Using the Cultural Formulation Interview to Support Recovery (CFI)

Chacku Mathai, guest host:

Good afternoon everyone and welcome today's recovery to practice webinar entitled using the Cultural Formulation Interview to Support Recovery. My name is Chacku Mathai and I am your guest host today. After some housekeeping information and a short overview of recovery to practice we will begin today's presentation. On behalf of SAMHSA and the recovery to practice team, we are pleased to welcome you today and thank you for joining us on today's webinar. We have over 100 people attending so far. We expect that number to grow. Welcome. I would also like to thank our presenters, Roberto Luis Fernandez and Oscar Jiminez-Solomon for sharing their knowledge and experience with us today.

At the bottom of your screen, you will see a "download materials here" box where you can download our presenters' bios as well as a PDF of the presentation slides. At the end of the session you will be able to download a certificate of attendance you can use for applying your continuing education credits specifically for your professional association.

This webinar has been preapproved for continuing education hours from ADAC to qualify for these continuing education hours and you must attend the full webinar, complete a brief quiz and the webinar evaluation. More information on this at the end of today's webinar. At the completion of our webinar an opportunity to provide feedback will automatically open up on your browser and your screen. Please take a few minutes to provide us with your feedback. Finally, if you have registered for the webinar you will be e-mailed a link to view the archived recording. This link will be available on the recovery to practice website where you also find links to past recovery webinars.

This webinar has been hosted by the SAMHSA's recovery to practice initiative. The overarching goal of this initiative is to improve the knowledge and ability of the behavioral health workforce to use recovery oriented practices every day. What do we mean by recovery oriented practices? In 2011 SAMHSA released this working definition of recovery and a set of guiding principles that incorporate aspects of recovery from both substance abuse and mental health conditions. Some of you may recall many of us in mental health and addiction recovery were brought together to build this working definition of recovery. SAMHSA's working definition of recovery is a process of change in which individuals improve health and wellness, live the self-directed life, and strive to reach our full potential. The 10 principles of recovery shown on this slide along with the four major dimensions of recovery home, health, purpose and community form a solid foundation for developing recovery oriented lives and building recovery oriented systems and services necessary to support them. SAMHSA's recovery to practice initiatives helps turn these principles and the into workforce practices. The recovery to practice

curriculum was developed by disciplined -based curricula format by actual discipline associations. The goal was to promote understanding and uptake of the recover principles and practices. Developed by the six professional associations for educating their members set about recovery and behavioral health these materials are adaptable for use by other disciplines and other organizations seeking resources to build a recovery oriented workforce. Links to these curricula are available at SAMHSA's recovery to practice website.

Recovery to practice is expanding its discipline focus to embrace multidisciplinary services in integrated settings. For those of us that work in integrated healthcare organizations have opportunities every day to promote recovery and wellness. We can powerfully communicate hope for recovery in the value of self-care and wellness just in how we approach our work. Recovery to practice can help you strengthen your recovery oriented practice through the webinars, newsletters and conference based educational events.

This webinar is going to be focused on introducing participants to the Cultural Formulation Interview. An evidence-based tool will be used to guide practitioners and understanding the worldviews of people seeking services.

I'm excited now to introduce you to our speakers for today. Dr. Roberto Luis Fernandez is a professor of psychiatric and director for the New York State Center of excellence for cultural competence in Hispanic treatment program New York State psychic Institute. His research focuses on developing clinical interventions and novel service delivery approaches to help overcome disparities in the care of underserved cultural groups. His work centers on improving treatment engagement and retention in mental health and physical health care by persons with anxiety, depression, schizophrenia and other serious mental illnesses. He also studies the way culture affects individual experiences of metal disorder and help seeking expectations including how to explore this cultural variation during a psychiatric evaluation. He led the development of the DSM 5 Cultural Formulation Interview.

