CORE ELEMENT:
PRACTICING CULTURAL RELEVANCE

In the context of in-home therapy, **Practicing Cultural Relevance** is: 1) the ongoing process of acquiring an understanding of how the values, beliefs, attitudes, and traditions of racial, ethnic, religious, sexual orientation, gender identity, socio-economic, and other groups contribute to our own and other people's cultures; 2) learning about personal circumstances, conditions, nature, and experiences that influence our own and other people's thinking, behavior, and community roles; 3) acknowledging differences and similarities in power and privilege among groups of people; and 4) using this knowledge to work effectively with all people.

CONTRIBUTION TO THE OUTCOME: Actively working to understand the broadly defined, overall norms for each family's identified culture, the conditions of the family's local community, and the family's specific beliefs and traditions demonstrates that the IHT team values diversity and can adjust treatment to each family's situation. Discussing cultural considerations with each family highlights differences and similarities with the clinician's own culture that may either enhance or interfere with collaboration. Evidence of cultural considerations throughout the work — from first to last meeting with the family — underlines the strengths-based approach of IHT. Continuous learning about each family's culture shows commitment to reducing health disparities through ongoing learning and improvement.

REMINDER: Review all Elements. See especially: Engagement, Assessment and Clinical Understanding, Collaborative Intervention Planning, and Engaging Natural Supports and Community Resources. Each matrix describes the work of IHT as a practice shared between a clinician and a Therapeutic Training and Support (TT&S) staff member. Unless specifically noted as the province of the clinician only, the practices expect teamwork and refer to either or both staff members, as fits each family situation.

IDEAL PRACTICE	DEVELOPMENTAL PRACTICE	UNACCEPTABLE PRACTICE
Cultural self-assessment in context of IHT work		
• Routinely conducts a self-assessment of practitioner's own privilege status in multiple dimensions (gender, race, ethnicity, socio-economic status) in relation to IHT work. • Takes an inventory of practitioner's own values, beliefs, attitudes, knowledge and awareness prior to working with each family. • Takes responsibility for continued growth in comprehension of the racial, ethnic, religious, and other affiliate groups connected to the work. • Addresses cultural differences between clinician and TT&S partner.	• Engages in this step at start of services but not on an ongoing basis. • Adheres to a limited or simplistic definition of culture. • Touches on obvious differences and similarities but not all dimensions. • Inventories own culture but without growth; not sure what to do and doesn't seek help.	• No self-assessment or inventory. • No effort at growth. • Unaware of privilege status. • Ignores or denies differences/similarities between clinician and TT&S. • Assumes family is responsible for explaining cultural considerations. • Assumes that if family doesn't mention any issues related to culture, then there aren't any.
Resolving practical barriers		
• Invites each family member to share their preferred identities (race, ethnicity, religion, sexual orientation). • Amplifies understanding in subsequent discussions. • Asks about youth and family members' preferred language for signed, spoken and/or written communication at intake. • Assesses literacy status and cues to ensure effective communication. • Offers options for ensuring effective communication across language/ literacy differences. • Identifies and acts on any practical concerns about meeting times and locations that relate to culture (e.g. religious observances, family privacy boundaries, concern about stigma, inclusion of specific family members). • Regularly assesses quality of communication between family members and IHT.	• Engages in discussion at intake but limited or no follow up. • Discusses superficially or one-dimensionally. • Discusses with only a subset of family. • Tries to discuss but stops if topics are uncomfortable. • Does not consider possibility that family members may have limited understanding of communications and be covering up due to shame or embarrassment. • Explains available options for working in preferred language but does not follow through. • Uses vocabulary or jargon that family is unlikely to understand. • Adapts to family needs but communicates that the flexibility is a burden.	• Assumes race, ethnicity, religion, or other identity based on superficial data without discussing. • Assumes family has "no culture" and/or culture has no role in their work without explanation. • Assumes similarities without discussion. • Places burden on family to bring up and share cultural considerations. • Assumes language or literacy needs without discussion. • Uses child as interpreter. • Disregards needs and concerns that are based on culture. • Fails to offer options.

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Family culture discovery		
• Invites initial and ongoing discussion with family members about their unique values, beliefs, attitudes, assumptions, and life experiences within the larger racial, ethnic, religious, sexual orientation, gender identity, socio-economic, immigrant/refugee, or other groups with which they identify. • Explores the vulnerabilities and resilience that emerge from the family members' culture and experiences. • Engages in initial and ongoing discussion with individual family members to discover differences and similarities among family members and between generations. • Explores roles and privilege differentials within family. • Creates "safe space" in which to explore.	• Engages in discussion at intake but limited or no follow up. • Superficial or limited exploration of impact of culture. • "Asks" rather than "explores" or "invites." • Discusses only with the family as a whole without recognizing possible differences among individuals. • Discusses only with youth or caregiver without bringing views together with whole family. • Gathers general cultural information (race, language) without exploring what is unique to this family (values, attitudes). • Completes CANS items without narrative. • Engages in conversation but does not incorporate into treatment.	• Assumes without discussion. • Attempts to "homogenize" family culture without acknowledging individual differences. • Assumes family is "just like me" based on generic categories. • Assumes experiences of culture are the same for all family members. • "Takes sides" in treatment based on generational or other differences.
Community culture discovery		
• Acknowledges and explores, initially and on an ongoing basis, the neighborhood and community environment of the youth and family (available resources, community crime rates, socio-economic conditions, racial tensions at school) and the impact on behavior, symptoms, and diagnoses. • Explores the impact and specific needs of youth who have experienced immigration-related separations from community or family. • Explores other displacements (homeless shelter, foster home placement). • Uses awareness of community impact when assessing behavior.	• Engages in discussion at intake but limited or no follow-up. • Superficial or partial discussion of community factors or impact of immigration-related disruption in attachment. • Confuses practitioner's sense of discomfort in a neighborhood with being "unsafe." • Minimizes impact of community/ neighborhood.	• No consideration of community. • Pathologizes behavior ("oppositional" or "conduct disordered") without considering impact of community factors. • Talks about community with stereotypical or negative descriptions ("bad neighborhood," "ghetto," "soccer mom lifestyle").
Cultural differences among family members and clinical team members		
• Opens discussion of differences and similarities in culture and in power and privilege. • Reflects actively with family on how these affect dynamics of working with families.	• Engages in this step once without revisiting. • Minimizes power differential. • Discloses aspects of self without checking in with family on impact.	• No awareness or no effort to discuss or reflect. • Self-disclosure for own benefit. • Shares, but with a "hidden agenda."

