlfriend to meet my parents and my father was Italian and my mother is Colombian. And I have four brothers, five boys growing up. So after a few minutes the family together might meeting my girlfriend, she puts me aside and says, hey, why are you guys fighting? I have to explain to her and say we are not fighting. That is how we communicate. Our elevated voice, our extreme hand movements these are not signs of fighting, these are Italian, Colombian, our families way of communicating we wave our arms around and it is common in our family.

So how does culture affect an intervention? When we talk about substance use disorder treatment and behavioral health services, it affects how we communicate. It affects how clients manifest their symptoms. How they cope what is the range of family and community support when addiction strikes the family and what is the willingness to seek treatment over the past 20 years doing this work especially with Hispanic Latino communities, there are factors that have been shared and play a role in understanding the Haverhill health needs read and the decisions the Latinx committees make in wanting or being able to access services. They include things like racism, discrimination, economic impoverishment, mistrust, fear cultural and social influences. It affects, culture affects intervention by influencing what type of threat or event is perceived as traumatic. By influencing how an individual to interprets the meaning of the crisis and how those individuals and communities express the true Maddock reactions.

It also affects the individual and community interprets the service provider in their community. Do I trust provider and do they know who I am enough to be able to help me?

In 2 days' time, want to make sure we address a little bit how culture shapes how we live, especially when we are living through a pandemic. When the illness goes through a large population of the world, culturally and biologically -- so there are groups of people that culturally we are seeing they look at protecting themselves one way and then we see others that look at it is not necessary to protect themselves.

Some cultures and subcultures, there was picture of college students at large gatherings and beaches and pools. Then we see large groups of people with masks and then we see many people that do not go out. And then culturally people that believe in vaccines and people that do not.

We do know is COVID-19 is disproportionately affecting immigrant and minority communities. Many of the reasons for that safe communities that live in multigenerational households because also the work they do from front facing jobs, cloaks grocery store clerks only 17% of Hispanic workers have the kind of jobs where they can work from home.

The rest of them that were working at the kind of jobs they could not work from home so they have to go to work. There was limited testing for immigrant and Latino communities, there

were language barriers. Many immigrants and Latino communities never got information in a linguistically appropriate way for social distancing or washing your hands or any of that. So they were totally unprepared.

Have you heard of the iceberg model of culture? For those of you who have not, this model includes two parts. Smaller part above the water, which we place the culture that is explicitly learned, conscious, easily changed, easily recognizable, objective knowledge. Those are the aspects of culture that are visible.

At the bottom, which is 90% of the iceberg, are the areas that are not visible. So let's have our first poll question.

>> SAMSON TEKLEMARIAM: The first bull neck question, everyone will see it pop up on your screen in a moment to think about gender, race and age as aspects of culture. Where would you place them on the iceberg?

There are two options and about 10% of you have already voted, thank you so much. The polling question is now launched on your screen. You can send in questions by the way to our presenter anytime using the questions tab under GoTo Webinar control panel. We will gather your questions for the presenter and present those to him at the end of the presentation during a live Q and a and we will answer them in the order we received numbered 60% of you have answered the poll and I will give you five more seconds.

I'm going to close the poll now and I will turn it back over Dr. Pierluigi.

>> PIERLUIGI MANCINI: Thank you, Samson, so 73% answered that it was the top part of the iceberg and 27% said the bottom part of the iceberg.

The reason why you may not see additional visual aspects of culture like gender, race, even age at the top part of the iceberg anymore is because today we have to implement policies to address issues like transgender individuals. We have people with dark skin or other markers of race who are not African-American but identify themselves as Caribbean, Haitian or African. With many of them as Afro Latinos with many advantages, better nutrition, exercise -- it is not easy to tell how old we are.

With issues of gender and race, these are very interesting in today's times, we now have to separate them into subjective and objective areas. For example, gender identity, identifying as his/ is subjective him, but gender expression is objective but then skin color is objective but race identity of subjective bids everything underneath the water is invisible and our cultural programming and unconscious bias. It is how we relate to difference to other people. When

we first see each other and we encounter people from another culture, usually first interact only with the top 10%. The 10% is not as clear as it used to be.

