Health Habitus Integration Training for High Fidelity Wraparound Teams

Under the auspices of the current grant, the Center for Research on Cultural and Structural Equity in Behavioral Health (CCASE) at the Nathan Kline Institute for Psychiatric Research developed and implemented the Cultural and Structural Competence (CSC) training for providers working with families with children and/or youth with serious emotional disturbances. Health Habitus Integration (HHI) is the primary component of the CSC training; it is designed to enhance understanding of the structural and cultural determinants of health and integration of this understanding into practice. The final form of this training aims to equip behavioral health providers with salient skills and tools to integrate their social and cultural determinants insights into their HFW skillset as they worked with families and youth, and with colleagues in their care teams. Below, we briefly (1) discuss the Theory of Health Lifestyle, revised by CCASE, (2) describe the CSC training components, (3) suggest the theory's suitability for providers trained in HFW, and (4) conclude with preliminary evaluation findings of the CSC training.

The Social Determinants of Health framework and the Health Lifestyle Theory

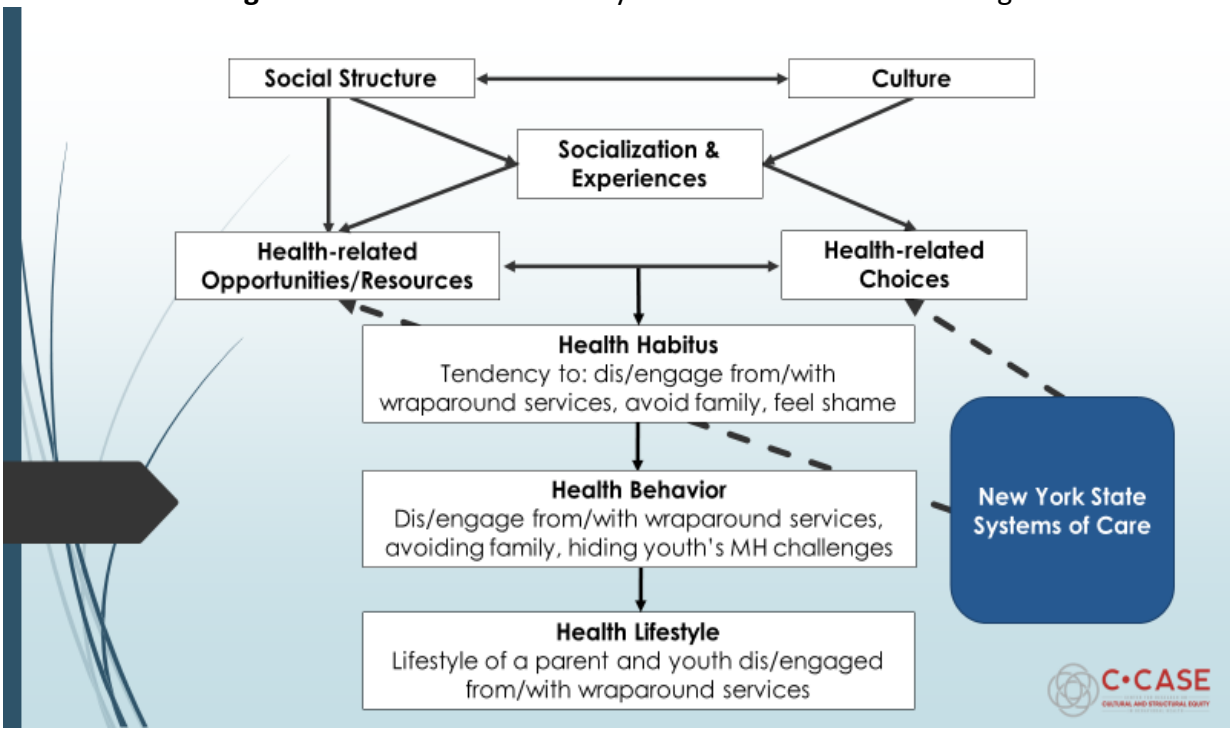
For more than two decades, public health practitioners and researchers have recognized the influence of social determinants on mental and physical health. Social factors such as race/ethnicity, social class, gender, age, and stigma or discrimination, are the building blocks of social structure and determine individuals' place in this structure. These social factors have been identified as distal fundamental causes of health and health disparities (Compton and Shim, 2015; Link and Phelan 1995; Phelan, Link and Tehranifar 2010; Hatzenbuehler, Phelan and Link,2013), which are conceptualized as affecting more proximal causes (e.g., access to medical care, adherence to treatment, adoption of certain health beliefs), and protecting or increasing health risk. Consequently, when interventions address only one causal pathway (e.g., locating a public mental health clinic in one's community), other pathways (e.g., race-related and/or substance use-related stigma deterring access to services in the community) continue to operate and produce disparities (Link and Phelan, 1995).

