

Opening Case

Marcus arrives on time, but sits by the door.

33 years old. Released after six years. Referred for therapy and substance-use screening. Quiet. Brief. Skeptical. Says: "I already know how this goes."

The clinical problem begins before diagnosis.

Will the provider read guardedness as attitude, or as a survival strategy that must be understood before trust can grow?

Self-study prompt: watch your first conclusion.

The Dilemma: What do you do next?

Marcus reports poor sleep and alcohol/cannabis use after release. He wants to see his children but feels ashamed asking family for help. Probation wants attendance updates.

A Push for disclosure and warn him that noncompliance will be reported.

B Complete the intake, stay neutral, and avoid the deeper issues for now.

C **Explain role and limits, ask what would make this useful, assess substance-use function, map reentry barriers, and name one next step.**

Choose before you advance.

If you chose A: the room becomes another system

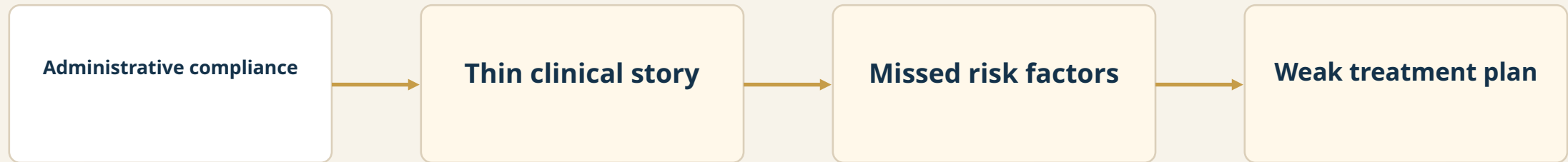
A Pushing for disclosure before trust may confirm Marcus's fear that treatment is surveillance with softer furniture.

- Threat response increases; useful clinical information decreases.
- Substance use function, shame, sleep, family support, and reentry barriers remain under-assessed.
- Documentation risks becoming label-heavy and clinically thin.



Teaching point: accountability does not require humiliation. Ethical care can be firm, clear, and dignity-preserving at the same time.

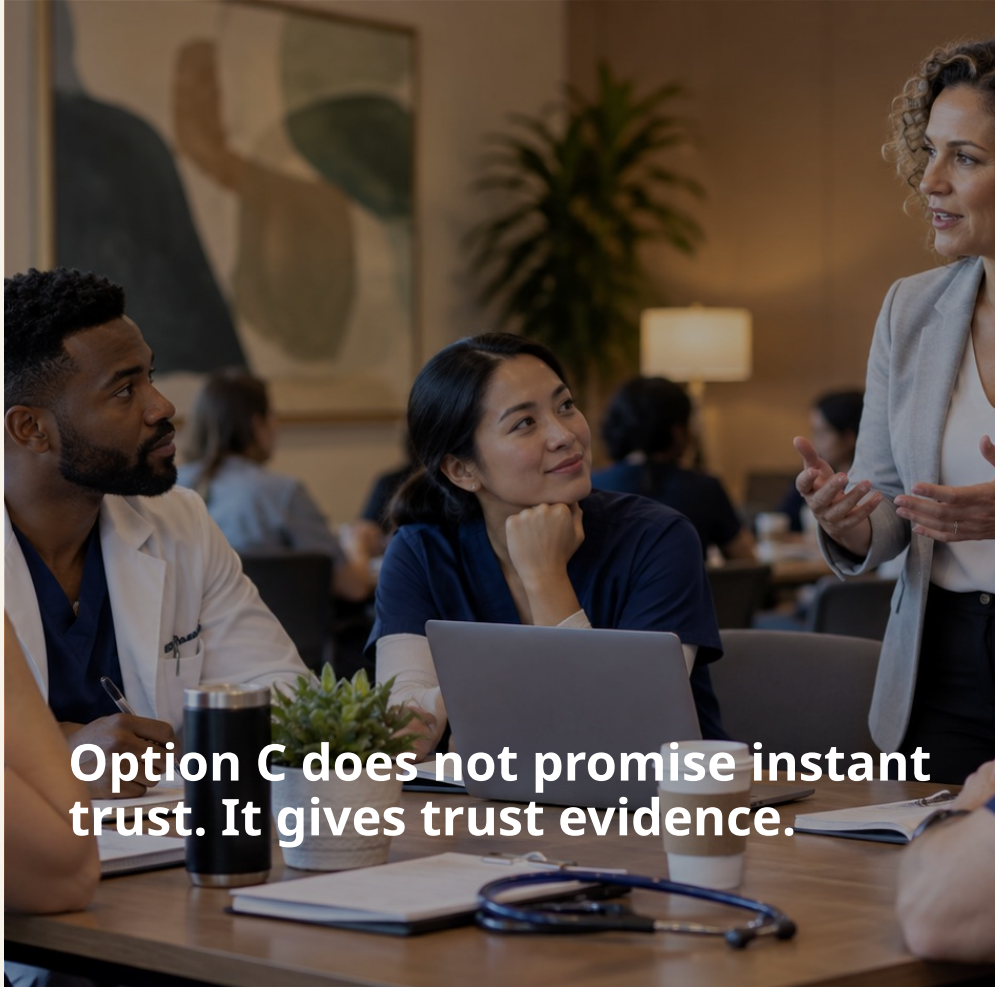
If you chose B: the file may be complete, but the formulation is not