We need to continue to understand that. You come the definition of cultural competence is the organization's ability to recognize, respect and address the unique needs, worth, thoughts, communications, actions, customs, beliefs and values that reflected individuals racial, ethnic, religious and/or social groups or sexual orientation.

How do we acquire this way every day we acquire knowledge, skills and competencies, even when we are unaware of it?

With workshops like this we are aware of things but everyday life we receive subliminal messaging we are not aware of. And we need to be careful because that also affects decisions we make when we make policy, rules, laws and other directions and instructions that affect individuals ability to access services.

And there is social difference between competence and awareness. Competence is the ability to effectively operate within different cultural contexts. Awareness is simply a sensitivity and understanding but which is important but not enough.

Cultural competency involves understanding and respecting their persons cultural values, beliefs and practices. This includes understanding that individuals beliefs about law enforcement and their views about law enforcement and health and healthcare. What is their connection with their family of origin or if they are foreign-born, what is their connection with their country of origin? So we need to go deeper.

And then language competency is important because it is the degree which the client or staff member is fluent in English. And fluency is the ability to speak, read, write and comprehend. It is a four tier definition for fluency. It is not just the ability for someone to speak a little bit of English and then go back to their native language, and for us to sit there and judge, oh, but I just heard them speak English. So I know they speak English so I don't know why they are speaking this other language. We need to be conscious about fluency which is to speak, read, write and comprehend.

You need fluency in order to receive services in that language.

We also have to be careful about attitudes. Because of prime factor affecting communication is the attitude of a provider towards people who speak other languages or who have limited English proficiency. And then also the attitudes or the ability of people to demonstrate how open they are to working with people who speak with an accent.

Let's talk about Latin X behavioral health issues and start with talk about the paradox. Latinos are healthier when they first arrived to the United States. But they become less healthy the longer they are here we did a study at my agency with adults and adolescents and with immigrant adults that came in for substance use disorder treatment. Primary drug of choice used to be alcohol. Within five years in the United States, they have become drug users usually living up to marijuana and cocaine within five years.

Then we did another study with adolescents. Some of them who moved to the United States and have never used a drug in their lives and within their first year in the United States they were drug users-- within the first year. So behavioral health is a quality-of-life issue, so without the coping mechanisms, individuals are forced to have a very difficult life.

The issues with the statistics and what I mentioned earlier is out we collect information and we only really measure the top three groups, Mexican, Cuban and Puerto Rican and then we have a broad category of "other". So we have information about the drug use of Hispanics and Latinos in general. 42% alcohol abusers, 17, current alcohol users. 20% binge alcohol users. Illicit drugs, 6% among Mexicans, 9% Puerto Ricans. 412 and over and age we have issues with opioids increasing more lately. But we have to remember that those media reports and the public health approaches have focused the opioid epidemic rescue issues on whites of the middle class and suburban communities. In the communities of colors have been dealing with opioid and other drug crisis that goes back decades.. For those of you familiar we had in opioid epidemic in the 70s with a lot of black and brown people dying from opioids.

And we did not have a miracle opioid antidote then. When demographics changed all of a sudden we had all of this available.

So there are problems and issues of how we address drug use and drug crises in the US.

Substandard living conditions, mass incarceration and institutionalized racism all contribute to the current state of affairs when it comes to Latin X communities and opioids.

The statistics that we have, you can see the community continues to be disproportionately impacted by opioid use disorder. The top three groups, Mexican, Porter can and Cubans and then 22% for "other" grid we need to do better and find a better way to measure how we do that. We do have a very large uninsured community among the Latinx community.

And then we continue to see an increase in black and brown faces in opioid overdose deaths. Latino tallies increased by 52% compared to 45% with whites. And Blacks increased by 83%.

We have social cultural factors. So discrimination is associated with increases with recreational substance use among Latino adults regardless of gender. Family conflicts from stress. An adult

Latino immigrants may be less willing to seek treatment for fear of deportation or discrimination. This one is very much real. Last year word came out of Washington and it never became policy but this is how serious any kind of news can affect someone that even if legal permanent residents were going to use benefits that it would affect their ability to become citizens.

