Culturally Relevant Leadership

Assessing CRL at the Morehouse School of Medicine African American Behavioral Health Center of Excellence

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Part I: Organizational Context

The African American Behavioral Health Center of Excellence (AABH CoE), a project of the Center for Primary Care at Morehouse School of Medicine in October, 2020, is an innovative national behavioral health (BH) training and technical assistance (TA) center dedicated to fostering safe, effective, equitable, and culturally appropriate solutions to the behavioral health challenges of African Americans (with the term "behavioral health" referring to stressors and symptoms related to mental health and substance use disorders (Levin & Hanson, 2019; Shepley & Pasha, 2017). Funded by the U.S. Department of Health and Human Services Substance Abuse and Mental Health Services Administration (SAMHSA), the Center is supported by a distinguished community of behavioral health educators, researchers, service providers, and African American stakeholders focused on eliminating behavioral health disparities for African Americans nationwide.

AABH CoE Goals

The four primary goals of the Center of Excellence, each supported by a Core Team within the organizational structure, are to: 1) increase the capacity of behavioral health systems to provide outreach, engage, retain, and effectively care for African Americans; 2) improve the dissemination of up-to-date information and culturally appropriate evidenced-based practices and approaches across the continuum of behavioral healthcare for African Americans; 3) increase workforce development opportunities focused on implicit bias, social determinants of health, structural racism, and other factors that impede high-quality care for African Americans; and 4) increase collaboration between the CoE and SAMHSA training and technical assistance providers, to infuse culturally appropriate information regarding African Americans in all training and TA funded by SAMHSA (AABH CoE Documentation, 2020).

AABH CoE Strategy

To achieve these goals, the Center focuses on several key strategies, including identifying, promoting, and supporting the implementation of: 1) culturally appropriate programs that address African Americans' unique behavioral health needs and experiences, 2) culturally relevant evidence-based practices, 3) community outreach initiatives, and 4) public education. The Center's continuum of services is concentrated in three main areas: technical assistance (TA), professional training, and "written and recorded resources" (AABH CoE, n.d., para. 2). Efforts supporting these three areas include (respectively) the development of processes and systems that "determine proper care determinations and levels" (Bowen et al., 2014, p. 28); training programs focused on teaching, learning, evaluation, prevention, recovery, and culturally responsive intervention techniques; and the development of and contribution to trusted sources of BH education and information through a variety of publications. Moreover, the Center collaborates with local community organizations and grassroots initiatives to gain valuable insights and develop tailored interventions and support networks.

The Center's cooperative and collaborative partnerships include: 1) frequent collaboration with SAMHSA and its full range of training and technical assistance centers, and with the SAMHSA Office of Minority Health Equity (OMHE) and the other OMHE Centers of Excellence; 2) a close relationship with the Center's home institution, the National Center for Primary Care at Morehouse School of Medicine; 3) highly productive relationships with sub-awardees the University of Missouri at Kansas City, the American Psychiatric Association, the National Council on Behavioral Health, and the University of Texas at Austin; and 4) collaborative initiatives with a host of national, regional, and local organizations, including the Addiction Peer Recovery Technical Assistance Center and the Opioid Response Network, to name a few. The Center has also forged a strong partnership with the U.S. Department of Health and Human Services (HHS)

and a number of organizations and initiatives to advance the conversation surrounding the behavioral health and wellness needs of students at Historically Black Colleges and Universities (HBCUs), along with opportunities to attract HBCU students to careers and career advancement in the behavioral health field.

Issue Background

In response to the ever-present need for culture-specific interventions and practices (Gurung & Eshan, 2009; Barrera et al., 2013), the Center of Excellence prioritizes the training and empowerment of behavioral health providers through specialized programs and continuing education opportunities. This approach helps to enhance providers' cultural competency, thereby promoting the delivery of effective and inclusive care for African Americans. The Center fosters community engagement by organizing (and preparing providers to organize) community forums, listening sessions, support groups, and educational events. These events are designed to encourage open dialogue, destigmatize discussions of behavioral health challenges and services, and promote help-seeking behaviors.

A growing body of research makes a persuasive argument for careful consideration of culture in behavioral health practice. Much of it echoes the narrative of Benuto et al. (2020), who assert that "Across the behavioral health field there is an urgency to employ cultural considerations into professional practice" (p.2). Such 'urgency' stems from the notion that a lack of cultural components and competence increases the field's potential for the kinds of disparities and biases that can interrupt and often invalidate the benefits of treatment and care experiences. Regarding care administered to African American clients, it has been found that the cultural competence of BH providers will serve as a direct mediator between race and clients' behavioral health needs (Planey et al., 2019) and, therefore, treatment outcomes. Understanding this, the Center of

Excellence actively engages in efforts to identify and document the root causes of behavioral health disparities among African Americans, by highlighting peer-reviewed studies, data, and publications that contribute to evidence-based practices and policies. The data from these endeavors can then inform guideline-consistent care that actively and effectively produces accurate diagnoses and effective treatment for African American clients.

The Center is federally funded and, in the three years since its inception, has introduced training and technical assistance (TTA) to organizations dedicated to improving behavioral health systems, increasing access to behavioral health treatment, and supporting and sustaining culturally appropriate resources, services, and workforces. The organization boasts an academically and administratively relevant foundation, given its home in the Morehouse School of Medicine. Its work is spearheaded by professionals educated at master's and Ph.D. levels, holding degrees in various relevant disciplines, including psychology, public health, public administration, and divinity.

Part II: Problem of Practice

The African American Behavioral Health Center of Excellence is facing considerable challenges in its attempts to help the behavioral health field stabilize and ultimately reduce the global systemic and structural inequities that African Americans experience in attempting to address their behavioral health challenges. When care is provided from a Eurocentric lens rather than an Afrocentric one, the approaches, interventions, and perspectives used in behavioral health care may not adequately consider Black clients' cultural backgrounds and experiences or the physical and psychological implications of those experiences. This can result in a lack of understanding and engagement, a danger of miscommunication and misdiagnosis, early withdrawal from services, ineffective treatment outcomes, and shorter retention of treatment gains.

In nearly all applications, Eurocentrism (an approach and worldview based on White European values, experiences, and ways of knowing) results in a "racist, divisive, ahistorical, and dysfunctional" view (Hoskins, 1992, p. 247). This is particularly true in behavioral health contexts. For example, according to Minsky-Kelly and Hornung (2022), under a Eurocentric lens, many BH diagnostic categories result in harmful, racially disparate diagnosing practices because they severely minimize—if not entirely eliminate—the experiences of African American clients. We will expand more on this in our literature review.

The Role of Race

Race plays a significant role in behavioral health contexts. Not only are the circumstances and symptoms of African Americans' presenting illnesses often exacerbated by historical and racial trauma (Woll, 2021), but the disparities and challenges they face in accessing behavioral health care are often rooted in systemic and structural inequities. These inequities can perpetuate a Eurocentric framework in the provision of care, where the dominant cultural norms and practices may not align with African American clients' cultural backgrounds and needs. Perhaps the most adverse consequence is that 'racism' is often not seen to have a negative or traumatizing impact on one's mental or behavioral health (Minsky-Kelly & Hornung, 2022). In fact, the DSM-V—the most current edition of the Diagnostic and Statistical Manual of Mental Disorders—fails to recognize any form of racism or any experience that does not involve death (actual or threatened), serious injury, or violence as constituting "trauma" or being "traumatic." (American Psychiatric Association, 2013). As a result, African Americans remain inadequately diagnosed, which results either in a dismissal of important BH needs or in the provision of services embedded in contexts and conditions that actually oppress the ones in need of care.

There is a need for a shift toward an integrated and culturally relevant approach that recognizes and values Black individuals' unique experiences, beliefs, and perspectives, and uses this understanding in the delivery of behavioral health care. Leaders at the Center of Excellence teach that the behavioral health issues of many African Americans are rooted in challenges associated with the social determinants of health (SDOH), the social and economic life circumstances that can have profound effects on human well-being. Among the many common disparities within the social determinants of health is the lack of equal and equitable access to mental health and substance use disorder treatment for those who identify as African American. An understanding of the social determinants is central to the Center of Excellence, and its work emphasizes the dissemination of information and resources for culturally appropriate workforce, leadership, and organizational practices and structure.

Cultural incompetence has long been recognized as a challenge within the behavioral health profession (Davis et al., 2015). While many policies and practices emphasize the need for an integrated and culturally relevant approach to providing behavioral health care, many inequalities may persist because the leadership of many behavioral health organizations and systems are lacking in cultural competence and cultural humility. Not only are culture-specific tools and resources required to address the needs of the population served, but the human beings who use those tools and resources must have more than a superficial understanding of both the general challenges and characteristics of the culture and the wide diversity within that culture. In addition, any knowledge or understanding of the culture and its members must be well balanced by cultural humility, including a consistent awareness of: 1) openness to the other; 2) the limitations of one's ability to truly "know" another culture, 3) the influence of one's own culture and life experiences on one's attitudes and perceptions of others and of difference in general, 4)

power differentials and dynamics in the surrounding organizations and systems, and 5) a lifelong commitment to self-reflection and systemic change (Hook et al., 2013; Yeager & Bauer-Wu, 2013; Tervalon & Murray-Garcia, 1998).

The term "African Americans" generally refers to individuals of African descent residing in the United States. This includes individuals who identify as Black or of African heritage. The Center's population of focus includes the general population of African descent in the United States who face 1) behavioral health disparities and 2) challenges in attempting to address their behavioral health issues. This population includes adults, adolescents, and children, including individuals from many socioeconomic backgrounds and walks of life. The Center aims to help the behavioral health field address the systemic and structural inequities experienced by this population and ensure equitable access to behavioral health services and improved outcomes for African Americans nationwide.

Cultural Competence Gap Identification

Leadership at the AABH CoE posits that the absence of a diversified, culturally competent and culturally humble workforce has impeded the ability of the behavioral health field to adequately address the issues facing African Americans who need safe, relevant, and equitable behavioral health services. These challenges might include disparities in access to behavioral health services, perpetuation of cultural stigma surrounding behavioral health conditions (and often surrounding the receipt of behavioral health services as well), inadequate representation and diversity in the behavioral health workforce, implicit bias and microaggressions on the part of White staff, and systemic barriers to care of even adequate quality and duration. The Center is committed to helping the field identify and explore these and other challenges, so it can develop

strategies and interventions that will address both the root causes and the many manifestations of these challenges.

While receiving services from clinicians and recovery supporters who match their own cultural background might be psychologically safer for many African American clients and patients, the field does not yet include enough clinicians of color to make that possible. Even more important, if African Americans were adequately represented in the leadership of behavioral health organizations and agencies, more organizational and systemic cultures might be better prepared to foster cultural competence and cultural humility throughout all staff, all policies, and all practices. However, although the behavioral health field does include many well trained, skilled, and effective Black practitioners, it has fallen behind in its efforts to prepare and hire these professionals for leadership. Partner feedback and impact analysis indicate that the field has yet to see improvement in the professional maturity or leadership capacity needed to discover and intentionally develop culturally relevant practices. Few Black behavioral health practitioners have received the training, mentorship, and field opportunities needed to foster true leadership. These challenges severely hinder the safety, reach, and effectiveness of behavioral health services for African Americans.

So the Center of Excellence is working toward developing policies and practices that are balanced by what might be competing constructs. Beatty and Guthrie (2022) note that competing constructs can complicate the movement toward cultural competence, namely through one's "personal experiences, social identities, and various worldviews" (p. 22).

AABH CoE Leadership Initiative

At the beginning of 2022, the Center's leadership created a leadership development initiative whose purpose is twofold:

1. Assist Black behavioral health professionals in constructing new knowledge and integrating new ideas regarding culturally relevant leadership; and
2. Foster leadership approaches that honor the nuances and complexities of context in culturally relevant leadership practices, giving participants more opportunities to demonstrate how their competency ties into the overall deliverables of their organizations.