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• Shares aspects of own values, beliefs, attitudes, and life experiences with purpose and intent to partner in shaping an effective treatment alliance with the child and family. • Always assesses whether disclosure meets youth/family or practicioner need. • Implements changes in practice to improve work with family members as a result of shared understanding of cultural identities.	• Makes a mistake with unintended impact, but does not address or resolve impact. • Does not explain the reason for sharing. • Fails to document purpose and intent of self-disclosure. • Attempts to improve practice but without full shared understanding or full collaboration with family members. • No ongoing check-in on whether changes are an improvement.	• Conveys self-disclosure in judgmental way ("You should have done what I did"). • Claims to "know exactly how you feel." • No shared understanding. • No effort to make changes, or makes wrong changes without learning from them.
Strengths in the context of culture		
• Engages in initial and ongoing discussion specifically about strengths — including individual, family, and community strengths — related to youth and family culture. • Helps family to recognize and "discover" strengths in cultural differences; shares potential strengths even if family members cannot.	• Engages in discussion at intake but limited or no follow-up. • Superficial discussion of strengths (listing activities, generalizations about strengths). • Bases ideas of strength on narrow definition of culture or what is acceptable as strength (mother "should" speak up, father "should" help with child care). • Documents only youth or only caregiver. • Over-identification by practitioner with certain roles that exaggerate strengths.	• Discusses problems only, with minimal or no discussion of strengths. • Assumes strengths based on stereotypes ("All black people go to church," so church community is a strength). • No conversation linking strengths to culture; interpreting strengths based on own culture. • Mistaking strengths (family roles, beliefs about mental health) for concerns. • Disrespects others' cultural practices.
Beliefs about treatment		
• Explores in initial and ongoing discussion family members' beliefs regarding physical health, mental health, behavioral and emotional responses, substance use, attitudes toward medication, and treatment. • Uses therapeutic alliance and other practice approaches to align culturally influenced perspectives (if different) of family and practitioner.	• Partial or superficial discussions. • Explores beliefs but only as "issues," not as strengths. • Discusses family beliefs without sharing practitioner's own beliefs (when appropriate) or finding common ground.	• Assumes without discussion. • Disregards beliefs, imposes own cultural values, or tries to convince family to comply with "shoulds" and "shouldn'ts" without regard to their culture.
Addressing cultural misunderstandings		
• Offers options for facilitating discussion between family members and other external team members about cultural considerations that may impact teamwork and decisions about culturally specific interventions.	• Engages in partial or superficial discussion with team. • Brings up discussion with team, but without preparing family. • Suggests that family "call out" concerning behaviors but without offering effective support	• Assumes without discussion. • Addresses "family culture" with team, but without including family. • Insists that family address issues even when family does not want to. • Sees problem, but says nothing.

IDEAL PRACTICE	DEVELOPMENTAL PRACTICE	UNACCEPTABLE PRACTICE
• Invites and supports family to address behaviors by team members that result from misunderstanding of culture. • Supports family in addressing teamwork concerns. • When observing actions that appear insensitive to family culture or experience, addresses this directly and respectfully with other team members and family. • Models effective advocacy around cultural differences. • Promptly acknowledges and corrects own actions that may indicate cultural bias or misunderstanding.	or coaching in how to do it. • Does not explore range of options for family communicating with team. • Addresses behaviors indirectly or in sugar-coated way, or addresses in hostile manner. • Addresses behaviors with some team members but avoids confronting others. • Acknowledges own mistakes belatedly. • Acknowledges, but doesn't know what to do next and fails to ask for family's input on how to avoid similar behavior in future.	• Sees no problem. • Creates conflict in team due to manner of addressing problem, or by ignoring problem. • Blames family for being "too sensitive." • Joins negativity of team members. • Blames someone else: - "I'm sorry but..." - "My supervisor made me do it." - "You're too sensitive." - Overly apologetic so family feels sorry for practitioner.
• Educates families to understand how cultural norms (for example, discipline of children, expectations of women) may be in conflict with U.S. laws and prevailing customs and how this could be problematic in some domains.	• Discusses only the most obvious safety concerns, or only in relation to Department of Children and Families. • Over- or under-emphasizes impact of different practices.	• Communicates that families "should" adapt to U.S. prevailing customs regardless of their own identities.