That means that if you are a permanent resident and eligible for public substance use disorder treatment through your local Department of behavioral health or health department, if you were to access those, what the message said was then you could not apply to become citizens because they would deny you. Or that you may lose your permanent residence.

Is shocking. Many people did not ask for treatment. Many people said I am not going anywhere because I am not going to lose my chance-- become a permanent residence, I have worked too hard. I have a substance use disorder or mental illness, I will just stay here and not do anything about it because of those kinds of unfounded rumors. And it is real. Even when you have families where they are living in one household and a family is here with no immigration problems but some members of the family may be waiting for their paperwork. No one in the family decides to get help because they don't want to bring attention to that household while somebody is waiting for their paperwork. And understanding the whole immigration issue is important but that is another conversation be

Latinos experience this disparity in access to opioid medications for severe pain. So residents of low income neighborhoods are significantly slightly to receive an opioid prescription. Despite reporting the same levels of pain to the doctors than other peoples who reported and got medication.

The reason for this varies. Some of it is that the doctors believe Latinos can withhold pain better or more or they believe they are just going to sell the drug or they are going to abuse the drug.

Even when they do get a prescription, many of them live in neighborhoods where the pharmacies do not carry opioids because of break-ins or fears of break in spirit so even if they do have a prescription they do not have a way to get it filled area

Other factors in the criminal justice system, opioid use in Latinos are more likely to be criminalized, there's the true saying that in this country, when it comes to substance use disorder, if you are white you are a patient but if you are black or brown you are an inmate. That is very much true on a comes to Latin X communities, you are more likely to be criminalized resulting in higher rates of incarceration as compared to whites but Latinos are less likely to be offered substance use treatment or less likely to be enrolled in programs designed

to reduce the likelihood of overdose or infectious diseases better associated with opioid use while in jail or prison.

So in general some national survey suggest that opioid use disorders remain largely untreated and criminal justice settings and most people resume use after they are released.

And then I want to talk a little bit about the three stressors that Latinx community feels. Migration stress is stress related to displacement and disorientation that comes from moving and adjusting without resources. It is not only for the person that immigrated to the US, but also to the family member that is here so, as I mentioned earlier, there is stress in the household because, whether you are here with permission or without permission, there is stress in the household because all these fears that even if you have a permanent residency or a naturalized citizenship, there is this. That if you use public services or do something wrong that they will still take her citizenship or residency away, so there is a lot of stress in that.

Acculturated stress is stress that is related to adjusting to the circumstances or the new cultural context in your new country. So younger people adjust a lot faster, usually because I have to go to school and they spend all day in school as they make friends a lot faster than the parents do. They live at a quicker pace than older people.

But a stressor of that is that it then creates is generational conflict or younger people than become more acclimated to living here and have conflict with parents, grandparents or other generations in the household. Traumatic stress is the result of exposure to stress prior, during and after they migrate. Need to pay attention to that because a lot of time people just move here and they get one, two or three jobs and they do not pay attention to their emotional well-being because of that.

Let us not forget mental illness. One of every four Americans has eight mental health problem but Latinos have a higher risk for depression and anxiety were almost 18% of Latinos will face depression at one point in their life. What is interesting is second and third generations of Latinos have an increase in mental health issues because of dealing with that acculturation.

The second and third generation are children of immigrants and the children of those children. There is also lack of insurance, lack of information on mental health issues in many Latino communities. We do have many people avoiding going to a counselor because of stigma. Some members of the Latinx community view mental illness as a punishment from God so they have to overcome those issues.

So most minority groups and immigrants discussion of cultural dynamics behavioral health can take place without considering ways in which culture intersects with issues of poverty and equity including access to utilization of care. Individual racism and lack of cultural competence

on the part of providers and programs. So there are some systemwide barriers that need special consideration for most minority populations because the issues happen by cultural dynamics.

Systems of providers do not set out to be difficult in helping minorities access behavioral health services. Sometimes the best intentions do not yield the best results. Latinos are less likely to seek and complete substance abuse treatment, less likely to remain in treatment for shorter periods and generally receive fewer services and are less likely to report satisfactory treatment.