Under this Initiative, first piloted in 2022 and intended for wide dissemination during the Center's remaining grant years, the Center intends to: 1) help the field and its new Black leaders reach the needed state of accountability and responsibility, 2) make the field more cohesive in its approach to cultural relevancy in behavioral health practice, and 3) help each participant develop and execute a personal leadership development plan. These objectives are rooted in growth that, when done correctly, ensures that everyone is advancing personally and professionally and the value of this growth is seen throughout the communities they serve.

Part III: Review of Literature

Historical Context

To address the needed improvements in African Americans' behavioral healthcare outcomes, we must first understand the current obstacles to healthcare access and use. These obstacles are deeply rooted in historically inequitable and unjust systems. Briggs et al. (2014) discuss this history in depth, noting that people advocated for better conditions for individuals with mental health conditions as early as the 1840s. Any relief provided to families eventually became inaccessible due to insufficient funding and lack of regulation. For African Americans, this lack of appropriate care was compounded by racist practices within the scientific community, such as creating race-specific "disorders" and inhumane "cures." Although admittance to mental health facilities increased in the early 20th century, the stigma toward mental health conditions remained

particularly strong in public attitudes toward African Americans, fueled by stereotypes such as an association of urban violence with “malfunctions of the brain.”

After World War II, more federal funds were directed toward criminal justice and healthcare initiatives, but these allocations did nothing to address systemic factors such as economic injustice and institutional racism. Federal legislation expanded the role of Medicare and Medicaid to advance a deinstitutionalization initiative, using new medications and policies to reduce the patient census in hospitals and other mental health facilities. However, African American communities had limited physical access to public mental health options established by this legislation. The gap between needs and solutions was met, not with a healthcare solution but with a criminal justice one.

Over decades, the African American community witnessed and experienced these and other events and developed a mistrust of mental health providers. Briggs and colleagues (2011) provide additional historical context for the lack of trust in mental health systems. Against this systemic and historical backdrop, the general societal stigma around behavioral health conditions continued to discourage people from seeking help.

The current lack of racial diversity among behavioral health practitioners contributes to this mistrust and inhibits African American access to modern advances. Just 4% of the U.S. psychology workforce identifies as Black, compared to the 12% of the population they represent (American Psychology Association, 2018). Cultural obstacles often impede African Americans seeking mental health services. Communication dynamics between physicians and patients differ considerably depending on whether patients are African American or White. Doctors are 23% more verbally dominant and engaged in 33% less patient-centered communication with African American patients than with White patients (American Psychiatric Association, 2017). When

individuals are seeking behavioral health services, they are far more likely to want to receive services from someone they perceive as responding empathically to shared personal disclosure (Briggs, et al., 2011). Rapport with patients is not only a desirable skill in a practitioner. Given the general stigma toward behavioral health conditions, it is particularly important to remove any potential point of friction.

That stigma, combined with the relative lack of African American representation among behavioral health professionals, has increased the urgency of the need for targeted outreach. However, most approaches toward targeted outreach, including grassroots initiatives, have proved too costly and lacked government reimbursement. Davis et al. (2015) expanded on social determinants such as poverty and service fragmentation as key contributors. For example, an African American is three times more likely to live below the poverty line than a non-Hispanic White (American Psychiatric Association, 2017). Okoro et al. (2022) advanced this work further during the COVID-19 pandemic by identifying the lack of access to health insurance as another barrier limiting the utilization of existing infrastructure. Many decades of mistreatment of the African American community must be overcome to address this issue.

Cultural Humility and Competence Background

Recognizing the poor quality, embedded mistrust in healthcare systems, and lack of African American representation among doctors and behavioral health professionals, the AABH CoE has been identifying and disseminating culturally relevant approaches to improve outcomes. Scholars point to cultural competence (CC) and cultural humility (CH) as critical proficiencies to develop. This is especially relevant to this project, given the previously mentioned lack of racial diversity in the provider population.

First, CC has long been regarded as a necessary set of skills for clinicians to effectively treat clients from different backgrounds (Tormala et al., 2018). Scholars define these skills in substantially similar ways. Alizadeh & Chavan (2016) discuss the ability to interact with people from different backgrounds and the required learning elements, including: 1) learning about other cultures, 2) learning about one's own biases, and 3) developing communication skills that bridge the two in ways that work with all groups. Haas & Abdou (2019) add to this definition by identifying the need to create culturally responsive practices. Briggs et al. (2011) take a slightly different approach, calling for "culture-specific" practices. A reasonable way to think about CC involves knowing the client's background holistically, understanding the gaps that exist based on the practitioner's background, and being intentional about filling those gaps so that the client's experience is comfortable and thorough.

Scholars later began to explore cultural humility further, due to the potential gaps in practitioners' understanding of their own background and its impact on client care. Tervalon and Murray-Garcia (1998) developed the initial work, defining CH as distinct from CC. They posit that CH involves a learning mindset and a lifetime commitment to ongoing reflection and engagement with clients, colleagues, and the communities they serve. This reflection should include self-critique and inquiry into power dynamics and ways of developing client-focused care. CH also includes an openness to partnership with existing community-based client advocacy programs. While this humility and curiosity mindset may seem unnecessary to some medical experts, CH may be a necessary raw material for CC to be present at its highest level, and a particularly important and appropriate component of behavioral health care.

Afrocentric Model

Social workers and mental health researchers have explored intervention frameworks that employ cultural values unique to African Americans. The Afrocentric model of psychology and the concept of Afrocentricity itself emphasize that African Americans must be researched in the context of an African and African American worldview that sheds light on the many etiological factors that influence their behavioral health. The concept of Afrocentricity, initially conceptualized by James Baldwin and others, is the understanding of African American behavior and psychological functioning through the lens of their value system, emphasizing their well-being (Jones et al., 2007). Integrating an Afrocentric lens into our understanding of CC and CH is crucial to driving the desired outcomes for the community.

Cultural Humility and Competence in Action

Scholars offer many ideas for developing these skills at both individual and healthcare practice levels. In terms of strategy, essential characteristics of a culturally competent mental health practice include: 1) a comforting, inviting location for the client visit, 2) a welcoming environment with minimal bureaucratic hurdles, 3) continual reflection and self-critique on the part of the practitioner, 4) acknowledgment of background differences, 5) culturally appropriate collateral material, and 6) tailoring approaches to the client (Briggs et al., 2011). These characteristics represent the *culture* that enables cultural competence.

One development study in Portland, Oregon serves as a representative model of implementation of this strategy (Briggs et al., 2014). The researchers followed a five-stage approach to assess whether or not they could increase African American clinic usage. Their plan entailed: 1) needs assessment within the African American community, 2) program development of a culturally tailored clinic, 3) start-up implementation and observation of lack of use, 4)

evidence-based practice to address usage challenges, and 5) implementation of tailored African American community engagement strategies. The study utilized materials prepared by African American professionals. This model included facilitated discussion with participants regarding brain functioning and its relationship to primary and behavioral health, linkage to stressors at work and home, and the prevalence of mental illness in the broader community. Practitioners also discussed broader societal stigma and effective ways of accessing resources. The results were a fivefold increase in clinic usage by African Americans. This example of how a tailored, culturally competent program can lead to positive results is an encouraging data point indicating that these approaches can have practical use.

Other frameworks can be developed that conceptualize the strategies noted above. Okoro et al. (2022) developed one framework highlighting three pillars: Mental Health and Well-Being, Healthcare Access and Utilization, and Social Well-Being. These pillars emphasize philosophical tenets similar to those of the Portland study: individualized approaches, identification of stressors, tailored education, representative messengers, and widening of support circles. Another study by Watson-Singleton et al. (2018) showed similar emphasis points. Clinical interventions improved using African American facilitators, incorporating cultural values and resources with familiar terminology and settings. This study differed from the others mentioned by introducing individual factors such as religion and health goals.

In terms of observable skill level, the literature points to several areas that are capable of development. Interviewing and language skills emerge as appropriate places to start. As noted above, there is a risk that practitioners will oversimplify differences based solely on race. It is essential that practitioners interview without presumption, and creating a safe space for clients to share their personal stories is one approach that scholars recommend. The Cultural Formulation

Interview (CFI) is one effective tool. CFI uses 16 open-ended questions to solicit information on the problem, possible causes and context, prior experiences, and current state, all through a lens of cultural appropriateness. Notably, a skilled interviewer recognizes what to ask and how to solicit the most transparent and relevant information (Haas & Abdou, 2019). Language proves critical here, as it is a primary mode through which culture is expressed. The interviewer must know language norms (Briggs et al., 2011).

Learning and Development Effectiveness

It is critical that any training and development initiative be effective. While the behavioral health professional community includes therapists, social workers, clinical supervisors, case managers, and others, physicians (most often psychiatrists) are an important constituent. Historically, physicians have not prioritized leadership skills, as their education focuses on technical mastery (Throgmorton et al., 2016). However, in a development program for physicians, measuring the achievement of learning objectives is critical. The Kirkpatrick model is a widely recognized learning evaluation assessment tool for training initiatives consisting of four levels (Alsalamah & Callinan, 2022):

- Level 1 - Reaction: Evaluates trainees' satisfaction and interest in the training program.
- Level 2 - Learning: Assesses the degree to which trainees have acquired new skills and knowledge through the training initiative.
- Level 3 - Behavior: Examines the trainees' capacity to apply the newly acquired knowledge and skills within their context.
- Level 4 - Results: Reviews the overall impact of the training program on the organization, measuring the extent to which the training has achieved program objectives.

One example of a physician leadership program in operation is at a Southwest Michigan regional healthcare system. They created a ten-month Physician Leadership Academy to improve communication across disciplines and to develop the emotional intelligence skills that are critical to healthcare improvement. The physicians received psychometric assessments, 360 feedback, coaching, and individual development plans. A formal evaluation concluded that the program positively affected their ability to lead change, communicate effectively, and build and manage teams. Surprisingly, participants also reported increased confidence and improved relationship building. The evaluators determined that healthcare organizations seeking to address leadership gaps can apply these strategies and techniques in creating and evaluating their programs (Throgmorton et al., 2016).

Adult Learning Application

Given that the population of focus for this training and development initiative is made up of behavioral health practitioners, it is important to look to transformational learning theory (TLT), which focuses on adult learners. The theory provides a framework for understanding personal development that drives deep and impactful change in individual perspectives and values. TLT is applicable to this area of inquiry because critical self-reflection and discourse are significant elements of the framework. Initially, John Mezirow formed TLT in 1978 as a ten-step process that begins with a disorienting experience and ends with a new perspective that one takes into one's life. The theory has evolved through many stages since then and now includes different types of learning processes, meaning, reflections, and the social and emotional contexts that affect learning (Kitchenham, 2008). Although consensus exists that, when transformational learning change has occurred, its impact is significant, there is also some debate in the scholarly community about the possibility of making it a repeatable process (DeSapio, 2017). Despite this concern, integrating the

Kirkpatrick Model and TLT will maximize the effectiveness of the AABH CoE's leadership initiative.

Measurement of Cultural Humility and Competence

Measuring progress is crucial to understanding whether a strategy and its specific tactics have the anticipated impact. The final part of the Kirkpatrick Model—Level IV, results—is typically measured less frequently due to difficulty ascertaining return on investment (ROI) from learning and development programs. When results are measured, they are usually related to the degree to which results meet original stakeholder expectations (Throgmorton et al., 2016). There are dozens of tools available to measure cultural proficiency, but they usually measure improvements in general cultural competency rather than improvements in competency related to the African American community. These tools also lack consensus on their validity, due to measurement issues (Lucas, et al., 2008). Using the consensus CC and CH definitions as the basis leads to the identification of three domains by which one might measure proficiency (Lucas et al., 2018) The first area is *knowledge*, seeking to measure the practitioner's understanding of the culture's characteristics and implications. The second area is *awareness*, focusing on the practitioner's understanding of bias and its perceptual impact. The final area is *skill*, measuring the practitioner's proficiency in interacting with clients in culturally appropriate ways. A survey instrument might be developed that asks clients to assess their practitioners across three dimensions: cultural knowledge, awareness, and skill. This approach would rely on the individual client as the expert on their own lived experience (Tervalon & Murray-García, 1998).