Neutrality is better than disrespect, but neutrality can still miss the clinical truth. Paperwork is not engagement. Screening is not formulation. A referral mandate is not motivation.

Practice question: what did you learn that changes the plan?

If you chose C: you create conditions for useful accountability



Option C does not promise instant trust. It gives trust evidence.

Context

ask what shaped the behavior

Alliance

earn trust before disclosure

Recovery capital

build supports before relapse plan

Ethical advocacy

report facts within scope

Course promise: leave with tools, not slogans

This CEU is designed for therapists, substance use professionals, professional counselors, peer support staff, supervisors, case managers, and reentry providers.

Clinical accuracy

Move from labels to questions that produce better data.

Engagement skill

Use transparency, pacing, and culturally responsive language.

Documentation strength

Write notes that preserve dignity and risk clarity.

Reentry support

Link treatment to family reality, recovery capital, and stability.

The outcome is practice change: what the provider says, asks, documents, plans, and reports differently.

The research matters because it changes the room

Treatment gap

HHS reports Black/African American adults remain less likely than U.S. adults overall to receive mental health treatment.

Justice disparity

BJS reported the 2023 jail incarceration rate for Black U.S. residents was 3.6 times the rate for White residents.

Behavioral health burden

SAMHSA reports mental illness and substance use disorders are overrepresented in jails and prisons.

Practice mandate

APA guidance frames race and ethnocultural responsiveness as a lifelong practice obligation.

Research becomes practice only when it changes the next question.

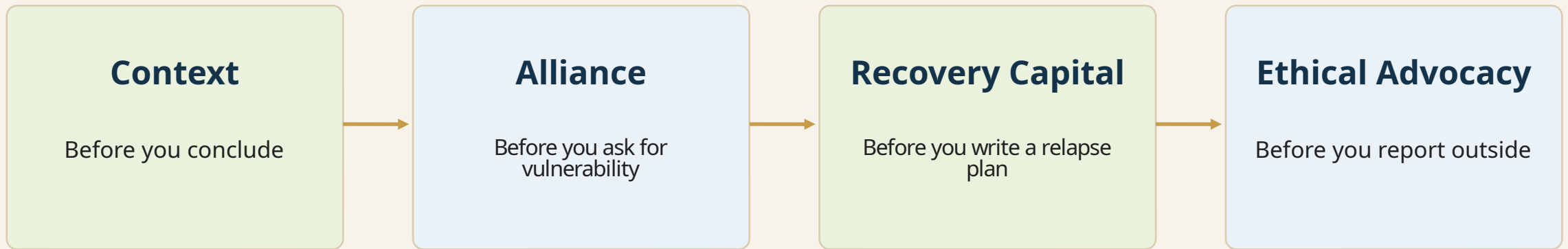
Original contribution: Keep the Family Close

Dr. Shipman's dissertation examined successful reintegration with positive family support among formerly incarcerated African American men in a major North Carolina city.

- Family support is not just logistics; it can rebuild identity and belonging.
- Shame, stigma, fear, and systemic barriers can disrupt help-seeking and reintegration.
- Programs should treat family and community support as clinical recovery capital, not an afterthought.



C.A.R.E. Framework: the clinical sequence



Use it during intake, supervision, progress notes, relapse prevention, court/probation communication, and discharge planning.