They have unemployment and housing instability. The decreased rates of treatment completion. Barriers are often exacerbated by a shortage of behavioral health petitioners that are culturally responsive to the cultural and linguistic needs of the population per the barriers and treatment may differ depending on the geographic area of residence, immigration status and the degree of acculturation.

They can have positive outcomes when they receive quality treatment services. The agency has started here in Georgia when I stepped down 3.5 years ago, we were seeing over 100 people a day, adult, children, adolescents, and providing services in English, Spanish and Portuguese. We had an unbelievable clinical team, over 40 licensed bilingual physicians, physician's assistant, clinicians, nurses, so people were treated at their level of need in the language they understood by people who were culturally proficient.

And there are successes so we can do this, this can be done.

Barriers can happen at three levels. The individual level, related to the individual's characteristics. So demographic variables, social structure, health beliefs and attitudes, enabling resources, perceived illness and personal health practices.

At the provider level is, what is the provider doing to prepare their staff. And by staff I mean everyone. Clinical and nonclinical. Administrative and nonadministrative. From the Board of Directors down to the volunteers. How are we helping them with their skills, attitudes towards individuals that are different than they are?

At the system level, related to the characteristics such as the health care system. Is there the will at the state level to address these issues to be able to speak up and implement the work that needs to be implemented to serve these communities?

For the past 20 years I've been working with immigrants and there are some specific barriers immigrants face regardless of their immigration status. There is lack of linguistic and cultural accessibility. There is reluctance to seeking services. Families are overwhelmed by their own migration experience are those that just arrive.

Many are unaware of the services that are provided or had experiences where services were not helpful. There are limited referral networks from schools, doctors' offices, lack of health insurance is a really big one. And there's different explanatory models that provide different solutions for how we need to do this. There are additional barriers, primarily for immigrant populations including refugees and those seeking asylum. Migration stress, displacement and disorientation that comes with moving bad acculturated stress, traumatic stress. But also a exacerbation of symptoms and disorders already present grade for example, somebody who comes in and already has a learning disability or primary care illness.

And they all contribute to destabilizing aspects of social adaptation. They see individuals becoming residentially separated affected by shortfalls in education and educational attainment.

Individuals that are still trying to learn the way the new country works and how they can fit in it.

And then the expressions of culture and healthcare. Health beliefs are those that people have as to whether or not they are sick and westernized medicine considers an illness uses something that applies to me. And what do they think will help them. As opposed to what I think should help them. Those factors contribute collectively to the decision of an individual and how they will choose healthcare and what it is they will choose to do to help themselves.

What are the advantages and disadvantages to me coming to see you for treatment? Traditional health beliefs for ethnic minorities and immigrants are things like health is viewed as the absence of pain, there is an external locus of control. Good health requires harmony with God. Evil thoughts or actions provoke illness. These may be caused by supernatural forces.

And then there are home remedies, and I will show you a slide in a minute about some of this in herbal teas and other healers that can come into play.

in our social sources of influence -- family, church, school, usually go to what we are familiar with so when we come to this we address that. Let us talk a little bit about inclusive bias and start with a brief video that will give us a quick version of that.

[Video]

>> That is something that happens deep down inside everyone's brain, let us say your brain is a house. There are rooms you know well and others who do not like maybe the attic, big dark room at the top of the house. You do not really know what is in there. Psychologists who are

experts in human behavior call that big attic in your brain your unconscious mind. A bunch of things happen in there but you do not know it. Things that happen in the attic, your unconscious mind, are called implicit. Implicit bias is one of the things that lives in your unconscious mind and you do not know they are there but they can be an idea or feeling you have toward a person or group of people you do not know review form implicit biases when you see certain things on TV, in a movie or when you see things around you or hear things on the radio or through other people. But these things are not always true.

Some implicit biases are a positive so if you really like Santa Claus you might get a happy feeling whenever you see a heavyset older man with white hair and a white beard and that is called positive implicit bias, when you have a good impression of someone you do not know but some are negative such as ones against other races. This is when one person expects other people to do bad things because they belong to a certain race but one example of a negative implicit bias is the feeling that all young black men carry guns, are involved in crimes and are dangerous. These negative implicit biases are dangerous because they are not based in truth. This type of implicit bias is a problem for everyone because it can lead to very bad situations for young black men like if a police officer has this type of implicit bias they will automatically think that young black men are all dangerous. This can lead to the officer shooting an innocent person.