Another approach to measurement involves Cultural Formulations (CF). CFs play a critical role in clinical practices by addressing cultural diversity in client interactions. The Outline for Cultural Formulation (OCF) evaluates cultural identities and contexts relating to mental health. It integrates

culturally relevant factors into the diagnostic and treatment processes, enabling more culturally competent care. One study used this development approach with clinical psychology doctoral students and a case study of an African American patient. The students were asked to develop a clinical plan factoring in potential cultural influences on the patient's condition. Students were given extensive feedback and then asked to perform a similar exercise months later. Improvement was noted across six themes highlighted in the responses: self-awareness, intersectionality, perspective-taking, scientific mindset, unsupported cultural statements, and power/privilege differential. The study concluded that these CC and CH skills and measures could be developed in a classroom setting (Tervalon & Murray-García, 1998).

Part IV: Conceptual Framework and Project Questions

Conceptual Framework

The research synthesis shapes the conceptual framework for the project:

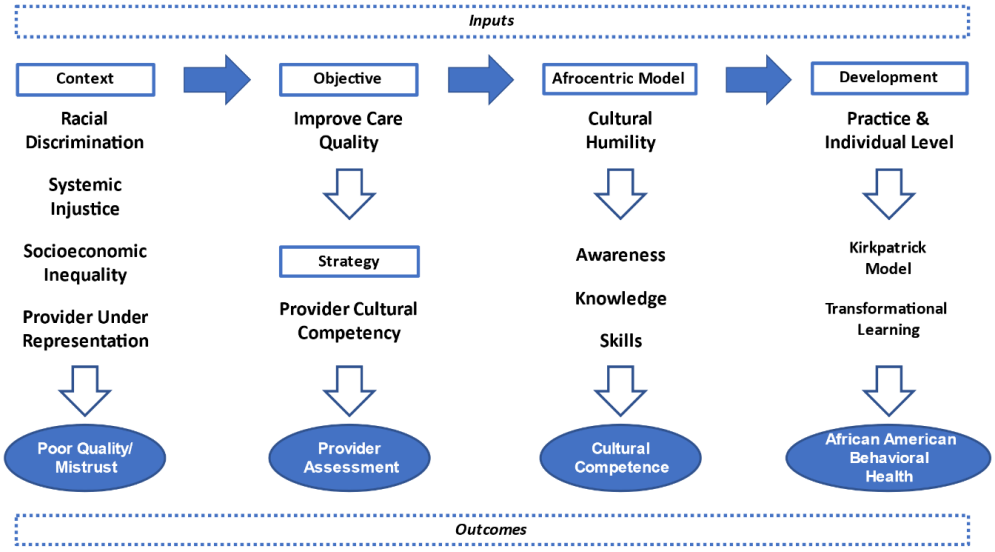

Figure 1: Project Conceptual Frame

The conceptual frame is organized sequentially in two directions: 1) top to bottom, with inputs at the top of each column leading sequentially to outcomes; and 2) left to right, with current state leading to desired future state. The following is a discussion of the sequence:

Context

The American history of racial discrimination, systemic injustice, socioeconomic inequality, and ultimate under-representation among behavioral health providers has led to the present situation. This outcome includes poor-quality care and mistrust experienced by the African American community (Briggs et al., 2014; Briggs, et al., 2011).

Objective

Due to the poor quality of many services and mistrust of the behavioral health field, the AABH CoE has an objective of identifying and disseminating information and tools that will help practitioners improve quality of care. The literature review points to cultural competency and cultural humility as important skills for treating clients from different backgrounds (Tormala et al., 2018; Tervalon & Murray-Garcia, 1998). The project under discussion is examining whether and how cultural competency is an effective strategy. This strategy would lead initially to an assessment of a provider's cultural competency.

Afrocentric Model

Assessing the provider's African American cultural competency requires culturally relevant curricula. This content will initially focus on assessing and enhancing African American cultural humility. Once cultural humility is present, then assessing and enhancing a provider's awareness, knowledge, and skills concerning African American clients will be the components used to build cultural competency in the cadre of behavioral health providers participating in the AABH CoE Leadership Initiative.

Development

The final phase of the conceptual model measures the linkage of Afrocentric cultural humility and competency and improvements in behavioral health outcomes. Development at the healthcare practice level and individual level are evaluated using the Kirkpatrick Model's four levels of reaction, learning, behavior, and results (Alsalamah & Callinan, 2022). Results evaluated as achieving transformational learning by participants in the AABH CoE leadership initiative will be interpreted as African American cultural competency.

Key Concepts

The key terms conceptualized in this project will be defined per our literature review as follows:

- An Afrocentric Model employs a cultural model unique to African Americans, understanding African American behavior and psychological functioning through the lens of their value system while emphasizing their well-being (Jones et al., 2007).
- Cultural Competency will be defined and measured according to awareness, knowledge, and skill. Awareness is the provider's understanding of personal bias and its impact. Knowledge is the provider's understanding of the culture's characteristics and implications. Skill is the provider's proficiency in interaction with clients in a culturally appropriate way (Lucas et al., 2018).
- Cultural Humility requires a commitment to reflection regarding power dynamics and client-focused care. This reflection includes engagement with clients, colleagues, and the communities served (Tervalon & Murray-Garcia, 1998).

Project Questions

The AABH CoE leadership initiative project will focus on the following research questions:

1. In what ways do cultural competence and cultural humility influence how African Americans receive behavioral healthcare in the SE Region within the African American Behavioral Health Center of Excellence at Morehouse School of Medicine provider network?
2. In what ways can cultural competence and culture humility enhance the leadership development training offered by the African American Behavioral Health Center of Excellence at Morehouse School of Medicine?

In Question #1, the clause "in the SE Region within the African American Behavioral Health Center of Excellence" denotes the broad collection of behavioral health organizations and systems in which participants in the AABH CoE Leadership Initiative work, volunteer, and otherwise provide behavioral health services.

Part V: Project Design

For each of the two project questions, a data collection table was compiled:

Project Question #1: In what ways do cultural competence and cultural humility influence how African Americans receive behavioral healthcare in the SE Region within the African American Behavioral Health Center of Excellence at Morehouse School of Medicine provider network?

Table 1: Data Collection Plan - Question 1

Data Source	**Data Collection Methods**	**Data Analysis**
Provider data including where African American population and practitioners over/under indexes against other races.	Obtain from AABH CoE	Analyzing existing AABH CoE material provides necessary contextual data to inform data analysis and findings.

Cultural Competency and Cultural Humility self-assessments	Survey administration to provider network; survey question development via existing tools and research	Analyze data within population itself for dispersion; analyze against any client outcome data from population; data collected will be a mix of Likert scoring and short answer qualitative; data analysis will be quantitative and thematic.

Project Question #2: In what ways can cultural competence and culture humility enhance the leadership development training offered by the African American Behavioral Health Center of Excellence at Morehouse School of Medicine?

Table 2: Data Collection Plan - Question 2

Data Source	**Data Collection Methods**	**Data Analysis**
Existing curriculum and training materials used by AABH CoE	Obtain from AABH CoE	Understand current state of cultural competence and cultural humility gaps in current offerings
Participant satisfaction data in existing leadership development programs	Obtain from AABH CoE	Understand the effectiveness of existing training offerings to ensure new content has the desired effect on outcomes
Participant satisfaction data in existing leadership development programs	~15 interviews with AABH CoE stakeholders (represents contractors, net work and staff)	Enhance existing data understanding with storytelling; best practices, ways to incorporate cultural competency and cultural humility, and other new ideas not being acted upon currently; thematic analysis

Training Participant Data and Cultural Competency and Cultural Humility Data	Existing AABH CoE data and new data collected from this project	Understand any relationship between existing leadership program participation and baseline self-assessment of providers

Data Collection Methods

The data collection plan supports examination of the two areas of the problem of practice and the investigation with similar forms of data. All data were collected and analyzed in adherence to confidentiality guidelines. For question #1, we used a mix of quantitative and qualitative data to understand the issue background and key stakeholder views related to cultural competency and cultural humility. Existing research and collateral material provided context for the organizational design elements. A cultural competency and cultural humility self-assessment survey tool was distributed to 150 behavioral health practitioners. The individuals, chosen by the AABH CoE, included current and former practitioners across a broad array of professional functions. Selecting through judgmental sampling, AABH CoE provided individuals who have thoughtful perspectives and represent a cross-section of viewpoints. The survey included fewer than 13 questions and contained both Likert-scale and open-ended responses.

For question #2, we examined the existing training curriculum, looking for opportunities to include information and tools designed to promote cultural competency and cultural humility. Individual interviews were conducted with 15 training program participants for a deeper understanding of their experience and ways to incorporate cultural competency and cultural humility. As in the other interview processes associated with this study, interviewees were chosen by the AABH CoE through judgmental sampling. The interview questions were provided in advance to allow participants time for reflection.

Tools and Protocols

The survey instrument for question #1 contained Likert and open-ended responses. Likert scale is 1-Strongly Disagree, 2- Disagree, 3-Neither Agree nor Disagree, 4-Agree, 5-Strongly Agree. The questions specifically map to key aspects of the project's conceptual framework. In this context, the terms "African American Behavioral Health Network" and "African American Behavioral Health Network SE Region" are used to encompass the entire network of behavioral health organizations and systems in which respondents work, regardless of location and populations served. The term "network" is also used to indicate the variety of conceptual and practice connections within the behavioral health field.

Table 3: Likert Scale Survey Instrument - Question 1

#	Question	Response Form	Concept Framework
1	The practices of cultural competence used by AABH CoE providers influence how African Americans receive behavioral health services within the African American Behavioral Health Network.	Likert	Objective and Strategy Link
2	By incorporating practices of cultural competence and cultural humility into treatment for African Americans who seek services through the African American Behavioral Health Network, there is an opportunity to improve treatment options as well as offer alternative service options that are equally progressive.	Likert	Objective and Strategy Link
3	I incorporate a lens centered on the African American experience for those who seek services within the African American Behavioral Health Network SE Region.	Likert	Afrocentric Model
4	I regularly reflect on the power dynamics of the provider/client relationship and its impact on the	Likert	Cultural Humility

	behavioral health services to African Americans who seek services within African American Behavioral Health Network SE Region		
5	I am aware of potential bias and its impact on my ability to give culturally competent treatment to African Americans who seek services through the African American Behavioral Health Network.	Likert	Cultural Competency Awareness
6	I am confident in my knowledge of culturally competent behavioral health services to African Americans who seek services within African American Behavioral Health Network SE Region.	Likert	Cultural Competency Knowledge
7	I am confident in my ability to provide culturally competent behavioral health services to African Americans who seek services within African American Behavioral Health Network SE Region.	Likert	Cultural Competency Skills
8	AABH CoE providers will not be able to sustain culturally competent treatment without the support of AABH CoE leadership and the organization.	Likert	Development
9	Based on your experience as an AABH CoE provider, how do you perceive the impact of cultural competence practices demonstrated by both providers and leadership on your ability to effectively engage and serve African Americans who seek services through the African American Behavioral Health Network?	Open-ended	Objective and Strategy Link
10	How do you perform self-evaluation as it relates to the provider-client relationship and its impact on treatment practices used to serve African Americans who seek services through the African American Behavioral Health Network?	Open-ended	Cultural Humility
11	How would you describe cultural competence related to the treatment practices used to serve African Americans who seek services through the African American Behavioral Health Network?	Open-ended	Cultural Competence

12	What would you say are two or three specific elements or components that could be integrated into the leadership or provider development training at AABH CoE to enhance or improve cultural competence and cultural humility?	Open-ended	Development
13	What potential challenges or barriers do you foresee in implementing cultural competence and cultural humility principles within your own practice as a AABH CoE service provider? How could they be addressed or overcome?	Open-ended	Objective and Strategy Link

The Interview Protocol for question #2 explored the impact of the Kirkpatrick Model framework on participants' transformational learning potential. The protocol included 3 scripted questions, as well as ad hoc clarifying or follow-up questions depending upon responses. The scripted questions are as follows and were sent 24 hours in advance of the 30-minute session, to allow for participant reflection:

Table 4: Interview Protocol Survey Instrument - Question 2

Interview Question	Kirkpatrick Model
1) How do you perceive the current leadership development training offered by the African American Behavioral Health Center of Excellence (AABH CoE) at Morehouse School of Medicine in terms of incorporating cultural competence and cultural humility principles?	Level 1 - Reaction
2) How would you describe the extent to which leadership training at AABH CoE effectively utilizes cultural competence	Level 2 - Learning

practices to support providers in delivering behavioral health services to African Americans?	
3) What potential challenges or barriers do you foresee in implementing cultural competence and cultural humility principles within the leadership development training at AABH CoE, and how could they be addressed or overcome?	Level 3 - Behavior

The interviewer closed by asking whether the participant felt that there was anything relevant that was not discussed and asking for any specific recommendations for the training.

