# Professional Readiness: Attitudes and Values

Essential Substance Abuse Skills

# Presentation Overview:

- Clarification of Values
- Cultural Considerations
- Building Trust
- Steps to Engaging American Indian/Alaska Native (Native) patients
- Supervision
- Stress/Stress Management and Self-care

# Clarification of Values

- What are the standards of care that guide your work?
- We may ask ourselves:
  - Where are my knowledge and skills best used?
  - Am I getting the support I need to help the people we serve?
  - Do my individual practice standards/values conflict the organization's  expectations?

# Clarification of Values

- Standards may be set by the organizations in which we work
- We may ask ourselves:
  - What is our overall agency mission and goals?
  - Who's needs are being met? Ours or the patient?
- How can we improve upon our services to meet the patients' needs?

# Clarification of Values

- Standards can be set forth by our profession:
  - Ex. Code of Ethics as per the National Association of Social Workers
    - The profession articulates its basic values, ethical principles, and ethical standards…to guide social workers' conduct.

# Clarification of Values

- Commitment to patients
  - Promote the well-being of patients. In general, patients' interests are primary.
- Self-Determination
  - Respect and promote the right of patients to make decisions for their own lives.
- Cultural Competence and Social Diversity
  - Seek to understand the nature of social diversity and oppression with respect to race, ethnicity, national origin, color, sex, sexual orientation, gender identity or expression, age, marital status, political belief, religion, immigration status, and mental or physical disability.

# Definition of “Culture:”

- The word ‘culture’ describes the integrated pattern of human behavior(s) that includes thoughts, communications, actions, customs, beliefs, values, and institutions of a racial, ethnic, religious, or social group.

- NASW (2011). Standards for cultural competence in social work practice: Washington D.C.

# Cultural Considerations:

- Native-Specific Cultural Risk Factors:
  - Lack of confidentiality (trust)
  - Lack of social services (rural/reservation)
  - Limited access to comprehensive health care
  - Circular migration
  - Unresolved trauma(s): historical or otherwise (ex. Urban relocation programs, boarding schools, history of abuse – sexual or otherwise)
  - Racism – Homophobia – Transphobia - Biphobia

# What comes to mind when you think of cultural competency?

# Cultural Humility:

- Another way to view this concept:

- “Cultural humility incorporates a lifelong commitment to self-evaluation and critique,
- to redressing the power imbalances in the physician patient dynamic,
- and to developing mutually beneficial and non-paternalistic partnerships with communities on behalf of individuals.”

- (Tervalon & Murray-Garcia, 1998)

# Some Key Distinctions from Cultural Competency:

- Acknowledges that we can never become truly competent in another's culture;
- Requires simultaneous process of ongoing self-reflection and commitment to lifelong learning;
- Works to redress power imbalances and develop mutually beneficial relationships with communities and individuals.

- *(AACN, 2011; Tervalon & Murray-Garcia, 1998)*

# Cultural Considerations:

- American Indian/Native American
  - 573 federally recognized tribes in the lower 48 states
- Alaskan Native
  - 231 tribal communities in Alaska

# Building Trust:

Cornerstone for all the communities we work with…

- Non-judgmental: No “right or wrong” – setting aside biases.
- Strengths-based: Identifying behaviors that support healthy lifestyle (ex. scheduling an appointment).
- Authenticity: Personal connection helps build the therapeutic relationship:
  - Important to take time to establish a connection before work can be done, specific with Native patients.
  - Introductions are important.
- Make no assumptions regarding sexual behavior (ageism).
- Make no assumptions regarding sexual orientation (straight vs. gay identified).

# Building Trust:

Engagement:

- Supply nutritious: apples, oranges, raisins, protein bars, sugar free juice;
  - May be the only nutritious snack of the day
  - Mindful of high rates of diabetes
- Can be as simple as offering a glass of water;
- Meeting at a place of their choice (creating ease for the patient)
  - Consider outdoors/park, another town if possible (transportation)
  - After-hours?
- If possible rearrange the furniture (remove any barriers to open communication).