Can you think of examples for other types of implicit bias, what are other situations where other types of implicit bias can lead to bad things for people?

>> PIERLUIGI MANCINI: Thank you again, Samson, for helping us with the videos. The human mind takes 11 million bits of information every second. Consciously we are only aware of 40 therefore we take mental shortcuts predinner went to introduce you to implicit bias so you have an idea of how sometimes unbeknownst to us we can be participates in the inflammation of policies that can affect other groups. The important thing is now that we know about it what do we do about it?

Let us launch the second poll.

>> SAMSON TEKLEMARIAM: This second polling question should pop up on your screen in just a moment. It should be coming up now, the question is: is being biased towards people who make me uncomfortable or people who are like me is:

Annual see four answer options there. Take a moment to answer this poll to connect with our presenter, another way to connect with the presenters you will see the questions box in the GoTo Webinar control panel, you can click on that questions to anytime and submit questions to our presenter. We already have some really good questions in. Please continue to send those in throughout the rest of the webinar and we will have time for a live Q&A at the end of

the webinar. Any questions we do not get to we will have on a Q&A document and the presenter in about two weeks or so will send out those answers in a document.

[Participant activity]

>> SAMSON TEKLEMARIAM: We will now close the poll and share the results and I will turn this over to your presenter.

>> PIERLUIGI MANCINI: So 53% if you answered affinity bias and that is the correct answer. Thank you so much. We evaluate all sorts of things every day from the minute we wake up to where we go to bed. Where we eat, how we are going to dress, how we get to work. Confirmation bias is also called confirmatory bias, when we search for, favor and recall information in a way that confirms pre-existing beliefs or hypotheses. So if I believe the sky is blue I will look for other sources of information that will tell me the sky is blue. Confirmation bias.

Affinity bias is being biased towards people who make me comfortable or people who are like me. And this has happened to all of us could you go to a large social gathering, we do not know many people but then I recognize someone either from subdivision, my apartment building or from my work or someone from my own racial group or someone I recognize and I go towards them because they are familiar to me. And they are someone I would immediately have some kind of recognition.

In group favoritism is when we have a group of people that we favor like the group of people that we want to hang out with that would confirm the way we think and feel. Those things are natural and happen to us naturally. When I introduced myself I told you Colombian, Italian, my father was Italian my mother was Italian was there anything that came that you noticed that came from your unconscious bias for those things? The associations we make, we have to pay attention from a certain group of people and how we feel about them or how we think about them, we have to pay attention. So let me show you a brief video about these associations about a nice group of people.

[Video]

>> PIERLUIGI MANCINI: Thank you again so much, Samson, for helping with the video. As you can see we have all these predetermined thoughts and beliefs without knowing the individuals. I want to move onto solution so we can have time for Q&A. After covering health disparities, cultural competence, barriers and all of this, I want to discuss some of the solutions.

First, how do we overcome the barriers? When I talk about cultural and linguistic competence and service delivery, it has to be comprehensive. It cannot just be the two hour training we

take every year. But middle management and Board of Directors might not be trained on this one the employees are. We need guidelines and we may need to hire someone to help implement the guidelines but there are guidelines both by CMHS and the national CLAS standard.

It is easy to see who lives in our communities. It is easy, you look at house of worship and grocery stores and you see those coming up in your communities, that means those immigrant communities are moving in. If you are not serving them and you are the provider in that area that means nobody is serving them. We need to be able to address issues like transportation, documentation, community education, workforce, encouraging individuals to enter the counseling profession. Teach the staff how to work with individuals who speak other languages and look at our policies and procedures internally

We need to recruit and retain staff members that can do that. For policy solutions, we need to look at the funding mechanisms. In my agency we had maybe 25% of adults that were not insured. They had no source of insurance whatsoever. So we had to have fundraisers and other ways to fund services because we knew they could not afford it otherwise.