Timeline

The data collection for this project occurred over a period of approximately six weeks:

- Week 1-2:
    - AABH CoE data request and compilation
    - Finalize survey and interview questions
    - AABH CoE approval of data collection tools
    - IRB approval
    - Contact survey and interview participants
- Week 3-4
    - Collect population data, provider data, and client outcome data.
    - Begin data management and initial analysis
    - Compile existing curriculum and training materials used by AABH CoE

    - Collect satisfaction data from existing leadership development programs.
    - Administer cultural competency and cultural humility self-assessments
    - Conduct leadership development interviews with training participants
- Week 5-6:
    - Analyze leadership initiative participant satisfaction data and interviews
    - Compile and analyze cultural competency and cultural humility survey responses
    - Compile and analyze all collected data for integrated themes.

Recruitment Materials

The AABH CoE coordinated communication with both survey and interview participants. Dawn Tyus, PhD, the AABH CoE Director and Principal Investigator, sent an email directly to the potential participants, to honor confidentiality and the scope of the project. The Proposed Survey Recruitment Email, Proposed Interview Participant Email, Survey Preamble, and Second Recruitment Email are found in Appendices A, B, C, and D, respectively.

Part VI: Data Analysis Results

Data Collection Results

Background contextual information for both project questions was not made available, despite client agreement on its utility. Although analyzing data related to population and provider demographics and training program satisfaction survey data would have aided data analysis, it is not deemed necessary to the completion of the project. Additional data related to AABH CoE's organizational design that is publicly available (e.g., information on the website, publications, marketing materials, asynchronous development content, and training presentations) were used instead to inform findings and recommendations.

Survey Response

Survey response to the initial request was 5 of 150, representing a 3% response rate. After a second follow-up request by AABH CoE to 30 providers, the responses increased to 10, representing a 6% response rate. After a third and final follow-up request to the same group of 30 providers, the responses increased by 1, to a total of 11, representing a 6% response rate. Upon asking the AABH CoE whether there was an error in survey distribution that would explain the response rate, it was discovered that 23 emails were rejected due to the person most likely no longer employed at the organization and 13 email addresses were noted to be duplicates. These errors increased the survey response rate to 8%. Due to the lower-than-anticipated response rate, Project Question #2 interview responses were analyzed for data relevant to Project Question #1.

Due to an unexplained technical error, only one survey response included an answer to question #7: "I am confident in my ability to provide culturally competent behavioral health services to African Americans who seek services within the African American Behavioral Health Network SE Region." For that reason, the question was omitted from analysis. It was the only question affected by this issue. Given that there were two other Likert-scale questions addressing cultural competency, along with various open-ended questions, this omission is noted but does not impede findings or the development of recommendations.

Interview Response

The interview protocol for Project Question #2 was completed for 14 of 15 participants, representing a 93% completion rate. The interviews ranged from 30-50 minutes. In addition to the data collected during the interview recording and transcription, 10 of the 14 participants submitted written responses to the data in advance of the interview. The written responses were neither

solicited nor anticipated. They were included as additional data, coded, and included in thematic analysis. These supplemental data are useful in the context of the low survey response rate.

Summary Data Collection Table

A final table of data collection is below:

Table 5: Data Collection Results

Data Source	**Actual Responses**	**Requested Responses**	**Response Rate**
Surveys	11	144	8%
Interviews	14	15	93%
Subtotal	*25*	*159*	*16%*
Written Submissions	10	N/A	N/A
Total Data Points	**35**		

Although the survey response rate was low, when survey and interview response rates are considered together, the total response rate for all forms of data requested rises to 16%. Including the unanticipated written responses to the interviews, the total number of data points is 35. A response rate is not calculated for the total number of data points, as the 10 written submissions were not explicitly requested.

Data Analysis Plan - Project Question #1

For the survey questions for Project Question #1 (“In what ways do cultural competence and cultural humility influence how African Americans receive behavioral healthcare in the Southeast Region within the African American Behavioral Health Network of Excellence at Morehouse School of Medicine provider network?”) the data collected constituted a mix of Likert-

scored survey results and open-ended responses, so we used both quantitative and qualitative analysis.

Quantitative:

- Descriptive Statistics: Survey-participant demographics gave context to the interpretation of the data.
- Likert-Scale Items: Survey data collected via Likert-scale items were analyzed for measures of central tendency (e.g., mean, median) and dispersion (e.g., standard deviation, range). There was an assessment of the relative strength and weakness of the objective and strategy link, incorporation of Afrocentric model, understanding of cultural humility and the conceptualized lens of cultural competency (i.e., awareness, knowledge, skills).
- Correlation Analysis: We examined any relationships among the items explored and the strength and directions of these relationships.

Qualitative:

- Coding: After a thorough review of the interview transcripts, we performed deductive analysis by aligning data with 1) perceptions of objective and strategy linkage and 2) conceptualized definitions of "Afrocentric model," "cultural humility," and "cultural competency." We performed inductive analysis through an understanding that other coding is relevant but was not anticipated prior to analysis. The inductive coding was initially based on word clouds and word frequencies and refined through repeated review.
- Thematic analysis: Thematic analysis blended deductive and inductive coding, to determine relevant insights from responses.

Triangulation:

- Integration: The quantitative and qualitative data findings were analyzed for consistency and contradictions. Points of emphasis for leadership development programs were identified.

Data Analysis Plan - Project Question #2

For the survey questions for Project Question #2 (In what ways can cultural competence and culture humility enhance the leadership development training offered by the African American Behavioral Health Center of Excellence at Morehouse School of Medicine?) the data were collected via interviews, so the qualitative analysis was similar to that of the open-ended responses to Project Question #1 (above). The primary difference lay in the deductive coding and thematic analysis, as each question aligns with a Kirkpatrick Model level. The inductive coding process was also similar to that of Question #1 above. A triangulation of themes from both project questions ascertained consistency, contradictions, and macro insights to inform our findings and recommendations.

Analysis and Writing Support

Analysis tools for both project questions will include MAXQDA for statistical analysis and qualitative thematic software and Excel for data compilation and summaries. Writing support was derived from both the website Grammarly and a paid editor.

Survey Quantitative Analysis

Survey respondents represented seven different states, six provider functions, and diversity in age, gender and race. Due to the small sample size, analysis was not performed for individual demographic categories but the broad diversity is noted. The survey data were bifurcated into

Likert scale quantitative data and open-ended qualitative data. The quantitative data descriptive statistics for the seven survey questions that include data are summarized below:

Table 6: Descriptive Statistics

	SQ1 Link	SQ2 Link	SQ3 Afrocentric Model	SQ4 CH	SQ5 CC Awareness	SQ6 CC Knowldege	SQ8 Development
Mean	4.7	4.9	4.4	4.3	4.6	4.0	3.8
Standard deviation	0.45	0.29	0.64	0.75	0.50	0.95	1.11
Variance	0.20	0.08	0.41	0.56	0.25	0.91	1.24
Minimum	4	4	3	3	4	2	2
1st Quartile	5	5	4	4	4	3.5	3
Median	5	5	4	4	5	4	4
3rd Quartile	5	5	5	5	5	5	5
Maximum	5	5	5	5	5	5	5
Range	1	1	2	2	1	3	3

The means of the scores indicated the strongest support for Questions #1 and #2 related to the link between cultural humility and competent care and client outcomes. The mean of Question #5 related to cultural competence awareness (4.6) is slightly greater than that of Question #4 related to cultural humility (4.3). From the literature review and conceptual framework, it was expected that humility would be a necessary trait for being aware, so this relationship is moderately unexpected. There is a more meaningful difference between the higher awareness score in Question #5 and the slightly lower cultural competence knowledge score in Question #6 (4.0), indicating less comfort in applying knowledge despite their awareness of bias. Question #8 indicates that respondents do not feel as strongly related to AABH CoE as a necessary resource to sustain their support, indicating that they are aware of other potential support organizations.

The dispersion of scores does not indicate any outlier data. Questions 1, 2 and 5 indicate a tight grouping of data based on the range (1), variance (.08-.25), and standard deviation (.3-.5). The most dispersion exists in Questions 6 and 8, indicating the most misalignment among the respondents: range =3, variance =.91-1.24, and standard deviation .95-1.1.

Survey Question Statistical Relationship Analysis

A Pearson correlation coefficient test was performed to yield an understanding of the relationship of variables with one another. Given that the sample size is 11 respondents, definitive correlations should not be concluded, although relationships will be noted. Furthermore, there is no evidence of correlation equating to causation in the work performed. The analysis is summarized below:

Table 7: Correlation Statistics

	SQ1 Link	SQ2 Link	SQ3 Afrocentric Model	SQ4 CH	SQ5 CC Awareness	SQ6 CC Knowldege	SQ8 Development
SQ1 Link		0.516 (p=0.052)	0.664 (p=0.013)	-0.050 (p=0.443)	-0.149 (p=0.331)	0.428 (p=0.095)	0.450 (p=0.082)
SQ2 Link	0.516 (p=0.052)		0.179 (p=0.299)	0.115 (p=0.368)	-0.289 (p=0.195)	0.000 (p=0.500)	0.232 (p=0.246)
SQ3 Afrocentric	0.664 (p=0.013)	0.179 (p=0.299)		-0.017 (p=0.480)	0.516 (p=0.052)	0.593 (p=0.027)	0.346 (p=0.148)
SQ4 CH	-0.050 (p=0.443)	0.115 (p=0.368)	-0.017 (p=0.480)		-0.155 (p=0.325)	-0.127 (p=0.355)	0.168 (p=0.310)
SQ5 CC Awareness	-0.149 (p=0.331)	-0.289 (p=0.195)	0.516 (p=0.052)	-0.155 (p=0.325)		0.574 (p=0.032)	-0.149 (p=0.331)
SQ6 CC Knowldege	0.428 (p=0.095)	0.000 (p=0.500)	0.593 (p=0.027)	-0.127 (p=0.355)	0.574 (p=0.032)		-0.171 (p=0.307)
SQ8 Development	0.450 (p=0.082)	0.232 (p=0.246)	0.346 (p=0.148)	0.168 (p=0.310)	-0.149 (p=0.331)	-0.171 (p=0.307)	

For there to be a statistically significant relationship between two variables, the p value is typically less than 0.05. In our data set, there are three relationships at that level:

- Question #1, regarding a link between cultural humility and competence and treatment outcomes, and Question #3, regarding incorporating the Afrocentric Model lens into the treatment practices (p=.013): As the correlation coefficient is positive and close to 1 (.664), this indicates that there is a fairly strong and statistically significant positive linear relationship between the ways in which respondents rated the two questions.
- Question #3, regarding incorporating the Afrocentric Model lens into the treatment practices, and Question #6, regarding cultural competence knowledge (p=.027): As the correlation coefficient is positive and closer to 1 than not (.593), it indicates that there is a moderately strong and statistically significant positive linear relationship between the ways in which respondents rated the two questions.