The framework of social determinants of health has been invaluable in revealing the social and structural patterns of health outcomes and disparities. However, in its application, social determinants have been conceptualized and measured as individuals' access to and use of resources (e.g., income, education, transportation). This approach prioritizes individual behavior and confines the social determinants to the individual level, thus losing sight of the social context (e.g., policy, community, healthcare institution; Freese and Lutfey, 2011). The concept of health habitus refers to the structurally determined tendencies of individuals when caring for their health (Bourdieu 1977, 1990),. This concept has been suggested as one way to bridge the social level with the individual level which, in turn, addresses the aforementioned limitation of the social determinants framework (Freese and Lutfey, 2011). Health habitus, and how it sponsors and reproduces health behavior that, over time, and with repetition becomes a health lifestyle, constitutes the core of the Theory of Health Lifestyle (Cockerham 2005, 2013). We revised this theory to emphasize the role of culture, stigma, and intersectionality.

The Revised Health Lifestyle Model anchors health habitus in the social structure *and* in culture. Health habitus, as indicated above, motivates health *behavior* that, over time and with repetition, becomes a health *lifestyle*. A key revision to the model was the integration of stigma and how it is generated through culture, and becomes a feature of health habitus through socialization and experiences. First, social determinants, such as race/ethnicity, class, gender, age, and geographic location (rural vs. urban) are defined as the building blocks of social structure. Second, these social determinants intersect and shape a variety of types of socialization and of experiences. The intersection of these determinants directly influences one's life opportunities/constraints. Third, culture (i.e., shared beliefs, values and norms) is assigned a primary role, and an interplay between culture and social structure is posited. This interplay, through socialization and experiences, also influences life opportunities/constraints, which in turn, inform a range of life choices. Health habitus is generated at the interplay between life choices and life opportunities/constraints.

Finally, the provision of the wraparound services under the NYS SOC expansion grant was included in the model. These enhanced services, guided by the ten principles of wraparound, are suggested to have the potential to expand the life opportunities and life choices for families and youth. For example, HFW increases the availability of formal and informal supports for the family, and strengthens families' feelings of competence in making their own health decisions and working on the goals they identify as important. These supports and activities can thus transform a family and youth's health habitus, behavior and lifestyle (**Figure 1**).

Figure 1. Revised Health Lifestyle Model used in CSC Training



Elements of the Cultural and Structural Competence (CSC) training

The Cultural and Structural Competence (CSC) training consists of two main components and is provided by expert facilitators with advanced degrees in the social sciences and/or public health. The 6.5-hour training session is conducted in-person and is followed by a one-hour webinar "booster" at 4 weeks to enhance trainees' skills.

The first part of the CSC training reviews CLAS standards with a focus on the domains of culture, health equity, and structure. This component is lecture-based and is designed to provide trainees with a shared language for discussing cultural and structural differences and health disparities. It also includes a discussion on using the term "cultural humility" instead of cultural competence," and highlights the differences between implicit and explicit bias. This component also lays the foundation for the second part of the CSC training, the Health Habitus Integration (HHI) training.

The second part of the CSC training, the Health Habitus Integration component, is theoretically driven and aims to provide Family and Youth Peer Advocates (henceforth called, Peer Support Service providers) with the skills and tools to integrate their insights regarding social and cultural determinants of health into their HFW skillset as they work with families and with colleagues such as care managers and supervisors. As such, it consists of both didactic lecture sections that pertain to the theoretical and methodological components of the training, and practice sections that include hands-on activities for experiential learning.

The HHI includes a didactic phase to refresh trainees' knowledge on the role of culture in services; an introduction to the Health Lifestyle Model and how health habitus can interfere with engagement in services; writing of one's own health habitus; a didactic phase on conducting an in-depth interview designed to elicit the family and the youth's health habitus, using the interview guide as a tool; a practice phase where trainees engage in health habitus interviewing and composing a health habitus note in small groups; and a discussion on potential strategies for integrating the health habitus information into the peer support service providers' one-on-one meetings with the family and youth, as well as into the care manager's meetings with peer support service provider The follow-up webinar focuses on discussing an example of a family's health habitus note and strategies for integrating the information in the note into the peer support providers ' work.