Oscar Jiménez-Solomon, is senior staff in Department of psychiatry at Columbia University Medical Center, the research coordinator of the New York State Center of excellence for cultural competence at the New York State psychiatric Institute. He was born and raised in Peru. His research focuses on consumer empowerment in areas of culture, language access and financial wellness. He is currently the principal investigator of a project funded by the National Alliance On Mental Illness (NAMI) STAR Center to develop tools for youth experiencing first episode psychosis and their families -- and a board member of the American Society for Hispanic psychiatry. It is my pleasure to introduce them both to you. Roberto, you may now begin.

Roberto Luis Fernandez

Good afternoon. It's great to be here. I'm excited to be talking about the Cultural Formulation Interview. This next slide will tell you about the overview of what we are going to discuss today. We are going to be focusing on the importance of paying attention to the culture of the

person and the family as well as the community of the person in the process of helping that person recover from a mental health condition. First we're going to talk about what we mean by culture. Then the importance of having a cultural assessment when the person comes in for care. We are going to spend a few minutes on the development of the CFI. This evidence-based interview for assessing the role culture plays in how the problem is interpreted of the person and how health is understood and sought and the CFI was included in the DSM 5 which is the latest revision of the American Psychiatric Association diagnostic manual of mental health conditions so it is being used across the U.S. and internationally. The next part is briefly on the content of the formulation interview and briefly we will review the results of an international field trial that examined the CFI as part of the development process of the DSM 5. We obtained feedback from hundreds of patients and dozens of clinicians and relatives to finalize the Cultural Formulation Interview.

At that point we will switch presenters and Oscar Jiminez-Solomon will review the way the CFI promotes the SAMHSA recovery principles and present stories of three young people living with mental health conditions and how the use of the CFI was helpful in their care and we will end with a question and answer period that Chacku will moderate.

Let's get on the same page about what culture is or least how it is assessed using the CFI. In the process of creating the CFI, we defined culture as the process of meaning making that the person and the person's social network, their nearest and dearest, family and friends and others in the community, people go through to make sense of what is going on in their life. It is an ongoing process of meaning making and what makes that process cultural as opposed to only individual is this meaning making is influenced by our participation in specific social groups because we belong to many social groups that affect how we think, and that collective influence is what we consider culture. These social groups that can influence how we think and feel can be varied. They can be due to age. It could be an age cohort, a gender identity, sexual orientation, language, national origin, even a profession. Firemen, the veterans a policeman think about mental health conditions partly by virtue of being firemen, veterans and policeman. Everybody has a cultural background that influences them and by that fact we don't just intend the CFI to be used by ethnic or racial or sexual minorities. Everybody has a cultural background that affects their views.

The DSM 5, we listed these three components or ways of defining culture that you have on the screen. First we describe the process of meaning making as affecting values, orientation, knowledge and practices individuals use to understand experiences. They would talk about the aspects of the person's background that affect their experience and social context that can affect how they feel and understand and experience mental health conditions. Specifically, we wanted to emphasize the role of the immediate social network of the person which often means friends and family because this is some of the groups of people that most influence how we think.

This slide is up because I wanted to explain that is not as easy as just asking the person, tell me how your culture influences you? We are often unaware of many of the influences that affect how we think and they are very unconscious, sometimes they are simply out of our awareness so it's important during a cultural assessment to talk with the person how they understand the situation, how they define what is going on. How do their community, friends, and family help them understand and what should be done about it? Because of these multiple questions, we try to get at the person's point of view. Another element of culture that is important to notice is it isn't monolithic or single. We had many influences that affect our we think and feel at any given time and they can vary in importance either over time or for a particular setting or situation. This is the way in which culture affects us continually in a changing way. It is dynamic and we are mixes of cultural backgrounds and what we call a hybrid. We have a cultural background and therefore it is important to ask the person about a particular situation they are in and a particular problem they are defining. We don't necessarily define what is going on with us and discuss it in the same way we talk to our priest or minister then when we talk with the primary care physician or employment counselor. It also changes over time. It is dynamic so it's important to keep that in mind as we see changes in the cultural understanding as the person goes through the situation. The fact much of culture is not immediately obvious, the fact that it changes and we have many influences, it means we can't just assume by looking at a person what they're going to say is the most important aspect of their background or identity that affects how they feel. We have to ask directly and this is what the CFI does.