- Question #5, regarding cultural competence awareness, and Question #6, regarding cultural competency knowledge (p=.032): Given that the correlation coefficient is positive and closer to 1 than not (.574), this indicates that there is a moderately strong and statistically significant positive linear relationship between the ways in which respondents rated the two questions.

There are two other areas that approached the p-value threshold but did not reach it. Those relationships are in Question #5, for cultural competence awareness, and Question #3, related to incorporating the Afrocentric Model; and Questions # 1 and #2, related to the goal and strategy link. It is noted that the question about incorporating the Afrocentric Model demonstrated the highest number of relationships with the others, and it had a moderately strong self-assessment score by the respondents (mean = 4.4). Questions #1 & 2, regarding a link between cultural humility and competence and treatment outcomes, also demonstrated a relationship that was close to statistically significant. This, combined with the highest mean scores and smallest dispersion scores (previously discussed), clearly demonstrates respondent sentiment regarding its significance.

Survey Qualitative Analysis

The coding software MAXQDA has functionality for visualizing the data that provides a starting point for coding. The word cloud function enabled understanding of both word frequency and connections, which assisted in identifying relevant initial codes and themes. The resulting open-ended response coding analysis yielded the coding table. See Appendix E for the complete survey open-ended responses coding table used.

The coding analysis demonstrated a diversity of themes across the participants. In Questions #9-12, there was not a single theme that represented a majority of the respondents. In

Question #13, a majority of the respondents indicated that Macro Environmental factors (e.g. national and grassroots coordination, funding, etc.) would contribute both barriers and potential solutions to implementing cultural humility and competence practice at the local level.

Table 8: Surveys Code Frequency Summary Table

Question	Code	Frequency	%
Q9 Link			
	Personal Responsibility	3	33
	No link	2	22
	Outcomes	2	22
	Policy	2	22
	TOTAL	9	100
Q10 CH		**Frequency**	**%**
	Results	1	13
	Moderate	2	25
	Very Strong	3	38
	Weak	2	25
	TOTAL	8	100
Q11 CC		**Frequency**	**%**
	Moderate	4	50
	Strong	2	25
	Others	2	25
	TOTAL	8	100
Q12 Development		**Frequency**	**%**
	Advocacy	3	33
	Support	4	44
	History and Systems	2	22
	TOTAL	9	100
Q13 Link		**Frequency**	**%**
	Macro Environment	5	63
	Self Awareness	3	38
	TOTAL	8	100

Survey Quantitative and Qualitative Triangulation

Triangulating the Likert scale responses and open-ended responses indicates consistency. The Likert response scores for questions related to the linkage of cultural humility and competency and client treatment are supplemented by response sentiment on linkage manifestation and existing barriers that impede better outcomes. Eighty-eight percent of the responses discussed the importance of the linkage in some way. An example is as follows:

> *"As the Coordinator of Co-Occurring Disorder Services in Community Mental Health and also a region with a high African American population in the south (identifying location removed) it is vital that not only I bring a high level of cultural competency to the work I*

do but also provide education to staff and catchment area through a culturally competent lense (sic). As a Caucasian provider, the impact I make with this population and my ability to provide superior services is dependent on remaining culturally competent. Through utilization of diverse staff and on-going education we remain fairly successful in our ability to provide the best services we can to all populations we serve."

The remaining 12% spoke from limited personal observation of the link, but their Likert scores would indicate strong support.

In addition, the relationship between higher Likert response scores for cultural humility and personal bias awareness than for cultural competence knowledge application is supported by the open-ended response descriptions. Responses were evaluated as more detailed regarding personal reflection practices than were responses discussing how that reflection is demonstrated in practice. Thirty eight percent of the responses to the cultural humility prompt were so detailed that the categorization was "Very Strong." An example of a response in this category is as follows:

"The CLAS - Cultural and Linguistic Appropriate Standards can provide a self or provider evaluation. Providers and behavioral health care organizations should develop, implement, and promote a strategic plan that outlines clear goals, policies, operations, and management accountability/oversight mechanisms to provide culturally and linguistically appropriate services. The AABHCOE would be excellent in providing evaluations and tools for treatment and/or African American community relationships."

No responses to the cultural competence prompt were at a "Very Strong" detail threshold, with the largest concentration described as having a "Moderate" level of detail.

Supplemental Interview Data Analysis

To supplement the 11 survey responses to Project Question #1, the interview responses to Project Question #2 were incorporated into the analysis. A similar coding and analysis process was used for the interview and unexpected written submission data. Given the quantity of data, more codes and themes emerged. See Appendix F for the complete interview coding table used.

Table 9: Interviews Code Frequency Table

Question / Code	Frequency	Percentage	Total
Q1 - Reaction	24		
Q1 - Reaction > Effective	16	67%	19%
Q1 - Reaction > Environment	12	50%	14%
Q1 - Reaction > Help	17	71%	47%
Q1 - Reaction > Shift	8	33%	14%
Q1 - Reaction > Skills	7	29%	13%
Q1 - Reaction > White Paper Quote	2	8%	
Q2 - Learning	24		
Q2 - Learning > Help	23	96%	
Q2 - Learning > Knowledge	18	75%	23%
Q2 - Learning > Understand	5	21%	8%
Q2 - Learning > Community	2	8%	5%
Q2 - Learning > Improvement Ideas	2	8%	
Q2 - Learning > Shift	4	17%	9%
Q2 - Learning > Skills	4	17%	8%
Q2 - Learning > White Paper Quote	3	13%	3%
Q3 - Behavior	24		
Q3 - Behavior > Buy In	5	21%	8%
Q3 - Behavior > Implementation	2	8%	6%
Q3 - Behavior > Macro Environment	2	8%	2%
Q3 - Behavior > Open-minded	2	8%	10%
Q3 - Behavior > Safe Space	3	13%	
Q3 - Behavior > Understanding	4	17%	6%
Q3 - Behavior > White Paper Quote	3	13%	
Q4 - Recommendations	7		
Q4 - Recommendations > Content	3	43%	
Q4 - Recommendations > Resources	2	29%	
Q4 - Recommendations > Role Model	3	43%	
Q5 - Other	7		
Q5 - Other > Change	1	14%	
Q5 - Other > Racism	1	14%	
Q5 - Other > Resources	2	29%	
Q5 - Other > Safe Space	4	57%	

The responses underpin the link between cultural humility and competency and client care. Interview responses unanimously cited a combination of new skills, knowledge, and/or assistance from the development program. A representative sentiment derived from one of the unsolicited written responses prior to the interview is as follows:

"By incorporating culturally sensitive approaches and addressing the unique needs and experiences of African Americans, the training program can enhance providers' ability to deliver behavioral healthcare services in a manner that aligns with their cultural background. This can include fostering awareness of cultural nuances, promoting open dialogue, and encouraging ongoing education on culturally competent care."

The interview participant responses also discussed the importance of an Afrocentric lens for providers:

"The Black Well-Being model presentations were a great tool provided to help us consider in more detail, cultural context in which our clients may present and what goals they want to prioritize when receiving services. It also provides concrete ways for those we are serving to reflect on where they are and collaboratively develop a treatment plan."

Some interview participants recognized their lack of understanding of cultural humility and its potential as a raw material for cultural competency:

"Yeah. I perceived that I, I, I thought that it was really phenomenal. I thought it went really well. What really stood out to me, um, personally, what was it actually exposed some of my own personal ignorance, because I really didn't know what the difference was between cultural competency and cultural humility. And so once I was informed of what that difference was, it allowed me to kind of look at things in a different lens. And kinda recognize things within myself and then also within my organization and workplace and identify like, although we're maybe doing all of these, you know, cultural trainings, where is the gap? And I think it really, um, brought humility to a forefront to me. Um, it's actually, uh, been a term that I've been using a lot since attending the training because, uh, just like myself being a person of color and not really understanding the difference, I feel like other

minority groups don't either. And so, um, it really stood out to me and really resonated well with me. And so I did appreciate the emphasis on those aspects. Um, and then just hearing like, um, like the different examples and how they were used throughout the series of days and still demonstrated in different ways, I, I really saw value in it."

The interview data provided useful supplemental information to the survey responses.

Interview Qualitative Analysis

In addition to the analysis that was used to supplement Project Question #1, the interview response coding supported both a deductive and an inductive approach to answering Project Question #2. Given that the questions were linked to the Kirkpatrick Model in the conceptual frame, deductive coding mapped to the expectations of the Model. For the first question related to Level 1 - Reaction, many participants expressed a belief that the program was effective overall. An example of that kind of positive reaction is as follows:

"I thought the training was very informative and I thought it brought a lot of information we already like knew about in a sense but took it to the next level."

Question 2 mapped to Level 2 involved responses articulating examples of specific program learnings:

"The leadership training aided in the dissemination of evidence-based information and skills by being inclusion of cultural competency as a core ideal of the "curriculum." I believe that this boosted the knowledge and academic prowess of participants and providers"

Level 3 responses gathered in the third question measured participants' ability to apply learned knowledge in their professional settings:

"Since the onsite training, I've already started the work to implement cultural competence and humility in my professional environments. One thing that I've done that was successful was adding diversity and inclusion based questions in my interview questionnaire when screening new hires at my organization"

There were also responses that were unexpected and evolved into new themes. One of the more common themes concerned the personal "shifts" that participants identified in their own thinking. These shifts may be demonstrations of transformational learning in process:

"Yeah, um, in terms of like how I perceive the cultural competence, um, and cultural humility components of the training, um, I, I feel like it was very informative. It, it allowed us to reflect on tangible things, um, as far as like, what does this look like in your practice or what does this look like as you deliver behavioral health services? Um, I also feel like perhaps it could, it could present maybe an opportunity to do a little bit more deeper reflection as far as like what is your, maybe your understanding prior to leadership, the leadership training of cultural competence and cultural humility, just to be able to see like what are some areas that individually is like everyone is accountable for some level of growth within that."

Other codes that evolved from the interview responses spoke to the importance of safe spaces and environments, leadership buy-in, and the influence of macro-dynamics such as political climates. Both the survey and interviews also contained questions intended to gather specific suggestions for leadership development programming. Such responses ranged from content ideas to delivery mechanisms.

Overall Triangulation

Holistic examination of all data sources shows alignment among survey and interview responses and the project's conceptual frame. In particular, interview participants made connections regarding the relationships among these factors:

> *"I believe the training was great at showcasing cultural competence as it relates to delivering behavioral health care services. I'm not a direct care provider but at my organization I work to create resources for providers. The partnership with the CoE and my organization allows me to create tools and resources that are specific to the Black/ African American lived experience. Working with the cohort of care providers exposed me to different scenarios that sparked ideas for resources that I can create within my organization and that opportunity would not have presented it's self (sic) in any other environment. In addition, I think the training forced the participants, including myself, to do a self-assessment and review their experiences and see how that can also impact their ability to provide care for others."*

In summary, data collection across the survey and interviews yielded a robust collection of data and themes to inform the project findings and recommendations. The collection and analysis will be sufficient to answer the Project questions:

1. In what ways do cultural competence and cultural humility influence how African Americans receive behavioral healthcare in the SE Region within the African American Behavioral Health Center of Excellence at Morehouse School of Medicine provider network?
2. In what ways can cultural competence and culture humility enhance the leadership development training offered by the African American Behavioral Health Center of Excellence at Morehouse School of Medicine?