We talk about funding at the state level it has to start the tops of policy solutions is to have the states implement the CLAS standard. There are very few states taking the action on the CLAS standard and then the enforcement of the CLAS standard and there's good news that there's discussion of making tele-counseling rule that was temporary, and making it permanent, so that is good news.

The facility level is the same thing. The facilities have to have an organizational assessment plan that addresses culture and language and has to be embedded in the life of the organization. It is not a onetime thing, it has to be a living, reading is determined work with primary care provider serving minorities. You see experts in speaking languages and partner with them to provide substance use disorder behavioral health services for them. Modifying reimbursement practices is another one.

And at the provider level, again, I cannot emphasize enough the organizational assessment plan which is not easy. It may take you six months or a year but it has to look at every aspect of the organization. The Board of Directors all the way to the volunteers in every policy has to be looked at to make sure it is something conclusive of culture and language. Training of staff and effective interventions for those individuals.

An understanding peers cultural and linguistic competence agencies can become proactive. The few minority groups as distinct and having numerous subgroups. They hire employees who are unbiased and help them stay that way. They have cultural competency training and

celebrate other cultures and they help each other grow and finally, they advocate for cultural competence throughout the entire system in order for us to be able to move forward.

Thank you also much. Samson, I will turn it now back to staff and hopefully we have time for questions.

>> SAMSON TEKLEMARIAM: Perfect, thank you Dr. Pierluigi Mancini. We do have a lot of questions so everyone, here's contact information Dr. Pierluigi is shared and also social media in case you'd like to stay in touch and we're going to turn on our cameras. The first question comes from Joanna from New Jersey. She asks, what best practices have worked for you in working with multigenerational Latinx communities?

>> PIERLUIGI MANCINI: Great question, thank you so much. Multigenerational families are not easy to work with. It depends who the primary recipients of services are and I will use an example of a family we work with where the primary recipient was an adolescent girl and she was a US-born adolescent girl was having substance use disorder issues. Both of the parents or immigrant parents and were clueless. They were not drug users they were growing up, they were hard workers and there is definitely generational conflict about understanding, what the daughter was going to come up what was it that was being reacted to and there was a strong family and therapy component but what worked for us with the adolescent girls is we had a program based on a clubhouse model that besides the counseling sessions, there is individual counseling and family counseling that was provided to the individual, there was a clubhouse model where the client can come after school as many times as she could and we would send the van to the schools to pick up the kids and bring them to the clubhouse and help them at first we would help all youth with their homework as soon as they got the clubhouse. Then they would prepare dinner cells and then they would have socialization time and through that model there were areas they were able to work on in the clubhouse that was outside of the individual and family sessions that really give the opportunity for the girl to be with other Latinx youth going through the same issues and then the parents had their own separate group were the parents would then start understanding some of the culture clash and what the other kids are going through. Thank you for the question.

>> SAMSON TEKLEMARIAM: Next question is for Meredith from Pennsylvania who asks, have you seen changes in service delivery in Latin X communities because of higher X of COVID-19 in some of these communities?

>> PIERLUIGI MANCINI: Yes and no. So, one of the challenges I'm seeing nationwide, I am working on another project where we are trying to get a feel for the infrastructure nationally for Latin X service providers I have seen the challenge in the payer source must a lot of the telo-counseling programs I'm running into our private pay and not so much covered some of the

payer sources or those that are underinsured maybe getting up a in person and not able to cover the expense of the counseling program.

>> SAMSON TEKLEMARIAM: Next question is from Steve who asks, what are CLAS Standards? But to the cultural and linguistic access services is from the office of minority health. It is a guideline, 15 steps on how to help your organization become culturally and linguistically appropriate for you to be able to provide services. It is a beautiful framework and you can go to the office of minority health website and they are there. They are enhanced because they did and hands them not too long ago, they enhanced naturally and culturally and linguistically appropriate service standards.

>> SAMSON TEKLEMARIAM: The next question is from Frankie who asks, which challenges to due 65+ pop persons are there for addiction issues.