This slide reminds us in which so many ways culture affects us especially looking through ways of living with a mental health condition and improving from a mental health condition. It affects everything in the way we react to mental health conditions, how we identify them, whether we see them as an illness or problem and the help we seek. What we expect about our level of participation and attendance and what recovery means to us. There are many ways in which cultural background and identity affects how we think about the situation when we are going through it. As provider's culture also affects how we think of a situation. Whether we define it as an illness or something else as providers and which illness we define it as. How we communicate with the person seeking help. How we support individuals, our communications and priorities. In many ways these are affected by culture including our moral stance toward care.

POLL: Now, we're going to take a few minutes and go to a poll to ask you a question and get your feedback on what in your opinion, which of the following is the best way to learn about the cultural context of a person seeking services? If you don't mind clicking on those bullets, I think we can see how people are answering. A fair number of people think it is good to talk with the person about the cultural understanding directly. That goes along with the idea of the CFI. A substantial minority feel is important to let it come up naturally in the discussion. That is also something that could happen that one possibility is that happens more naturally and another possibility though that it isn't covered in some settings. Many of you feel it's important to ask a person to discuss the

culture which is very much in keeping with how we think of the cultural formulation.

In terms what a cultural assessment should be, these were items we kept in mind in defining the Cultural Formulation Interview because a cultural assessment should be comprehensive in the sense that it accounts for all of the relevant cultural factors that are involved. It should be thorough in that it explores these factors in sufficient depth. It should be standardized in that it can be reproduced in different settings and populations. It should be skills based in that the competency in discussing the person's situation is not there based on a shared background but shared on a set of skills the interviewer has in discussing these issues. It should be person centered in that it starts with the individual, not the clinician's assumptions about the group he or she thinks the person belongs to. It should be educational in the sense that it identifies gaps and cultural competence going forward that can be filled with information you do as you do more and more of these.

In developing the Cultural Formulation Interview in DSM 5, I'm giving you the background of how we developed it. We started content-wise with this outline for cultural formulation that was in DSM 4, the preceding edition of the DSM in 1994 and included these topics in a narrative framework of what a cultural assessment should consist of. For example, these are the five: a cultural identity should come first, the person identifying what aspects of the cultural background are most salient. Second was cultural explanations of illness which essentially are the person's views of the mental health condition and care. The third section is cultural factors related to psychosocial environment and levels of functioning and then we want to understand the person's context and how that affects and creates sometimes the predicament the person is in. The fourth section, it is important to discuss how the person seeking help and the person attempting to provide help and how they are relating to each other in different styles of communication might be helping or not helping the encounter. Then there is a fifth section that puts it together and tries to make it relevant.

That is where we started from. We started from a narrative description. What we did to improve the CFI is to go through a series of developmental processes, which I will go through in a minute but first here is a slide that tells you where you can find the CFI. When you download the slides, you will get these web links. The American Psychiatric Association has made these interviews available. They're all components of the CFI and have a made it available to you free of charge on the APA website so that is great in terms of dissemination. This is the development process. We reviewed the outline for cultural formulation. The narrative framework I discussed and the research that has been done and all the ways in which people all around the world had tried to develop into be used, they were involved in the development.

We created a slightly different version and we tested that in an international field trial that included this training approach we used during the field trial but we did it in six countries and 11 sites with over 300 patients and 75 clinicians and a fair number of relatives. We analyze those results and we revised the final core version of the CFI

into a 16 question version. We are in the process of sharing the results of that field trial ever since.