Part VII: Findings and Recommendations

Project Question #1 Findings

In what ways do cultural competence and cultural humility influence how African Americans receive behavioral healthcare in the SE Region within the African American Behavioral Health Center of Excellence at Morehouse School of Medicine provider network?

Objective and Strategy Linkage

The data analysis informs the findings regarding the first project question. First, the practitioners who participated in the survey demonstrated support for the linkage of cultural humility and competency and its potential to improve treatment practices. This evidence came from both the quantitative data, given that it was the subject of the highest-rated survey question; and the qualitative data, with more than half of respondents citing this as a personal responsibility of practitioners and seeing a link between this linkage and their practices. These data indicate that the AABH CoE's use of these principles as a key element of its leadership practices and its starting point in our conceptual frame is appropriate.

Macro Environmental Impact

It is important to note that more than half of the respondents also cited macro-environmental and structural barriers toward embedding these principles in their own practice. One example of such barriers that disproportionately impacts low-income clients is a clinic policy that charges a "no-show" fee, which discourages individuals from seeking treatment. A lack of representation of African Americans in positions of leadership contributes to the proliferation of such policies.

Afrocentric Model

There was strong support for the assertion that the Afrocentric Model is a critical element in the effectiveness of this linkage. Incorporating the Afrocentric Model demonstrated the highest number relationships with the other survey questions, while also receiving a moderately strong self-assessment score from the respondents. Survey and interview respondents illustrated how treatment practitioners can learn to understand African Americans' background, including elements of family, community, and religious practices, by recognizing subtle differences and encouraging open conversation. Practitioners' maintenance of this lens allows them to know their clients' current context, prioritize services, and collaboratively develop treatment plans. Some practitioners pointed to the importance of consulting with African American coworkers to gain insight on cultural practices. It is critical not to oversimplify groups of people based on visible characteristics. Identifying people by race alone ignores individual lived experiences stemming from socioeconomic circumstances, sexual orientation, and the many other factors that impact the identity of an individual (Haas & Abdou, 2018).

Disconnect Between Cultural Humility and Competence

Although practitioners repeatedly cited cultural humility as a necessary trait and self-assessed their cultural humility at a high level, they shared a mixed collection of detail regarding the nature of their self-evaluation practices. Just under 40% of the surveys shared very strong levels of detail in their responses. Several best-practice examples were provided that serve as a template for future content, including the use of tools like the DLA-20 functional assessment. However, there were several interview participants who recognized their lack of understanding of cultural humility, and more than half of the surveys did not provide strong or detailed descriptions of their own reflective practices. Furthermore, practitioners assessed their cultural awareness at a higher

level than they assessed the reflection activity needed to gain that awareness. This might contribute to an inflated self-awareness of personal bias and power dynamics. Feedback mechanisms such as PIPs and listening sessions, which include anonymous feedback from clients, staff, and colleagues, were cited as valuable tools for increasing awareness.

Cultural Competence Application

The disconnect between perceived awareness and cultural humility and competency practices impacts downstream cultural competence application. Practitioners assessed their awareness of their potential biases higher than their confidence in their knowledge of culturally competent care. The survey score of confidence in their knowledge of culturally competent care was one of the lower ratings noted, and practitioners cited others' lack of cultural competence as often as they cited detailed explanations of their own strong competence. The level of detail they provided regarding their own cultural humility and competence practices was lower than the level of detail they provided regarding their reflection and awareness practices. This indicates that they lacked a complete grasp of the subject, particularly of behaviors needed for cultural humility, either through lack of practice or lack of fluency.

Project Question #2 Findings

In what ways might/can cultural competence and culture humility enhance the leadership development training offered by the African American Behavioral Health Center of Excellence at Morehouse School of Medicine?

To maintain a focus on the effectiveness of the leadership development training, the data collection and findings will incorporate Kirkpatrick's Model and potential for transformational learning, as documented in the project's conceptual framework.

Development Program Reaction and Learning Sentiment

There was significant positive sentiment in responses to questions regarding their reactions and learning during the development program, which are Levels I and II in the Kirkpatrick Model. One hundred percent of the interview participants conveyed positive reactions to the program, with the highest concentrations conveyed through three sentiments:

1. Overall impressions of effectiveness: Participants found the experience informative and found that it validated issues they already knew. The evidence-based information was noted and well received by the participants.
2. Feeling that the program assisted their development or performance: This included an appreciation of peer comradery and opportunities for open and honest dialogue about behavioral health disparities.
3. Practical and theoretical knowledge was shared and understood: They cited increased awareness of cultural humility and competence and reported that they had learned the distinctions between the two concepts. Although these concepts have become trendy, many in the field do not know what they represent. There was a boost in academic prowess among the participants.

Barriers to Applying Behavior

Safe environments are critical, both to learning in a professional development program and to being able to apply the new behaviors in the workplace (Kirkpatrick Model Level III). Participants perceived the development program environment as open, inclusive, and supportive. They experienced a sense of connection among the participants and noted that the program facilitated shared understanding and peer support. Participants also noted that the presence of safety in a workplace environment could act as a catalyst for cultural humility and competency,

and that the absence of safety in that environment could serve as a barrier to those qualities and skill sets. Leadership buy-in appeared to be a significant driver of the safe environment, given participants' reactions to their perceptions of support and lack thereof at their workplaces. Once participants returned to their work environments and prepared to apply their new behaviors, there appeared to be a dilution of their reactions to the leadership program and the impact of the learning opportunities they found there.

Transformational Learning Potential

Despite this potential dilution of participant reactions, more than half of the responding participants noted personal shifts in perspective, indicating potential for transformational learning in addition to knowledge conveyance and skill building. Participants indicated that the program had fostered in them a process of personal reflection that had changed their attitudes and mindset. The training encouraged self-assessment, which leads to improved care for others. Increased awareness causes one to unlearn old behaviors and learn new behaviors. An awareness of these kinds of shifts often facilitates long-term personal change.

Improvement Recommendations for Leadership Programs

The interview participants recognized that learning and practicing the tools of cultural competence and cultural humility is essential to effective leadership. These insights left them enthusiastic about offering suggestions about ways to enhance the program so that cultural humility and competence skill building would be even more effective as the program evolved. Participants shared many ideas for improving future programs.

The first category of ideas was related to program content. Although they did not offer specific ideas for interactivity, participants stated that they desired more interactive experiences in

which participants would engage personally with the content, to maximize the potential for the kinds of shifts in perspective that they had experienced. Recognizing the historical context that created and still permeates the African American experience, a desire exists for greater historical and current context setting, to address the historical and current macro-environment and enable solutions that address the roots of these challenges. Discussing racism and the ways in which it affects clients and service delivery is important in Black communities.

The second category of improvement suggestions pertained to resources. Participants recommended providing ongoing support after the program ends, including recurring communication of trends, new research, and knowledge-retrieval practices. Recognizing differences in learning preferences, respondents suggested providing support in multiple modes. An example might be offering live and asynchronous visual and auditory information sources.

There was also a call for raising the expectations of future participants' roles in driving change. Encouraging peers and leaders to be role models for cultural humility and competency would reinforce the requirement that participants master cultural humility and competence in their own attitudes, words, and behaviors. It would also lead to potential new content areas, such as ways of influencing without authority. Practitioners have to work on themselves if they are going to be able to support others who want to do this work.

Recommendations

The following recommendations flow from the findings. They are organized into recommendations for the AABH CoE organization recommendations specifically tailored for the leadership development program. Recommendations for AABH CoE organization are focused on design issues such as culture, systems, market positioning, and messaging. Recommendations for

the leadership program itself include tactical organizational behavior suggestions for training content and delivery.

Recommendations for AABH CoE:

1. Afrocentric Model Integration: The findings suggest the need to embed an African American cultural humility and competency model into organizational and systemic strategic plans, policies, and design of all learning, marketing, and communications programs. The literature says that the integration of a care model most suitable to the needs and experiences of the clients being served helps increase practitioners' capacity to deliver coordinated care to the client population (Mancini, 2020). It is therefore recommended that behavioral health organizations and systems utilize the Adapted Star Not-for-profit Model (see Appendix G) or similar tools to ensure holistic organizational adoption.
2. Thought Leadership: It is recommended that AABH CoE periodically update and integrate tools such as the DLA-20 functional assessment into their curricula, to ensure that they remain at the forefront of emerging practices. According to Rosenburg (2017), such systems serve as qualified means of measurement "which are essential to achieve valid and reliable outcomes" (p. 520). Therefore, an effort such as digitally publishing and distributing a best practice primer would allow an organization or a system to provide a resource that partners could use to reinforce their position as thought leaders.
3. Safe Environments: The promotion of safe, open, and inclusive environments in organizational settings would help organizations and systems create the climate necessary for cultural humility and competence. Hook et al. (2017) posit that the more culturally knowledgeable practitioners are or become, the more effective they are at providing care, and the more attuned they are to understanding and addressing patients' needs. Moreover,

psychological safety plays a key role in achieving what Zacher (2014) refers to as "safer [patient] care" (p. 16) and thus safer treatment environments. At its core, this concept emphasizes collaborative practices that honor the innate human need to belong and interact. Hunt et al. (2021) recommend that practitioners strive to remove barriers and other factors that would otherwise discourage clients from feeling comfortable enough to speak freely for fear of interpersonal risk, out of concern that they will not be treated fairly, or for fear that their experiences are irrelevant. Eliminating these factors would support the objective of providing safe, open, and inclusive environments. One opportunity to achieve this would be for AABH CoE to create a climate assessment that can be used as a diagnostic tool for identifying strengths to leverage and opportunities to develop.

4. Marketing Partnership: Based on the findings, it is recommended that the AABH CoE initiate marketing partnerships with best-in-class and complementary organizations, to extend the reach of each organization and the impact of their growth initiatives. According to McNeish et al. (2019), partnerships and other types of community involvement "provide researchers and practitioners with culturally relevant information to make interventions successful" (p. 112), thereby making this an effective strategy for enhancing care outcomes. It is recommended that both national organizations such as the AABH CoE and individual behavioral health organizations and systems consider engaging with trade associations such as the Society for Healthcare Strategy and Market Development or healthcare marketing agencies such as 9Rooftops Health, based in Atlanta.

Leadership Development Program:

5. Contextual Curriculum: Research findings support the recommendation for the AABH CoE to include in its Leadership Development training curriculum modules that delve into

the historical context and deep-rooted issues of the African American experience. This can be done by facilitating sessions that address racism and its impacts on both client well-being and service delivery in African American communities. Because racism remains a continuing stressor in the lives of non-White behavioral patients (Sue, 2002), the likelihood of eliminating disparities in care increases when practitioners are knowledgeable of the pressing necessities that the lived experience of African Americans have engendered (Minsky-Kelly & Hornung, 2022).

6. Interactive Learning Methods: Another recommendation includes the introduction of more interactive and hands-on methods for interventions and care. This may include sessions on self-reflection and embracing new culturally competent behaviors. This would require and enable practitioners to clearly define cultural humility and competence practices in action, to facilitate the kinds of shifts in perspective that, according to Sue (2002), would improve both the adequacy and the appropriateness of the behavioral health care received by African Americans.
7. Ongoing Support: The findings suggest that the organization's leadership development program would benefit from post-training support that provides updated content, research findings, coaching, and other tools. The recommended support tools should be available in multiple formats (e.g., live sessions, recorded modules, written materials), to cater to different learning preferences, encompass many factors and skills (Leviton, 2006), and be geared toward priming organizations for change and transformation (Byrne $ Res, 2019).
8. Culture Champions: Another suitable recommendation involves encouraging past participants of the leadership training to act as role models, championing cultural humility and competency. Law (2013) notes that this dimension of cultural competence helps

increase awareness, appreciation, and respect within the organizational environment in which the competence component exists. It will be important to support this encouragement through modules on influencing without authority, emphasizing the importance of personal growth in aiding others especially when the participants are not the most senior leaders in their organizations.