Race and masculinity: protection, pressure, possibility

Avoid both colorblindness and stereotyping.

Protection

Emotional control may have preserved safety, respect, or survival.

Pressure

Systems may punish vulnerability and reinforce silence, hypervigilance, or distrust.

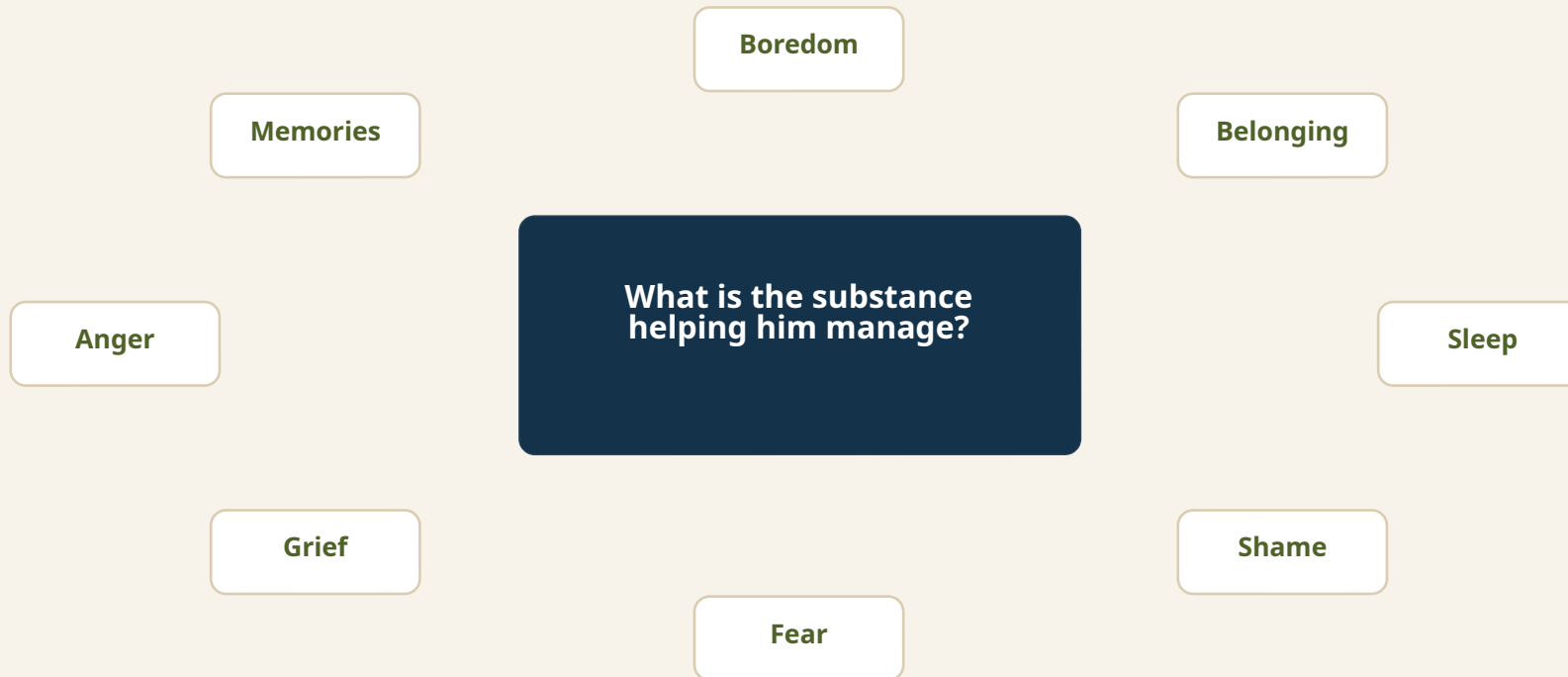
Possibility

Reframe help-seeking as strategy, fatherhood, health, legacy, freedom, and control of life.

Better question: What has this behavior helped him survive?

Substance use: ask what it does, not only what it is

A use pattern without function is an incomplete assessment.