This is the content of the Cultural Formulation Interview. It has three components. The two round components in the middle and the square component on the right. First is the core CFI which is what we call a basic assessment that can be used with any patient in any setting by any provider. Any person seeking help. It doesn’t have to be in a patient or identify as a patient. Anybody seeking help can be helped by these 16 questions we will go through in a minute. That is the basic assessment that gives a basic understanding of their cultural background. Sometimes we want collateral information and that is where the informant version comes in. It asks the same 16 questions about a person but from somebody else i.e., a family member.

Then there is the third component which are supplementary modules. If you want more information on any of the domains of the core CFI, this can be used as an adjunct in assessment. We usually recommended it at the beginning of the encounter. It is a way of getting the person's story and starting with the person's biggest interest and importance of their views right off the bat before going to what the clinician or provider thinks is important.

This is what the cultural interview looks like. You can see it has two columns. One for guiding the interviewer and the content of what the question is trying to get out and the questions on the right. You will see their introductions to a person seeking care to explain the purpose of the interview. There are probes in case we need to get more information. There are several ways in which we try to elicit the material and organize it into four domains.

The first domain is how does the person understand what is going on? We call it the problem. In most of the CFI, there is a bracket that says problem and these three questions which try to get at how the person and family and friends understand what is going on is what the provider uses going forward in terms of clarifying what the person sees as the problem. If a person defines the problem as feeling full, that is how they described being depressed or suicidal, we use the phrase of feeling full as we go forward so these questions asked about how the person defines the situation, how they describe it to their social network and what is it that troubles them the most about the situation.

The second domain has to do with the context and the understandings of cause the person has, and there's also a section on the role of cultural identity. We go through these three different types of items. Causes, both from the view of the person and the social network. What is it about the context that makes it better or worse and again the definition of background or identity, we describe it to the person similar to how I described it at the beginning of the presentation. We describe all of that to the person, then we ask the person what is the most important aspect of your background or identity? Then we ask how does that background or identity affect the current condition? It could be good or worse, and any other concerns the person has. For example, if they

haven't brought up yet or feel discriminated, this could be the place to bring in up.

The third domain, the cultural factors of how the person has coped in the past. The ways they have coped themselves on their own. The help they sought and what kind of help was most helpful and not helpful and we ask about all kinds of help. And some of the barriers to obtaining help.

POLL: Here is another poll. Have you ever experienced a misunderstanding between practitioners and persons using care, due to differences in cultural backgrounds, identities, experiences or expectations and you can see the options on your screen? We can see people “sometimes” is the biggest response or “often” is the second most common response.

This question I'm about to get to in a minute is about misunderstandings and current help seeking is an important aspect of the cultural formulation. The last aspect has to do with current help seeking. We asked the person what they need now and it has two parts. The preferences for care, what they think is most useful and the second one is what else does the social network think would be useful for you at this time? The last question relates to misunderstanding because sometimes doctors and patients misunderstand each other because they come from different backgrounds or have different expectations. We ask if they have ever been concerned about this and is there anything we can do to provide you with the care you need? The purpose of this question is we want to make sure to give an option to the conversation about acknowledging the provider is also present and there may be things going on in their relationship. A person may answer now or, in the future.

I'm going to skip the field trial in the interest of time, to tell you that we did it all over the world and it was found to be feasible, acceptable and useful especially by patients. As they provided it more than once they found it even more feasible.

At this point I'm going to turn over to Oscar to do the second part of the presentation.

Oscar Jiménez-Solomon:

Thank you, Roberto. Good afternoon everyone. I'd like to thank the recovery to practice team and SAMHSA for the pleasure to talk to you about this topic. My hope is to share my perspective on how the Cultural Formulation Interview can support the recovery process and outcomes of individuals in specific ways, and a concrete tool to help behavioral health services and professionals to develop recovery to practice in the areas of assessment, treatment planning and shared decision-making. When I first heard about the Cultural Formulation Interview I was excited and three years later I'm even more excited as I see and learn more about its potential and opportunities.