Reliability and Validity

The triangulation of the quantitative and qualitative responses across all data sources aids in ascertaining the reliability of responses. Validity is guided by the alignment of the questions with the conceptual framework informed by the literature review. There are also considerations related to reliability and validity. The data participant selection is based on voluntary opt-in judgmental sampling and may not be representative of behavioral health practitioners as a whole, or of all leadership development program participants. Due to the receipt of only 11 survey responses, there are limits to the value of statistical interpretation of the results. A low survey response size does not necessarily warrant the dismissal of a project's findings (Meterko et al., 2015). A primary issue of low response rates is non-response bias, e.g., an assumption that the experiences of non-respondents would differ meaningfully from those of the respondents. A common practice for addressing low response rates would be an analysis of non-response bias (Ford & Bammer, 2009; Meterko et al., 2015). While a detailed analysis of non-respondents was not performed, the diversity of the survey respondents and the triangulation of the data among all data sources gave credence to the findings' reliability. In total 35 data sources were collected which is deemed sufficient for the findings noted in this report. It is noted that, despite the fact that respondents and participants were informed of the confidentiality of their responses, participants may respond with recency bias or perceived desired responses to the AABH CoE or the project

team. This is more relevant for Project Question #2 interviews as, despite informed confidentiality, the interviews were recorded.

Please note that this project is not generalizable across other settings due to the scope of the actual data collection.

Limitations

While the findings and recommendations contained in this report are substantive and relevant, there were limitations to our project that inhibited the ability to go even further with possible detail and insight. The following limitations should be considered by other researchers who may attempt to find application to these findings in other settings.

1. **Scheduling Impact**: Our client had a very tight and demanding schedule, which made coordinating these efforts extremely difficult. We were challenged with balancing the needs of the client organization, the needs of the program, multiple demanding travel schedules, and our course deliverables.
2. **Survey Response Rate and Sample Size**: Both the timelines and the client schedule significantly impacted our survey response rate. The client is a project of an academic institution, so the timeline and launch of our survey left many potential respondents unavailable or competing with other more urgent priorities.
3. **Delays in Data Due to Client Responses**: An additional barrier to participant responses stemmed from client delays in responses to our requests for information and distribution and for potential incentives to encourage increased response rates. Many of the limitations lay outside of our sphere of control, and we endeavored to balance these challenges with grace and appreciation for the client's support for the project and desire to have the results of our assessment.

4. **Practitioner Self-assessment vs. Client Data**: It is noted that the data collected were practitioner self-assessment data and were not corroborated through client survey or interview data. It is possible that the findings and recommendations might have been altered if we had incorporated a direct voice from a cadre of clients.

Part VIII: Conclusion

Question 1:

In what ways do cultural competence and cultural humility influence how African Americans receive behavioral healthcare in the SE Region within the African American Behavioral Health Center of Excellence at Morehouse School of Medicine provider network?

Cultural competence and humility can significantly influence behavioral health service delivery to African Americans within the AABH CoE Network. While providers recognize the importance of these concepts, macro environmental and structural barriers hinder their full implementation. The Afrocentric Model emerged as critical for understanding African Americans' backgrounds and enabling enhanced treatment. However, a disconnect between providers' perceived cultural awareness and actual practice suggests a need for enhanced training on the reflection practices needed for cultural humility and cultural competence to be present.

Question 2:

In what ways can cultural competence and culture humility enhance the leadership development training offered by the African American Behavioral Health Center of Excellence at Morehouse School of Medicine?

Incorporating cultural competence and humility enhances the leadership development training offered by the AABH CoE. Participants reported positive reactions to and learning from the piloted leadership training. However, behavior application faces challenges when participants return to work environments lacking supportive climates and leadership. To strengthen the program's effectiveness, participants recommended more interactive content focused on African Americans' historical and current contexts, ongoing post-program support through diverse learning resources, and raising expectations for participants to drive change and model cultural humility and competence.

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APPENDICES

Appendix A: Proposed Survey Recruitment Email

Colleagues,

I would like to invite you to take part in our process improvement plan being conducted by two Vanderbilt doctoral students. The attached survey is a part of their data collection. Their project will examine the effects of cultural sensitivity and humility on providing behavioral health to the Southeast Region's African Americans. The problem of practice will concentrate mainly on the provider network for the African American Behavioral Health Network of Excellence at Morehouse School of Medicine. Investigating how cultural influences affect the experiences of African Americans seeking behavioral health services and the results and outcomes of those services within the SE provider network is the overarching goal of our practice study.

The project will also look at the possible advantages and improvements that cultural humility and competence can make to the leadership training programs provided by the African American Behavioral Health Network of Excellence. We hope to clarify the importance of cultural sensitivity and understanding in achieving equitable and successful behavioral health for African Americans by responding to the two important issues above. We appreciate your participation in this significant research project since your perspectives and experiences will help us better grasp these pressing concerns.

Appendix B: Proposed Interview Participant Email

Good day Leadership Fellows,

I'm writing to solicit your assistance in a brief research Project. I am currently working with two doctoral students from Vanderbilt to assess the effectiveness of our leadership program. In an effort to collect data and to gain insights from you. The doctoral students would like you to invest approximately 30 minutes of your time for interviews. The interview will be recorded but the data will be kept confidential by the interviewers.

I would ask for your cooperation in this important matter to improve the quality of our service delivery of Leadership Development Programs at the CoE. Please feel free to contact me should you have any questions. Please be on the lookout for an email from Le'Angela Ingram to schedule the interviews next week.

Appendix C: Survey Preamble

The following will precede the survey once participants click on the link embedded in the recruitment email.

Dear Survey Participant,

Before we begin, it is important you know that there are definitions and information that will assist you in your responses.

The project's focus is related to cultural competence and humility. Cultural competency involves holistically knowing the client's background, understanding what gaps may exist between the client and provider's background, and ensuring the experience is comfortable and thorough using cross-cultural skills. The related concept of cultural humility represents a commitment to self-reflection regarding power dynamics and client-focused care. This reflection entails openness to engagement with clients, colleagues, and the communities.

In the survey, we employ a mix of a five-point scale and open-ended questions to capture your responses. For each five-point scale statement, you will select from the options: "1 - Strongly Disagree", "2 - Disagree", "3 - Neither Agree nor Disagree", "4 - Agree", and "5 - Strongly Agree". Option 3 can be utilized if a question does not apply. For open-ended responses, please include relevant specific examples and storytelling which provide the appropriate contextual data.

Your responses will remain confidential and be utilized solely for this project. Thank you for your time and invaluable participation.

Appendix D: Second Survey Recruitment Email

Hi Colleagues,

I would like to kindly request you to disseminate this email to providers in your network to take part in our process improvement project being conducted by two Vanderbilt doctoral students. This project will examine the effects of cultural sensitivity and humility on providing behavioral health services to African Americans. Investigating how cultural influences affect the experiences and results of African Americans seeking behavioral health services is the goal of our process improvement plan.

Please click HERE to participate in this survey by Monday, July 31 at 5pm.

The project will also look at the possible advantages and improvements that cultural humility and competence can make to the leadership training programs and other organizational resources provided by the African American Behavioral Health Center of Excellence. We hope to clarify the importance of cultural sensitivity and understanding in achieving equitable and successful behavioral health for African Americans by responding to the two important issues above. We appreciate your participation in this significant project, your perspectives and experiences will help us better grasp these pressing concerns.

Thank you,

Dawn

Dawn Tyus, PhD, LPC, MAC, NCC

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Appendix E: Survey Open-ended Responses Code Book

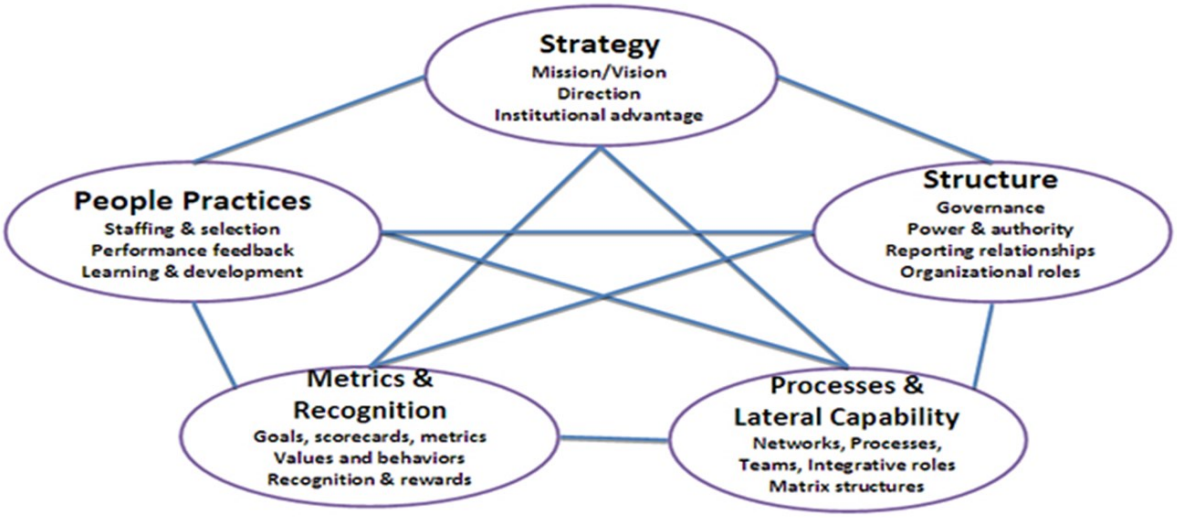
Question	Code	Code Definition	Representative Example	Frequency	Percentage
Q9 Link					
	Personal Responsibility	Characterized by references to individual accountability including personal commitment to understanding and respecting cultural differences, continuous learning and self-improvement in cultural competence.	"it is vital that not only I bring a high level of cultural competency to the work I do but also provide education to staff and catchment area through a culturally competent lense."	3	33.3
	No link	Characterized by references to a lack of perceived impact, personal observation or connection between cultural competence practices and the effectiveness of their service provision.	"By my experience, I do not see the impact of culturally competent practices by providers or leadership. Many leaders and providers show little to no impact or data in supporting African American."	2	22.2
	Outcomes	References to the positive results that African American clients experience due to culturally competent services.	"In the past it has not been good but under our new ceo I'm seeing progress"	2	22.2
	Policy	Participants seek policy solutions to guide linkage	"clinic policies that differentially impact low-income people of color, eg no-show policies"	2	22.2
	TOTAL			9	100.0
Q10 CH				**Segments**	**Percentage**
	Results	Focus on the outcomes of their treatment practices including progress or improvements seen in clients.	"The effectiveness of treatment practices is measured by my client's progress during treatment. When my clients are engaged and transparent during sessions, that's an indication that they feel valued and understood as a person."	1	12.5
	Moderate	Refers to narratives provided by the respondents that give general overview regarding their self-evaluation process including a thorough description of their strategies and techniques.	"Consult, specifically with African American co-workers who will give you honest feedback on cultural practices"	2	25.0
	Very Strong	Refers to very comprehensive narratives provided by the respondents regarding their self-evaluation process including a thorough description of their strategies and techniques.	"Self-evaluations are performed with successful treatment of individuals of minority status. Successful treatment is measured through various assessments including DLA-20. It is vital to create effective treatment plans that are individualized and culturally competent."	3	37.5
	Weak	Refers to minimal detail provided by the respondents regarding their self-evaluation process including a thorough description of their strategies and techniques.	"check in with patients regularly; engage in training to maximize awareness"	2	25.0
	TOTAL			8	100.0
Q11 CC				**Segments**	**Percentage**
	Moderate	Refers to narratives provided by the respondents that give general overview regarding their self-evaluation process including a thorough description of their strategies and techniques.	"incorporating importance of family, community, individual's spiritual practice"	4	50.0
	Strong	Refers to clear narratives provided by the respondents regarding their self-evaluation process including a thorough description of their strategies and techniques.	"We need to continue to individualize treatment approaches to remain culturally competent in the services we provide. It is through individualized care based on the person being served, ensuring their culture and norms are respected and brought into treatment that we provide competent care."	2	25.0
	Others	Refers to narratives provided by the respondents regarding their evaluation of others not of themselves.	"Most behavioral health providers are culturally Pre-competent, Unaware, or Cultural blind to the community they serve. Most providers and leaders are not connected to neighborhoods, coalitions, various groups and are not seeking to correct the issue."	2	25.0
	TOTAL			8	100.0
Q12 Development				**Segments**	**Percentage**
	Advocacy	Recommendations by respondents to incorporate teaching and promotion of advocacy for African American clients into leadership or provider development training.	"Take a proactive stance on the advancement of cultural competence and culturally congruent practices, training, education, connections, supports for the African Americans community."	3	33.3
	Support	Recommendations by respondents to modify or enhance the support provided to providers.	"Continue to Provide National mentoring program and paid stipends."	4	44.4
	History and Systems	Recommendations to incorporate a robust understanding of historical and systemic factors that impact African American communitie including systemic racism, socio-economic factors, and historical events that has shaped the African American experience.	"the historical development of systemic structural bias and ways that plays out daily for people with privilege and those with less; tools for ongoing self-awareness of bias"	2	22.2
	TOTAL			9	100.0
Q13 Link				**Segments**	**Percentage**
	Macro Environment	Refers to broad, systemic, or strategic suggestions for addressing or overcoming barriers including policy changes, organizational shifts, community-level interventions.	"A lack of understanding of social and environmental factors that contribute to mental health issues within the African American community. We must display a willingness to gain and an awareness and understanding about social and environmental factors that African Americans face. Also, we must gain an awareness and understanding of cultural diversity. We need to listen to understand the challenges that African Americans face within their community. We need to hear directly from African Americans, their thoughts, feelings, concerns, not other groups of people, but from them."	5	62.5
	Self Awareness	Recognition of the importance of understanding their own biases and areas of improvement.	"The largest barrier I see is providers not recognizing the need for cultural competency; they don't see what they don't see. The more we talk about it and ask those questions in professional settings - how does the clients cultural background affect their current issue; how can we encourage more of the community to seek mental health services?"	3	37.5
	TOTAL			8	100.0