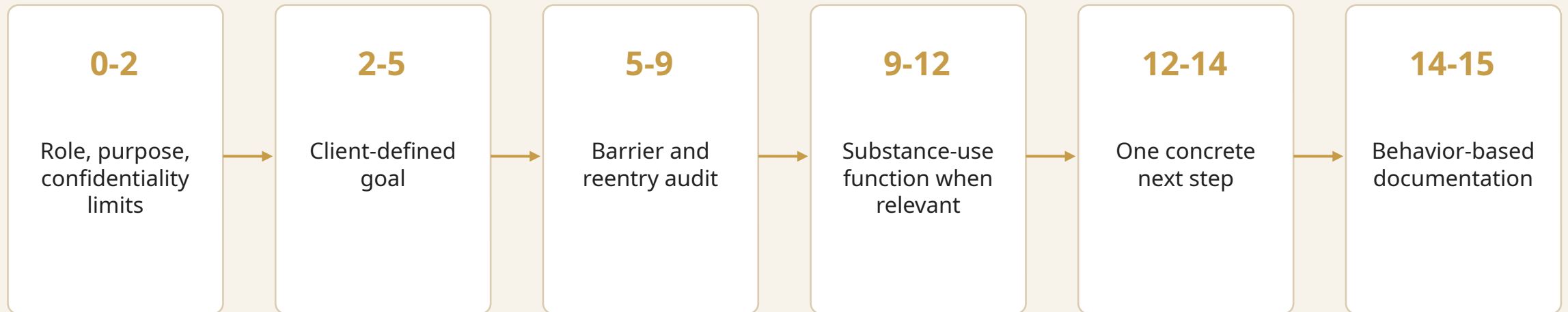
Assessment still includes amount, frequency, last use, cravings, withdrawal risk, overdose risk, consequences, legal impact, prior treatment, co-occurring symptoms, and recovery supports.

Reentry stability is clinical data



Missed sessions, relapse risk, irritability, shame, family conflict, and disengagement often make more sense after this map is completed.

The first 15 minutes: a trust-building sequence



This is the self-study rhythm too: every few pages, pause and apply the lesson to your own workplace.

Documentation: dignity and risk management together

Avoid	Use instead
Client is resistant.	Client expressed ambivalence and named concerns about trust and usefulness of services.
Client is hostile.	Client presented with elevated tone; clinician used grounding, validation, and redirection.
Client is noncompliant.	Client missed two sessions; barriers, outreach, legal implications, and next steps were documented.

If a label does not help the next provider know what to do, rewrite it.

Court and probation communication: useful without overstepping



Confirm release or legal authority.

Share minimum necessary information.

Use factual clinical language.

Avoid unsupported legal conclusions.

Document what was shared, with whom, why, and when.

Application Lab: three cases, one framework

Terrance

Missed sessions, mandated, dismissive. Start with barriers and motivation, not a noncompliance label.

James

Returned after 20 years; startle response, poor sleep, crowds. Assess incarceration trauma and sensory overwhelm.

Darnell

Late and guarded but keeps showing up. Treat attendance as a strength and build concrete goals first.

Learner task: name the likely barrier, choose the first sentence, write the documentation sentence, and identify whether supervision is needed.

Tools participants leave with

15-Minute C.A.R.E. Practice Card

Black Male Client Engagement Checklist

Cultural Humility and Bias Self-Audit

Culturally Responsive Assessment Prompts

Strength-Based Documentation Translation Chart

Reentry and Recovery Capital Worksheet

Treatment Goal Bank

Court/Probation Boundary Guide

The best CEU leaves a physical tool the provider can use tomorrow.

See the person. Understand the context. Use tools that support real change.

Culturally competent care is not a slogan. For Black men in the justice system, it must be clinically sound, culturally grounded, trauma-informed, substance-use responsive, reentry-aware, and ethically disciplined.

Accountability and healing can exist in the same room.

Selected research base and course sources

American Psychological Association. Race and Ethnicity Guidelines in Psychology.

Bureau of Justice Statistics. Jail Inmates in 2023; Prisoners in 2023.

HHS Office of Minority Health. Mental and Behavioral Health - Black/African Americans.

SAMHSA. TIP 59: Improving Cultural Competence.

SAMHSA. Criminal and Juvenile Justice and Behavioral Health resources.

SAMHSA / National Reentry Resource Center. Best Practices for Successful Reentry.

Shipman, K. L. (2025). Keep the Family Close: A Hermeneutic Phenomenological Study on Family Support and Successful Re-Entry. Liberty University.

Course materials should be used within scope of practice, agency policy, payer requirements, confidentiality rules, credentialing standards, and supervision/consultation processes.