My research and work focuses on developing effective ways to empower individuals in recovery. I am particularly concerned about how recovery supports and peer services can help address the cultural and socioeconomic context in which people seeking services or people in recovery live and work because this context can create opportunities for

individuals but also limit their capability to recover. In my opinion behavioral health services in the United States and Western world have been historically unable to address cultural topics and other contextual factors in effective ways. Services have been a lot more comfortable working with individuals and at times with the implicit notion or assumption that individuals are necessarily or always capable of changing their conditions. It seems like a very core value in our Western culture. We know recovery does not occur in a vacuum and that its stigma, discrimination, racism, homophobia and economic injustices that many individuals experience affects their ability to recover.

Behavioral health services and professionals must find ways to support individuals. Lessen their impact and figure out ways organizations and communities can address these effectively. And address specifically the social and cultural forces that limit the opportunities of individuals and families. During the first part of the presentation Dr. Luis-Fernandez commented on how the CFI came into being and its main domains and questions on some of the research behind it. What I would like to do is to do a walk-through through some of SAMHSA's recovery principles and give you some examples on the way the CFI framework and questions can help providers and services of those principles and practice. We won't be able to go through all the principles but we have prepared a handout you can download.

As you know, SAMHSA has been working for many years on recovery to practice principles in regards of improving behavioral health services. My first example is on principle number two. One of the most important principles that is recovery-driven: empowerment, self-direction and determination to choose recovery services and support. You heard from Dr. Luis-Fernandez questions one, two, and three ask individuals to articulate in their own words what their main concerns are. Many of us deal with behavioral health challenge, it is the way our challenges affect the things we care about, for example, medication side effects might bother us. Not for the side effects themselves but also because of how they impact our relationships, our ability to work and our ability to go to school. Another example is staying out of the hospital or away from illegal substances otherwise we might lose the job we worked so hard to get or ruined our efforts to get our children back. These questions seem to ask, one, two and three talk about what matters most to them. This is important because we know without personal motivation, recovery seems unlikely.

Some examples of how the CFI supports the recovery principles: this recovery principle by making explicit the perspective of the individual about what is happening to them and why this is happening which is the focus of question number four of the CFI. Explain what someone is going through from a biomedical or psychological perspective. What people in recovery usually talk about are their concerns and what is causing their concerns from their personal experiences and context? Is it a medication compliance issue -- maybe not having enough money for a co-pay? The practitioner and individual may be failing at employment because of lack of coping skills or job readiness but for a person in recovery it maybe the fact he is working as a custodian when he was promised to be helped to get a job in his field.

Another example is having an open conversation about the potential different perspectives because this might help us understand the solutions we might have. A problem may also be understanding what an individual feels; it may not be possible for the individual to truly participate in the decision-making process.

Another example is around recovery principle four. Question number 11 is where we ask individuals about things they may have done. Usually this is important point to hear about the individuals' spirituality, self-help, peer support and many other personal strategies. Question number 13 we ask about barriers that may be hindering the opportunities of an individual to recovery. This can help assess important financial barriers and all barriers such as discrimination or racism and it will help contextualize what might simply look like individual beliefs or idiosyncrasies. I recognize a role that organizations have in the recovery process of individuals.

Moving onto the next example. Principle number six, the CFI offers our perspective, practitioners with concrete questions to explore the role the social network of an individual is playing and can play in his or her own recovery process. Maybe one of the most important innovations of the CFI, specifically question number five prompts conversation of how members of the social network see what is happening to the individual. An individual may feel their family, friends and others in the community see what is happening in ways that are helpful or not helpful and knowing this seems really important to develop strategies to manage those differences, build allies, and develop an advocate for their support.