Appendix F: Interview Code Book

Question / Code	Code Definition	Representative Example	Frequency	Percentage	Total
Q3 - Behavior			24		
Q3 - Behavior > Buy In	Perception of support (or lack thereof) from their leaders or their organization towards the implementation of the learnings from the training program.	"the potential barrier will be human beings not being willing to unlearn and learn new things. that that's the whole purpose of the constant education. It's like we will have to learn somehow and people will have to be willing to learn, like, you know, and, and we wanna get people's buy-in. We don't wanna say we are shoving something down anybody's throat,"	5	21%	8%
Q3 - Behavior > Implementation	Application of the knowledge or skills acquired during the training program to their workplace or daily tasks.	"Since the onsite training, I've already started the work to implement cultural competence and humility in my professional environments. One thing that I've done that was successful was adding diversity and inclusion based questions in my interview questionnaire when screening new hires at my organization"	2	8%	6%
Q3 - Behavior > Macro Environment	External factors influencing participants' ability to apply the training program including political, legal, or other socio-cultural matters.	"I forsee barriers from a more macro perspective from like a political standpoint. I think they can be addressed from a more creative solution. For example with the supreme courts ruling on affrimative action (and a little before) I've seen DEI lose some of it's steam and there be less of a focus on this."	2	8%	2%
Q3 - Behavior > Open-minded	Participants' willingness to consider new ideas introduced during the training program including change readiness for themselves or others in organization.	"people have to do their own work. If you're working in this field, you have to do your own work in order to be able to support other people doing their work."	2	8%	10%
Q3 - Behavior > Safe Space	Participant references to feeling comfortable to apply the new skills or express their opinion including comments about the support in the workplace.	"people may not be receptive to my suggestions. If that occurs, in will continue to try my best by educating and increasing awareness."	3	13%	
Q3 - Behavior > Understanding	Explicit or implicit references regarding comprehension of concepts during the program.	"The terms cultural humilit and cultural competency. I, in my opinion, I feel have become buzzwords in 2023. So everyone is using these words, but there's actually a lack of understanding around these concepts and these principles. and there's so much academic literature, but at the, at the end of the day, it's still not widely understood, or even practiced."	4	17%	6%
Q3 - Behavior > White Paper Quote	Story telling or particularly insightful comment that may be used as a longer quotation in white paper		3	13%	
Q4 - Recommendations			7		
Q4 - Recommendations > Content	Feedback related to the information provided during the training program.	"incorporating interactive and experiential learning activities that allow leaders to directly engage with diverse perspectives and experiences can help overcome any initial resistance or skepticism."	3	43%	
Q4 - Recommendations > Resources	Feedback related to the materials provided during the training program.	"Continue to provide training and development opportunities that focus on increasing cultural competency. This could include everything from existing webinars and online forums/ trainings, workshops and seminars."	2	29%	
Q4 - Recommendations > Role Model	Feedback related to the expectation of story telling provided during the training program.	"Continuing to encourage leaders to be role models for cultural competency. This could involve things like publicly sharing stories about their own personal experiences with cultural difference, being open to feedback about their own cultural competence, and leading by example in terms of promoting cultural understanding within the organization."	3	43%	
Q5 - Other			7		
Q5 - Other > Change	Feedback related to the change management involved personally or organizationally	"How do you work in that system to help kind of influence change? Um, and so that's like, if you're working with people who are just starting their career, I think the conversation about, okay, this is what it means to be culturally, uh, to display cultural humility is a good conversation to have. A lot of people don't have that conversation, but when you're working with people that have worked even a little bit, it's like, okay, you're in these systems. What do you do now in these systems and how can that work? it's just two levels of, of conversations."	1	14%	
Q5 - Other > Racism	Feedback related to addressing underlying race-related issues that impact cultural competency and cultural humility	"there can be an aspect of incorporating how has racism impacted that service delivery, but also how does that show up in individually like that internalized racism aspect."	1	14%	
Q5 - Other > Resources	Feedback related to the materials provided during the training program.	"I know one thing I would more putting out information in regard to cultural competence and cultural humility. I would say if not monthly, biweekly things, it just, it can even be just little snippets of things, little articles here and there, you know, just because we as a people, but then also people within this arena that we're in, I feel like we playing catch up, we have to play catch up."	2	29%	
Q5 - Other > Safe Space	Participant references to feeling comfortable to apply the new skills or express their opinion including comments about the support in the workplace.	"I think one of the things that have definitely helped me is even just having allies, you know, having a support at work, having people who've had similar experiences just to validate. even one of my colleagues was like, I'm white and they're very light on me. They don't criticize me as much, but with you, they jump on you. And I'm like, yes. You know, just having someone notice, you know, and say that like, okay, that's how I've been feeling."	4	57%	

Appendix G: Adapted Not-for-profit Model

Adapted Star Not-for-profit Model



Adapted from Jay R. Galbraith, *Designing Organizations: An Executive Briefing on Strategy, Structure, and Process* (San Francisco: Jossey-Bass, 1995)

About the Authors

Le'Angela Ingram | Founder, Instructor, and Performance Management Leader

Le'Angela Ingram is principal and owner of the Ingram Consulting Group. For more than two decades, Le'Angela has used her lens as a behavioral scientist to provide training, consulting and executive coaching services to clients across three continents. She has supported the development of global leaders with emotional intellection; diversity, equity, inclusion, and accessibility (DEIA); visioning, strategic planning; and change management within the public, private, and nonprofit sectors. She facilitates teams and small groups, thereby creating change agents for organizations and facilitating programs that have high ratings in content and efficacy. As a Washingtonian, Le'Angela has a passion for supporting public service leaders and leaders in academia. Le'Angela holds a Master of Science in Applied Behavioral Science from The Johns Hopkins University and a Bachelors in Business Administration from Howard University. A lifelong learner, she is finishing her doctorate degree at 65 years young.

The passion of Le'Angela's work has led her to create more than 50 leadership development Programs currently in use in Japan and Africa. Working with Morehouse School of Medicine's Center of Excellence on this project affirms her commitment to highlight excellence in the field and the need for ongoing work to create equity for people of color in the area of mental health. Her dedication is highlighted by the exceptional work of Dr. David Satcher the 16th Surgeon General of the United States in his landmark book, *My Quest for Health Equity*.

Michael Smith | Founder and Executive Coach & Consultant

Mike Smith is the founder of Huddle Advisory, a firm that guides leaders and teams to their "Leadership Athlete" potential. Mike founded Huddle after 25+ years in sports and entertainment working with the National Football League, NBC, and Deloitte. His unique background includes leadership roles in Human Resources, Finance, Technology, and Administration. Mike has been repeatedly tapped to lead the most important initiatives ranging from creating a coaching culture at the NFL to Super Bowl weather planning to NBC's acquisition of Universal.

Mike transitioned from Finance to Human Resources later in his career because he has a passion for engaging people to drive both business performance and personal growth. Having been both a CHRO and CFO, Mike has a special lens to align business and talent strategy. He guides leaders and teams through skilled inquiry, objective data analysis, and practical counsel. Mike's diversified background and servant leader mindset allows him to work effectively with public company CEO's, startup founders, and rising talent across consumer-facing and B2B industries.

Born and raised in Philadelphia, Mike received his undergraduate business degree from La Salle University and his MBA from Villanova University. He later completed Stanford University's Executive Program for Talent Leaders and Columbia University's Coaching Program. Mike is certified in several leadership assessment tools, including Emotional Intelligence, NBI Thinking Preferences, and DISC.

Author Dedications

Le'Angela Ingram |

"Let us embark on a collective journey to change the narrative of mental health for African Americans - from one of neglect and disparities to one of compassion, understanding, and equitable care." - Dr. David Satcher

Guided by Dr. David Satcher's wisdom and vision, let this white paper serve as a testament to our commitment to championing mental health equality for African Americans and all people of color, and to ensure that his legacy remains an enduring source of inspiration. Together, let us forge a brighter, healthier future for all individuals, transcending the barriers that have hindered progress and embracing a more equitable and inclusive society.

Finally, thank you for the love and support of my family and my executive assistant Jorie Gelnett for demonstrating patience, commitment, and guidance with scheduling activities in between the many demands of this program. I could not have made it without their collective support. I would be remiss if I didn't pay homage to my cohort members and my project partner Michael Smith. I can't say enough about what a true partner and friend I've found in Michael throughout the program. I'm looking forward to working with him in the consulting arena.

Michael Smith |

"The secret to success is good leadership, and good leadership is all about making the lives of your team members or workers better" - Tony Dungy

Pro Football Hall of Fame Coach Tony Dungy's quote resonated with me instantly when I heard it about a decade ago. Success = Leadership = Making Lives Better. It is a simple equation yet so challenging to do. I hope this project helps the AABH CoE create leaders who are all about making the lives better for African Americans dealing with behavioral health challenges.

While this project ends my official Vanderbilt studies, it's only the beginning of my responsibility. It's time to pay it forward to the next generation of leaders so they can maximize their potential and impact.

This program tests your resilience. I wouldn't have made it to the end zone without my cohort, who challenged and supported me daily. Le'Angela Ingram and I instantly bonded in my first class in January 2021. Unfortunately for her, she has three jobs in my life: mentor, coach, and friend. I am grateful we are ending this journey together as project partners. While many friends and family helped along the way, no one carried the burden like my wife, Deirdre, and sons, Colin and Owen. There were too many nights and weekends to count where plans revolved around classwork. I am forever grateful for their support and sacrifice.