>> PIERLUIGI MANCINI: They have an difficult time not to be able to hug their family members. Latinx communities are very close knit . And the amount of hugging and kissing is unbelievable rate we are seeing many older members of the Latinx community struggling with that. It is bringing in a higher levels of depression which causes some of them to abuse substances to deal with the depression, with alcohol or drugs. The con alcohol is a problem among some of those members but usually pills, Xanax and other drugs in that same family as bringing them the most problem right now.

>> SAMSON TEKLEMARIAM: This question comes from Leela who asks, what sort of programs and resources may be available in the control setting such as prisons and institutions for that population?

>> PIERLUIGI MANCINI: It depends where you are. Members in the Latinx community can participate with others in that program but if language is a barrier than they do not have the linguistic access. or in other parts of the country where there is higher discrimination than those programs are not offered to members of Latinx communities. It depends on where you are and you can have wonderful treatment while in prison or not. Can we have great questions we can add in the Q&A document we will send you shortly after the webinar.

>> PIERLUIGI MANCINI: How we broach these things properly and succinctly working with children that are dealing with translators?

>> PIERLUIGI MANCINI: I don't know that you will like my answer. We should never ever, ever use children as interpreters. Interpreting is a skill. Interpreting from one language to another, it is a very delicate process. And when we ask children to do this, two things happen: We increase the risk for mistakes because the children's vocabulary is not that extensive. As adults as well, when they find themselves unable to find the right word, they invent or come up

with a substitute. And then the clinician is not getting the right information. And then the clinician is making a decision based on the wrong information.

The other thing we are finding when we ask children especially if the client is the parent of the child, is having the child interpret in that situation angels the power dynamics in the family. All of a sudden the child is in charge. And the parent is no longer able to parent because the child then has control over interpreting for the parent and will threaten that they won't be able to interpret for them in other situations. Depending on what is being interpreted, it can cause secondary trauma for the child. So think about the topics we discussed in substance use disorder treatment, we abuse substances. We perform behaviors that we are then ashamed of.

Cheat, rob, steal, have affairs, all sorts of behaviors we are ashamed of bad and if we ask children to interpret for that individual we are causing some harm for that child. So please to all listening, never ever ask a child to interpret for anyone. There are interpreters and when you do work with an interpreter make sure it is a trained qualified -- very few states of certification but if your state has a certification make sure they are certified interpreters. And ask them if they have had behavioral health interpreting, to make sure they know our language because we do speak our own language in behavioral healthcare. Thank you and good question.

>> SAMSON TEKLEMARIAM: Excellent questions. And thank you so much, Dr. Pierluigi Mancini for this incredible presentation, for your Q&A and for your expertise on navigating this topic. Can everyone come as a reminder, every NAADAC webinar has its own webpage that houses everything you need to know about that particular webinar. You can, after this event, you can go to www.naadac.org/cultural-humility-latin ex-communities-webinar, when you click on the online CE quiz, you will first be prompted to register for the quiz by taking a brief survey and then you'll be prompted to provide a small processing fee. If you are a member of NAADAC this processing fee is free and you can complete that registration process for jewel then immediately receive a confirmation email with next steps on accessing the quiz and CE certificate.

Here's the upcoming webinar schedule. There are some interesting topics with really good presenters like today. If you have not already done so make sure you bookmark this webpage. www.naadac.org/cultural-humility-webinars to stay up to date, on our web series. We have added speakers and I will be honored to wrap up the spurs with a special presentation on September 9.

As an additional resource, NAADAC, the association of addiction professionals provided a COVID-19 resources page including six excellent free webinars top concerns presented by leading experts in the field NAADAC offers two specialty online training series and you will see

the first year on clinical supervision and the next one on addiction treatment in the military and veteran culture.

As a NAADAC member, a quick review here of the benefits of becoming a member with a speed you can go to NAADAC.org/join any time to join us bad note are short survey will pop up at the end take time to give us feedback and share your notes with us, and let us know how we can continue to improve your learning experience bad

Thank you again, everyone for participating in this webinar and thank you Dr. Mancini for your valuable expertise, leadership and support in the field. I encourage all to take some time and browse our website and learn how NAADAC helps others and you can stay connected with us on LinkedIn, Facebook and Twitter. Have a great day everyone.