Principle number seven, hopefully by now we have some good ideas on how the CFI can help practitioners and individuals on the road to recovery in the context of culture, social relationships and other social dynamics. Talking about cultural anomalies also about culture of views and expectations for some practitioners. This question, number 16 prompts individuals and practitioners to talk about how cultural differences or dynamics between individual and practitioner may shape their partnership and therapeutic alliance. It might be in the form of a question. It not only helps potentially improve communication between practitioners and people receiving services but may actually shift the dynamic between a provider and the person receiving services.

I'd like to comment briefly on principle number eight. We know orientation is important to our work in recovery. Question 13 asks to consider the role structural factors may be playing on barriers to recovery. This seems important and is important because it might help us understand there are external forces in the context in which the people make recovery efforts and recognizing this context helps us move from thinking of the onset of behavioral health challenges as sole individual, as the results of individual process to a more contextualized processes. In many cases might help us to respond to traumatic circumstances or experiences that may be the most productive responses. It might help us avoid blaming the victim or the characterization of poverty or that we simply don't understand.

In the last few minutes I would like to talk to you about stories of three individuals. Particularly one of them that I hope can help illustrate how this standardized tool can help practitioners and individuals have conversations about some of these issues and address barriers to recovery that can get in the way of individuals.

The first story is the story of Ronke. A 19 year-old African-American woman who in the process of the CFI, we discovered she considers herself an artist. She loves designing clothes the most importantly she considers herself a woman of faith.

What bothers her most is the way taking medications has been blocking her from finding her purpose it every time she has a difficult feelings or others around her think it is a sign of mental illness. In fact, she actually sees what she is experiencing as a spiritual experience and is now ready to tell her provider how she really sees things. She feels she is really happy and elated and connected to God and others interpret this as psychotic. Most important of all, the last time she told her clinician what she really thought and felt, she felt shamed and patronized and invalidated when she was told she was not having a spiritual experience but was in denial. We must recognize as to whatever is happening in the room, may not just be a result of what is in the room, but what is happening with the individual’s experiences. Was there some form or racism or prejudice or simply the perspective from the clinician a clinical judgment or observation. We don’t sure but we do know Ronke is experiencing is prompting her to feel distressed and that the clinician might have to work harder to gain her trust and insight into cultural formulation.

Moving to the last part of Ronke's story. What matters most to her is her faith. She loves clothes and designing close and one day she would like to become a naturalist and not have to depend on chemicals. When her clinician first tried to engage her, how she saw what was happening and how the clinician could help Ronke met her with distrust. In time, Ronke and her clinician developed trust. Probably the most pivotal moment was when her clinician did not try to convince her she was not having a spiritual experience but asked her if she thought about embracing her framework and cultural formulation. Have you thought about what your God-given purpose is? How can I help you fulfill her purpose?

The lesson from Ronke’s story is she did not need to be convinced she was mentally ill to remain engaged. Her provider and Ronke have still to this day, some different perspectives to what happened to her and in her case it was not a deal breaker the fact that they have different perspectives. Still Ronke knows this and still the relationship with her and does allow her to trust the clinician with feelings of loneliness, etc. and memories of painful experiences. Two years later, Ronke is pursuing her goal of going back to college and she is well. Hopefully this example has given an idea of the practical application of the CFI and you will two examples in the PowerPoint that will give you a better sense of how these can be applied and some of the lessons through the process of recovery and engagement that hopefully the CFI can offer to you. At this point I like to turn it back to Dr. Lewis-Fernandez.

Dr. Lewis-Fernandez:
Thank you, Oscar. We are going to spend a couple more minutes and discuss some training possibilities and a concluding slide.

The training possibilities is that we are excited about the fact there is a web-based one-hour training on the core CFI in particular that is going to be coming out next month. It is going to be initially available free of charge in your state and we are very excited about the possibility of obtaining permission to have it more accessible nationally and internationally. There will be CME and CEU credits for the New York State folks and again we are in the process of making this available more widely. It includes a discussion by five people about their own experiences. We are very proud to say these are people living with mental illness and have generously contributed their stories as a way of training other people and involved many of them in the recovery movement. In this example, peer specialist training, and they hope their experiences can guide other people through this difficult experience. Many of them are recalling in the videos how they felt and as if they were back in the past at a time earlier in their recovery process so hopefully that will come out soon.