# Building Trust:

- Affirming their Native cultural/heritage (ex. asking about their tribal nation/community).
- Utilizing supportive family/connections.
- Accessing cultural knowledge and spiritual practices.
- Providing incentives:
  - Literature speaks to the patient/provider relationship regarding incentives, is the patient seeking services only for incentives? Or is the patient personally motivated? As long as the patient is returning for services - you have a golden opportunity to engage and build TRUST!

# Building Trust:
continued

Service providers work from a positive-service delivery model:

- Strengths-based approach: collaborate, identify and exemplify strengths as a way to empower.
- Convey authentic interest (mindfulness);
- Acknowledge and provide support for positive steps already made!  Ex. returning for follow-up appt. (support), “people in care live longer and do better than those who are not in care”;
- Advocacy (front-line prospective).

# Building Trust:

Building trust may require of us to challenge systems:

- **“Whose needs are being met?”**

  - Ex. office located in area where community infrequently visits.
  - Complex organizational process, barriers, steps.
  - Intake forms reflect diverse patients (ex. transgendered patients).
  - Implementation of programs where providers do not reflect the community served.

# Building Trust:

- Other barriers to solutions:

- Service provider's personal bias
- Limited referral resources
- Lack of funding
- Unrealistic timeframes and others
- Others

# Building Trust:

Confidentiality:

- Issues of drug use, sex, sexual identities, gender identities and sexual behaviors may be highly stigmatized within Native communities.
- It is critical we maintain the highest level of confidentiality if we are serious about improving the quality of life for all people.
- Native people may have a personal (family) experience with breaches of confidentiality

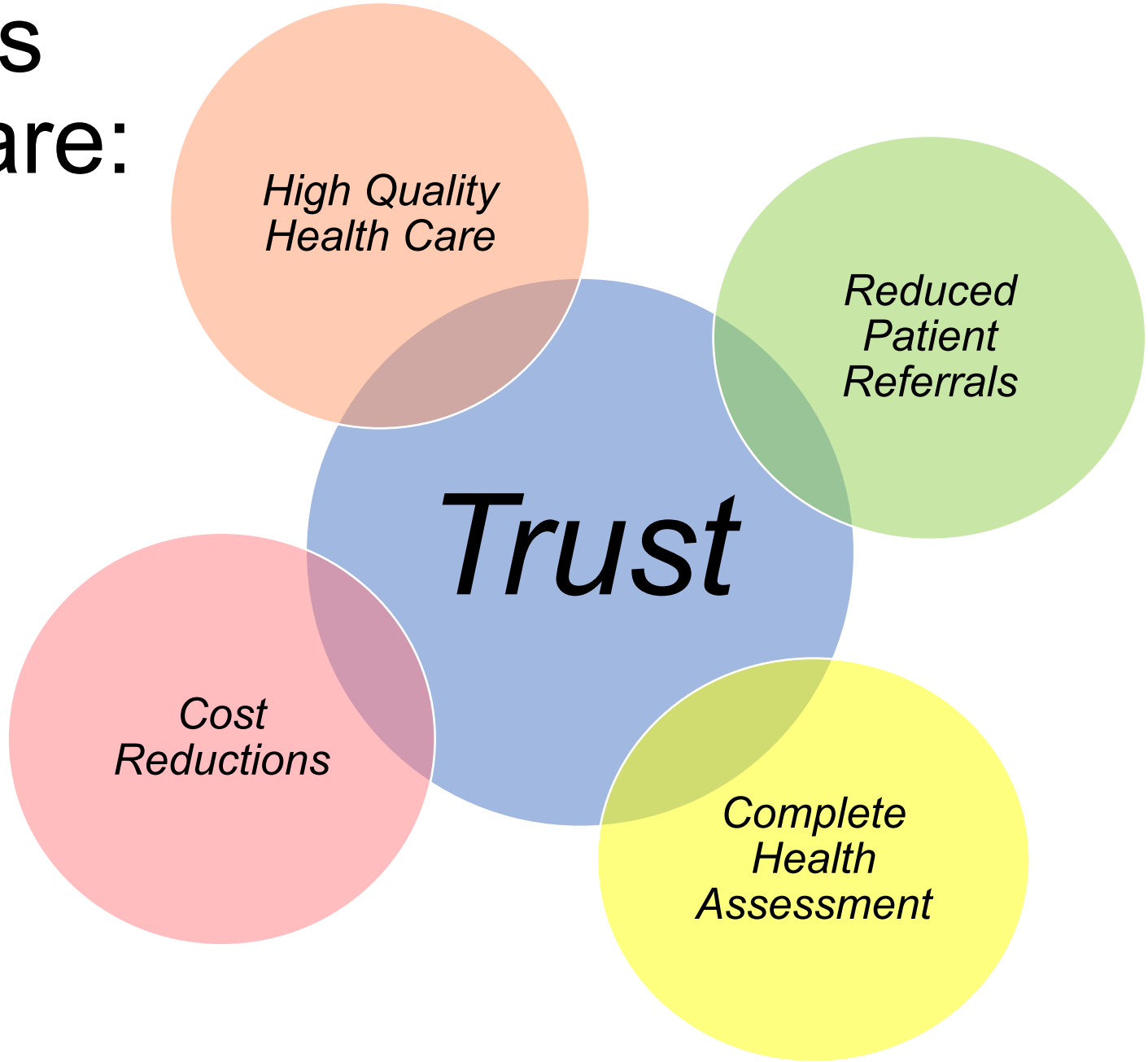
# Building Trust:

- Breach of Confidentiality:

- Breach: a disclosure to a third party without consent or court order, of private information that the physician has learned within the patient-physician relationship.

- Disclosure can be oral or written, by telephone or fax, or electronically, for example, via e-mail or health information networks.

# Trust Impacts Quality of Care:



# One of the biggest mistakes we make is assuming that other people think the way we think

# Steps to Engaging Native patients:

- Step 1: Knowledge of Native-centric world views
- Step 2: Understanding roles of western medicine
- Step 3: Providing Formal Introductions
- Step 4: Explaining Confidentiality
- Step 5: Understanding Circular Migration

# Steps to Engaging Native patients:

- Step 1: Knowledge of Native-centric worldviews

- Many Native people do not conceptualize themselves as most important:
  - Conceptualize the world based upon their membership to a community (ex. tribal identity).
  - Self may be secondary to family and community.

- “Family” can include others than just blood relatives:
  - In-laws, people of the same clan, distant relations, others in the community, adopted members.

# Steps to Engaging Native patients:

- Step 1: Knowledge of Native-centric worldviews (continued)

- In contrast, most medical models only focus on the individual – for appropriate reasons.

- Stigmatized health concerns can call attention to their families or community and create shame-based discrimination.

- The importance of modesty and non-verbal communication.

Steps to Engaging Native patients:

- Step 2: Understanding roles of western medicine

- For many Native people…
- Western medicine has ties to historic and traumatic experiences. Ex. sterilization practices;

- Medical models can also be tied to other non-Native experiences. Ex. Reservation acts, exploitation of natural resources and government re-location acts (1960s).

# Steps to Engaging Native patients:

- Step 3: Providing Formal Introductions

- As Native people are accustomed to explaining their membership within a given community to other Natives, explaining your role within the agency or within your community can be helpful, ex. Explain where you are from, if you have worked with other Native communities?
  - Important to take time to establish a connection before work can be done.

- Professionalism discourages personal interaction

Steps to Engaging Native patients:

- Step 3: Providing Formal Introductions (continued)

- Shaking hands is necessary.

- Small talk is a great way to gather information about the patient.

Steps to Engaging Native patients:

- Step 4: Explaining Confidentiality

- Native people can be highly distrustful of both Native and non-Native service providers:
  - As explained previously, weariness of western medical experiences and;
  - Personal connection to, or relationship with Native service providers.