From August 2018 through the end of Year Three, seven CSC trainings were held in six NYS counties: one training each in Kings, Oneida, Onondaga, Rensselaer, and Westchester counties, and two trainings in Albany county; a total of 146 individuals have been trained.

Mixed Methods Evaluation of CSC Training

To evaluate CSC implementation and inform training refinement and follow-up activities, we used a mixed-methods approach, incorporating same-day and follow-up quantitative surveys and in-depth qualitative interviews. Data collection activities are ongoing, with the goal of collecting 200 same-day surveys, 75 follow-up surveys, and 40 qualitative interviews.

Data Collection Tools: Survey & In-Depth Interviews

Self-administered same-day evaluation surveys are given to all participants at the end of the in-person CSC training. The survey takes approximately 10 minutes to complete. It assesses health habitus-related knowledge and CSC training experience, including the perceived utility of health habitus, trainee self-efficacy, and opinions on how health habitus training concepts and tools can be incorporated into practice, as well as trainee demographic characteristics. To date, a total of 138 trainees have completed same-day surveys, for a response rate of 94.5%.

To assess CSC training efficacy and impact on practice, our team also conducts a follow-up assessment at least three months after training. This second assessment includes a survey to ascertain health habitus-related knowledge, attitudes, and practice since same-day CSC training, including intentions to maintain or begin using CSC training principles post-training (survey duration 10-15 minutes). The survey is administered either in-person on a laptop using the Audio Computer Assisted Self Interview program or online via an emailed link. To date, 49 trainees have completed the follow-up survey.

Follow-up qualitative interviews (duration 35-50 minutes) are also conducted at least three months after training, to contextualize the training assessment and begin identifying implementation experiences. These interviews collect information about trainees' experience during the training as well as their understanding of health habitus, its relevance to their work, and any personal or professional insights they might have gained through the training. The interview asks about trainees' experiences in applying the specific tools and resources provided in the CSC training, including identifying barriers and facilitating factors, and addresses whether and how the CSC training has been incorporated in practice, including reasons for not implementing the CSC training (interview duration 35-50 minutes). The interviews are conducted in-person and audio-recorded for verbatim content analysis. To date, 27 trainees have participated in an interview at one of three conferences (the Annual Conference of Families Together in New York State, in May 2019; the 2019 Wrapaganza Training and Implementation Conference, in August 2019; and the 16th Annual Central Region Fall Conference for Family Peer Advocates, in October 2019). Data analysis is underway and findings will be available in Year Four.

Analytic Plan

For the preliminary reporting included in this report, descriptive statistics were used to characterize the sample from the same-day assessment. We also provide descriptive statistics of trainee's same-day knowledge, attitudes, and perceptions to the CSC training. To quantify health habitus knowledge immediately after training, the percent correct of the seven knowledge questions from the same-day survey was computed. The perceived utility of CSC training components was measured by asking trainees how useful they found (1) writing their own health habitus, (2) practicing health habitus interviewing, (3) using the interview guide, and (4) writing a health habitus note as a group, very, fairly, or not useful. A utility score was computed for each trainee by assigning responses of "very useful" a value of "2", "fairly useful" a value of "1", and "not so much" a value "0"; scores ranged from 0 to 8, with higher values indicating greater perceived utility.

For the follow-up surveys, descriptive statistics describing the sample and their self-reported implementation of health habitus principles in HFW practice are provided.

Preliminary Findings

Demographics. Table 1 provides the distribution of trainee characteristics from same-day and follow-up evaluations. A total of 138 individuals completed same-day evaluations. Over half (62%) of the trainees were either Family (n=65, 48%) or Youth (n=19, 14%) Peer Support Service providers; the remaining trainees were care managers (n=27, 20%) and supervisors (n=25, 18%). Most trainees were White non-Hispanic (75%) and Female (91%). Trainees ranged in age between 19 and 72 years; those aged 19-29 years, and 50 years and older represented the modal age groups.

Table 1. Same-Day and Follow-Up Survey Respondent Demographics (n=138).