This is the last slide that summarizes basically some of what we discussed. We feel the DSM 5 CFI interview promotes recovery principles and can be used with every person seeking help for mental illness or mental health condition. It was developed to be person centered to avoid stereotyping and eliciting a person's point of view and it is implementable and operationalized and can guide clinical assessment and treatment negotiation following the shared decision-making approach. Many of these things happen evidence-based in the sense we developed them in an evidence way but many of these outcomes and how the CFI can help people to show it does that, we are now in the process of conducting research. I'm going to stop there and we're going to turn it over to Chacku.

Chacku Mathai:
Thank you, Roberto and Oscar. There are a couple of questions we want to present from the audience and continue the conversation. The first question that came in is has the CFI been validated with refugee populations in the United States?

Roberto:
The answer is not exactly. Most of the data we have on the Cultural Formulation Interview comes from the field trial and the field trial has certain settings in the U.S. where they did work with clients and patient populations across the country. There are people in New York to California some of those sites could have refugees among their patients but there wasn't a single site where they were all refugees. On the other hand, in the Netherlands, at least one of the sites had a refugee base so it was used by people who specialize in the care of refugees but more research could be done in this area.

Chacku:
Another question - what successes have you seen utilizing the tool with interpretation services?

Roberto: An excellent question. This is like we are hoping a whole career research for some of my junior colleagues in there is much work left to be done. I know in the field trial we excluded people who needed interpreters because in order to test the CFI originally, we wanted people with the patient, clinician could communicate in the same language. Everybody spoke the same language when they came to the room. However, there were many languages. There were 12 or 15 languages around the world. In California there was not only Mandarin or Cantonese, there are many languages involved but they weren't through the interpreter. It is something we are interested in. How could you use the CFI with that interpreter and again something that requires more research.

Chacku: Thank you. Another question that came in earlier is the conversation about how the culture interview is introduced. What if we learned about the best ways for this cultural assessment or Cultural Formulation Interview to be introduced? Is it, “Now were going to talk about your culture”? What is your take on how that is done?

Roberto: That's a great question. The way we conceived the CFI, and it is a bit of an error against is we are hoping people will start their usual interview using the CFI so in fact it's not like we have done this and I were going to do this politically correct thing. The way we thought of it is that people would start with the introduction we have at the beginning of the CFI which is a very standard introduction but it adds the issue of culture and says something like this is our suggested language. I would like to understand the problems they bring you here so I can help you more effectively. I want to know about your experience and ideas. It is very person centered and that is how you would start from the beginning and then you keep going with what brings you to the clinic? How do you understand it, how do you explain it to your social network? Basically it substitutes for the usual way of starting and we feel a lot of information you would get in a regular evaluation you would get through this.

In the field trial, it took 22 minutes so it is a big chunk of the first interview. We hope and we try to show in research that you spend that time getting the person's story first. Of course, you can spend more time, but if you at least spend 20 minutes doing that, you're more likely to get a rapport and understanding and participation and commitment from everyone. That is our hope.

Chacku: Oscar, did you have anything to add?

Oscar: No, I was just looking at some of the other questions coming up. I was curious about the question on the use of the CFI in a peer context.

Chacku: That is certainly one of the questions we had and being raised by the audience as well. Had this been used or can it be used I peer-run or family-run organizations?