# Steps to Engaging Native patients:

- Step 4: Explaining Confidentiality (continued)

- Might be helpful to explain the process step by step.  Ex. double-locked, limited access to charts and liabilities;
- Might be helpful to explain who and who does not have access to charts;
- Fully explain reasons why you would need to disclose/report: self harm, harm onto others, child abuse/abuse, others.

Steps to Engaging Native patients:

- Step 5: Understanding Circular Migration

- Many Native people travel daily, weekly, or monthly from reservation/rural communities to urban areas for work, education, medical care, romance, shopping and substance use.

- Urban dwelling Native people may live in urban areas and return home to reservation/rural areas for family/community events, ceremonies, etc…

# Steps to Engaging Native patients:

- Step 5: Understanding Circular Migration (continued)

- Circular Migration can be a challenge to treatment plan adherence.

- As a result, a Native person might be labeled as: ‘resistant’, ‘non-compliant’, ‘hard to reach’, ‘unmotivated.’

# Supervision: Administrative – Evaluative – Clinical

- Consultation with your supervisor can be a component of decision-making.
- May not always be available.
- Not always helpful
- It is your ethical obligation to seek clinical supervision and not work under case evaluation only.

# Supervision:

- Three goals of an effective supervisor…
  - Assure delivery of quality treatment and services
  - Creates a positive work environment
  - Develops staff skills

# Supervision:

- Effective  Supervisors:

- Set clear expectations that are understood
- Provide feedback with respect in a timely manner
- Teach or demonstrate needed skills
- Provide a supportive and respectful environment
- Often leads by example
- Facilitate meaning, purpose, and manageability in the workplace
- Promotes self-care and models said concept with supervisee.

# Stress:

- Stress begins with a life situation that knocks you out of balance

- When life situations are perceived and cognitively appraised as distressing, emotional reactions (fear, anger, insecurity) develop leading to physiological arousal (illness, disease).

# Bio-Psycho-Social Stress:

- Biological:
  - brain, muscles, skin, limbic—emotions, endocrine—glands/hormones, autonomic nervous—expending and conserving energy, cardiovascular, gastrointestinal
- Psychological:
  - thoughts and feelings
- Sociological
  - surrounding environment

# Stress Symptoms:

- Skipping rest and food breaks
- Binge eating
- Increased overtime and no vacation
- Increased physical complaints
- Changed job performance
- Self-medicating
- Sleep: too much or lack of
- Emotional Changes (low self-esteem, depression, anxiety, irritation, anger)
- Many others

# Burn-out:

- An emotional exhaustion in which the professional no longer has any positive feelings, sympathy, or respect for patients.
- Skorupa and Agresti, 1993

- An adverse work stress reaction with psychological, physiological, and behavioral components often associate with:
  - stress
  - fatigue
  - frustration
  - apathy (an absence of emotion or enthusiasm)

# Burn-out:

- Stages of Burnout Development:

| **Stage One:** | **the honeymoon – satisfied with the job** |
|---|---|
| Stage Two: | fuel shortage – fatigue sets in |
| Stage Three: | chronic symptoms – physical effects |
| Stage Four: | crisis – actual illness can develop |
| Stage Five: | hitting the wall – physical and psychological problems can become severe enough to cause illness that is life-threatening. |

# Burn-out: (continued)

Simply put: for sustained, unmanageable, painful stress:

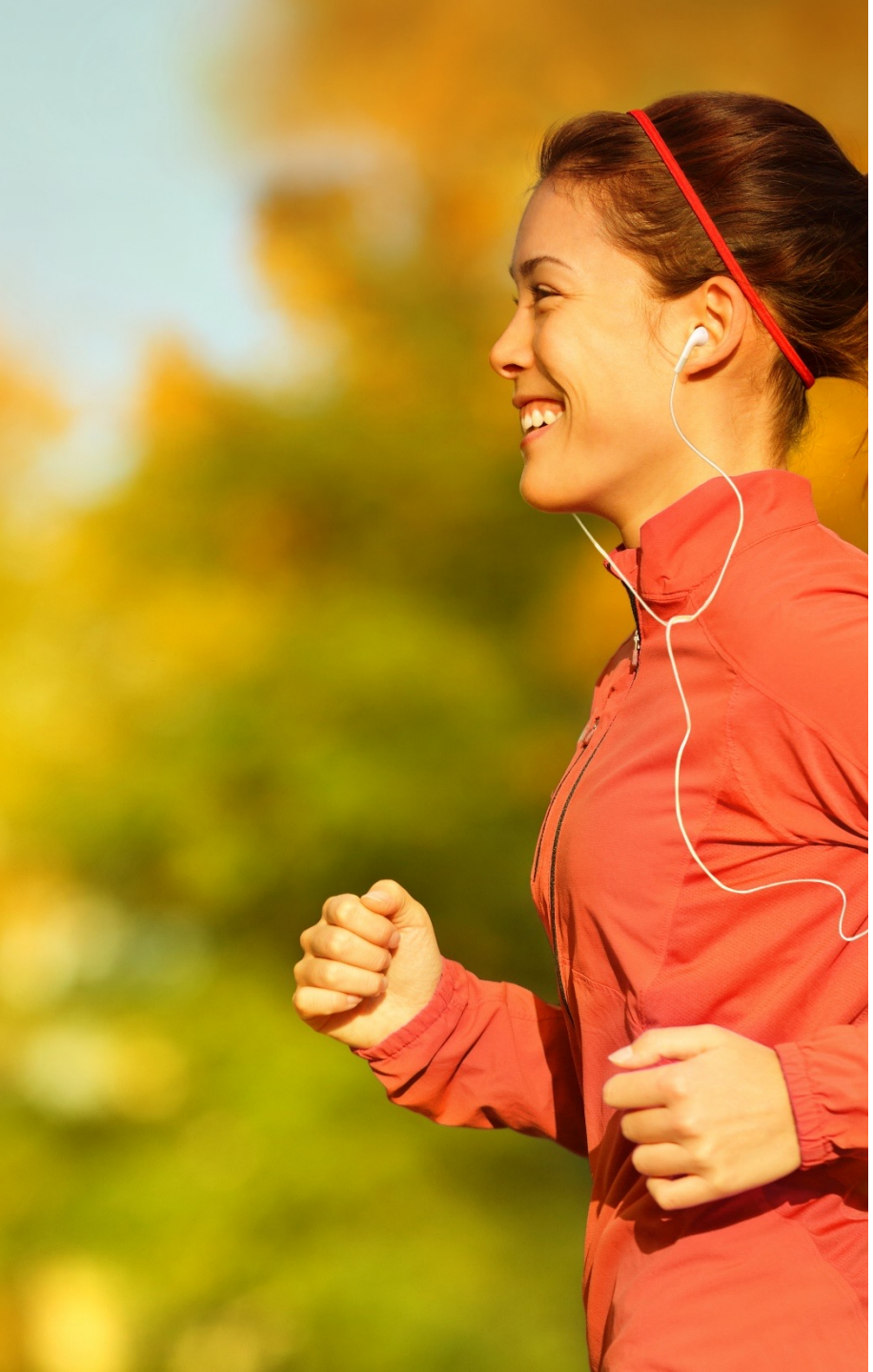
**Your response is your responsibility.**

- Seek help!
- Set limits
- Manage symptoms
- Explore new interests, new areas, new challenges