Measures	Same-Day	Follow-Up
All Respondents	138 (100%)	49 (100%)
Role		
Youth Peer Advocate	19 (14%)	15 (31%)
Family Peer Advocate	65 (48%)	24 (50%)
Care Manager	27 (20%)	3 (6%)
Supervisor	25 (18%)	6 (13%)
Race/ethnicity		
Black	25 (18%)	6 (13%)
Hispanic	9 (7%)	7 (15%)
White non-Hispanic	102 (75%)	34 (72%)
Gender		
Female	123 (91%)	40 (85%)
Male	12 (9%)	7 (15%)
Age		
19-29 years	36 (28%)	14 (32%)
30-39 years	30 (24%)	10 (23%)
40-49 years	25 (20%)	9 (20%)
50 years or more	36 (28%)	11 (25%)

Forty-nine individuals completed follow-up evaluations (**Table 2**). As with the same-day surveys, most individuals were Peer Support service providers (31% were Youth Peer Advocates, 50% Family Peer Advocates), White non-Hispanic (72%), Female (85%), and either aged 19-29 years (32%) or 50 years and older (25%). The mean time since training was 6 months (median 4 months).

Same-day knowledge. Table 2 provides descriptive statistics related to same-day knowledge. Overall, the mean same-day knowledge score for all trainees was 5.8 of a possible 7, or about 83%. By role, Youth and Family Peer Advocates had mean scores of 5.95 (85%) and 5.82 (83%), respectively, while care managers and supervisors had scores of 5.67 (81%) and 5.52 (78%), respectively. Trainees were highly accurate in their understanding that health habitus is shaped by the interaction between health choices and health-related opportunities and resources (98% correct) and that recognizing

biases is a component of practicing cultural and structural humility (98.5% correct), but only 63% of trainees responded that the health habitus qualitative interview is a purposeful guided conversation.

Table 2. Trainee knowledge assessment, perceived utility of Health Habitus Integration training, and intention to elicit client health habitus, from the same-day evaluation (n=138).

Measures	% Answered correctly or Answered Yes (n=138)
Knowledge assessment	
Health habitus is shaped by interaction between health choices and health-related opportunities and resources	131 (98%)
Being self-aware, recognizing one's own biases, and respecting different world views and experiences will help in the practice of cultural and structural humility	134 (98.5%)
The health habitus qualitative interview is a purposeful guided conversation	80 (63%)
Characteristics of an active listener	110 (83%)
The purpose of the health habitus note is to record information from the health habitus qualitative interview	124 (93%)
The purpose of health habitus note to integrate information into family encounters	111 (87%)
The purpose of health habitus note to help the family follow their care plan	99 (76%)
Perceived utility of CSC Training components	
Writing own health habitus	126 (94%)
Practicing health habitus interviewing	125 (96%)
Using Interview Guide	128 (97%)
Writing health habitus note as a group	114 (90%)
[*]**Do you plan to elicit a client's health habitus in the next 30 days?**	
Yes	88 (64%)
No	33 (24%)
If yes, when:	
At my next family visit	26 (30%)
When I meet with the youth alone	14 (16%)
When I meet with the family alone	33 (37.5%)
When accompanying a family member or youth to a provider appointment	2 (2%)
At some other time	13 (15%)
If no, reason (check all that apply):	
Families for HFW are not yet enrolled	16 (48.5%)
I feel I need more training in health habitus	12 (36%)
I feel I need more training in HFW	12 (36%)
I have families I work with, but need more time to schedule a visit	5 (15%)

[*]*missing=17*

Same-day perceived utility of and intention to elicit health habitus. Trainees reported high perceived utility of CSC training components. The mean utility score of the training components was 6.04 out of a possible 8. At least 90% of trainees reported that it was useful to write their own health habitus, practice the health habitus interview, use the interview guide, and write a health habitus note as a group. Of note, Youth Peer Support service providers s showed the highest perceived utility score (6.74), followed by Family Peer Support service providers (6.26), care managers (6.26), and supervisors (4.92). When trainees were asked if they planned to elicit a client's health habitus in the next 30 days after the training, 64% said that they would, but 24% reported that they would not; notably, 17 (12%) individuals skipped the question. Of those who responded in the affirmative, most planned to complete their client's health habitus in a family visit setting. Of the trainees who responded negatively, 48% noted that their families were not yet enrolled in HFW; 36% reported that they needed more training in health habitus; 36% reported needing more training in HFW; and 15% indicated that they have families to work with, but needed more time to schedule a visit.

Summary of preliminary data and next steps. To date, HH knowledge and interest in implementing HH is high among workforce participants. Many are continuing to find value in training components, particularly writing one's own health habitus. Follow-up was scheduled for summer and fall of 2020, however, due to the COVID-19 pandemic in NYS, these data may be delayed.

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