Oscar: That's a great question. We didn’t have time to go over this particular story but I will mention this briefly. This is a particular

instance I can actually comment on where the cultural formation interview was used with Mike in the context of peer support. The practitioner was the peer support provider and this is a peer support provider online. The focus of the work was to help Mike be able to have a conversation with his father about what he really wants to pursue which to go back to school although that is a worry for him and may be being a little overprotective and gender role expectations are coming up about a good job. Ultimately through the relationship with the peer support provider, it has become clear to Mike is he doesn't have to choose between him and his career or his recovery goal and his father but he can with support have this conversation with his father and bring him aboard. I'm not aware this is actually being tested in terms of research and peer context. We are very happy to work towards that.

The online module Roberto was referring to earlier, one of the scenarios was actually happening in the context of a peer supported employment setting. A young man, Nicholas, his main concern, is that he doesn't have a job and he wants to work. The interaction with the peer provider or peer support person is to help them understand what is happening and what he can do and how work is important in the context of his identity as a young man.

Chacku: Thank you. There is a number of questions moving towards implementation in various settings, whether it is addiction recovery coaching or peer run services. Reentry support programs for those of us that might've been in criminal justice systems and settings. One of the bottom line questions that asked, is that you are feeling that all presenting problems have an underlying cultural involvement and thus require culturally based intervention? You mentioned defining culture is meaning making and there is a meaning making process you are either both understanding or engaging about how a person perceives what they're going through so I would love to hear you respond, either one or both, to that and how that leads to work in future settings?

Roberto: I would take a quick stab, Oscar and then I will shut up. My position is every experience is culturally based, of any kind. Not just an illness, problem or concern. We make meaning in the context of culture. There is no such thing as life outside of it so we are always in some social group or many social groups. We inherit culture and re-create culture. We pass it on to our children. It is a process of making sense. Everything in my opinion not require is asking the person. What sense do they make of what is going on? We call that cultural because we don't just stop at the idiosyncratic idea a person may have but we connect that idea with whatever background or identity they have. That is, I guess my short answer.

Oscar: Definitely yes. The perspective I might add to what Roberto was sharing was something that maybe reiterates something that I said during my piece, that the part of what the CFI captures that is contextual. That is what is happening in the room that is not happening in the room necessarily or what we bring from the outside. Really what's happening in interaction is a little bit of a microcosm of the society at large and we bring our expectations about each other and the way we express it in the

way we seek help, there is no way you can escape that. From that perspective, the notion of culture and the things that are harder for us to talk about like racism and stigma and discrimination and things that are big forces we can't avoid when we are sitting in the room and shape expectations we have of each other. Also our ability to recover.

Not only that but everything structural is also related to cultural values and ideas. The fact we have a certain number of minutes to talk to people in certain settings. It comes from a sense of what is important.

Chacku: This is certainly a great start to this conversation which as you said is not over. There are lots to learn. I certainly feel this is not only a transforming tool and a variable to be entering into the work but it is revolutionary and something all of you have been working towards for some time. There are number of questions continuing but we are out of time. If you're in the audience and have additional questions reach out to the recovery to practice initiative. Reach out to Dr. Fernandez and Dr. Solomon. You can see their information below. Also you can e-mail directly to RTP.

As we move forward in this process, I went to give you a reminder if you're interested in continuing education hours click on the NAADAC link where you will be directed. I think you will see some additional e-mails here. You would be directed to a page and an evaluation and a quiz to complete to receive your certificate.

If you are not interested in receiving continuing education hours, you may download a certificate of participation as well as the participation slide in the download box.

Please also complete the feedback survey that will automatically load directly following this webinar. I'm going to go back one slide in encourage you to check out the webinars and development.

There is a 3 webinar series coming to him shared decision-making. This is an important part of the process and incorporating -- and the learn more webinar on psychiatric advanced directives. Please join us for as many as you can and if you can't join us, all of these webinars are recorded and made available online on the recovery practice website.

On behalf of SAMHSA I'd like to thank you for joining us and taking the time out of your day to attend today's webinar. We appreciate your interest. We also think Roberto an Oscar for all the time you have taken in presenting. Thank you and good afternoon.