# Practicing Self-Care

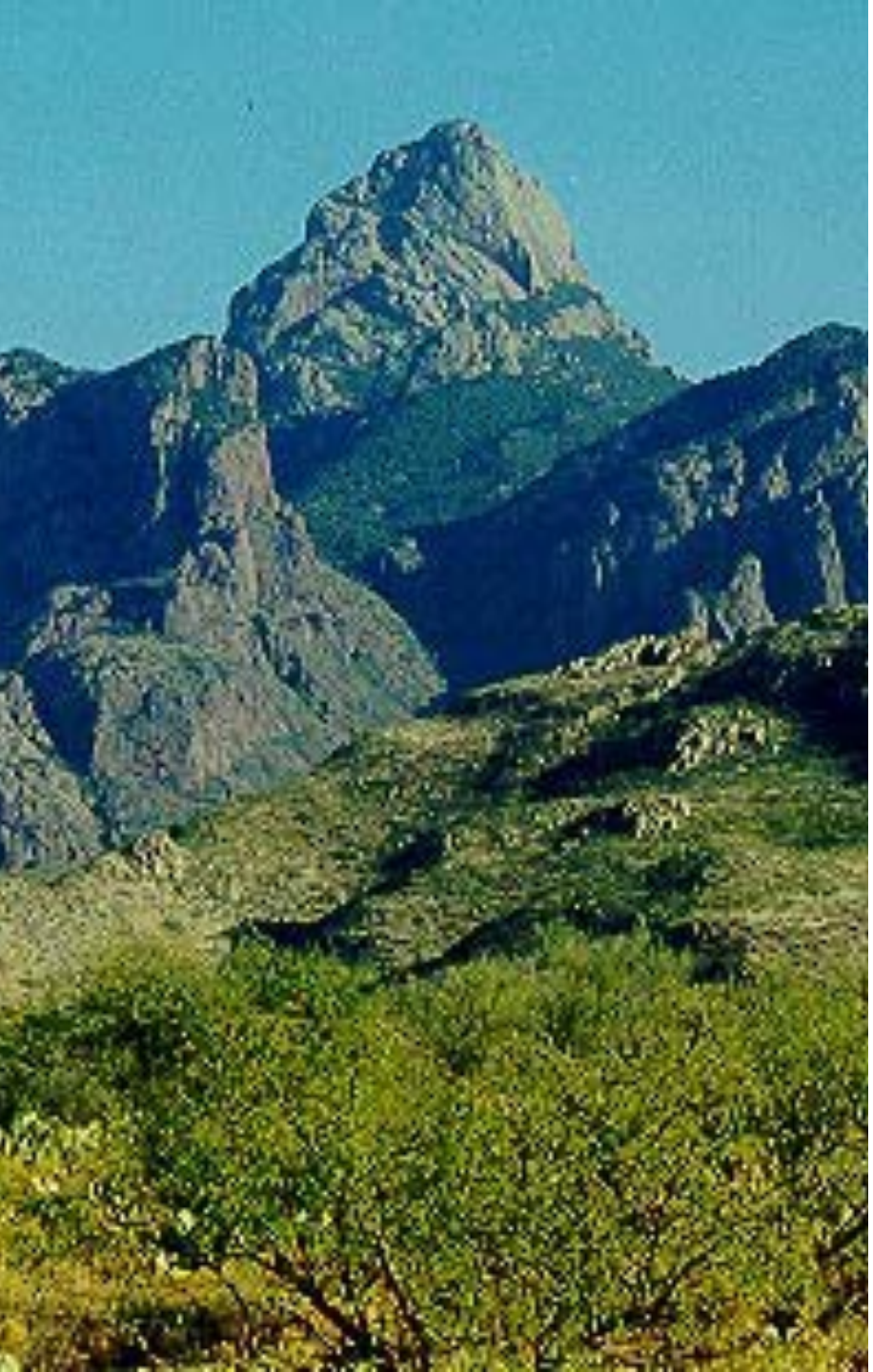
- Help for the Helpers!

- The greatest gift you can afford your patients, your colleagues, and your own family is the practice of self-care.
- We often work with our patients on taking care of themselves. Therefore, practicing what we promote takes on even more significance
- Work stays at work, leave it there
- Consider accessing EAP services, this can give you access to little to no cost, confidential therapy services



# Stress Management:

- Humor
- Meditation
- Ceremonies (Traditional, Baptism, Wedding …)
- Prayer/Spirituality
- Volunteer
- Relaxation Techniques – nerve/muscle
- Exercise – make it fun! Example: Fitbit goals



# Thank You!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