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ABSTRACT

This monograph provides a tool to help providers and other substance abuse treatment professionals gain a greater understanding of the cultural, social, political, and economic forces affecting substance abuse treatment among Hispanic Americans, African Americans, Asian Americans/Pacific Islanders, and American Indians/Alaska Natives. An introduction discusses: the health and social consequences of substance abuse (HIV/AIDS and other infectious diseases, violence, and crime); culture, help-seeking behavior, and access to care issues (barriers to treatment, homosexuality, and rural areas); engagement and retention issues; cultural competence; universal cultural themes in the development of culturally competent treatment programs (family structure, cultural healing, and spiritual beliefs); and managed care and culturally competent substance abuse treatment. The next four sections focus on the four cultural groups, looking at: population composition and sociodemographic profile; migration experience; substance abuse epidemiological data; health and social consequences of substance abuse; culture, help-seeking behavior, and access to care issues; practices to meet treatment needs; conclusions and recommendations; information resources and references. (SM)

Cultural Issues in Substance Abuse Treatment

U.S DEPARTMENT OF HEALTH
AND HUMAN SERVICES
Public Health Service
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Services Adminstration

CSAT
Center for Substance
Abuse Treatment
SAMHSA

CULTURAL ISSUES IN SUBSTANCE ABUSE TREATMENT

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Public Health Service
Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Treatment

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Dear Colleague:

The Center for Substance Abuse Treatment (CSAT) of the Substance Abuse and Mental Health Services Administration is pleased to offer, *Cultural Issues in Substance Abuse Treatment*, which sheds light on the critical role that cultural perspective contributes to treatment efficacy. The monograph discusses cultural characteristics of four fast growing ethnic minority subpopulations in the United States. Because we know that substantial differences in patterns of substance abuse exist among ethnic groups, the manual provides a sociodemographic profile, substance abuse epidemiological data, health and social consequences of substance abuse, and access to care issues relevant to each.

It is the Center's hope that this monograph will contribute to the understanding of cultural factors related to substance abuse, and that readers will continue to seek and utilize information about the cultural values and factors that can provide strength and sustenance to ethnic minority groups and incorporate them into treatment interventions and program designs. It has been CSAT's experience that the best treatment programs are those that recognize the importance and acceptability of culture as a viable concept in directing programs and policies for ethnic minority clients.

We welcome your feedback on this and other CSAT publications, as CSAT's mission to "improve the lives of individuals and families affected by alcohol and drug abuse by ensuring access to clinically sound, cost-effective addiction treatment that reduces the health and social cost to our communities and the nation," is accomplished with your input and support.

H. Westley Clark, M.D., J.D., M.P.H., CAS, FASAM
Director
Center for Substance Abuse Treatment
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Services Administration

PREFACE

The Center for Substance Abuse Treatment is pleased to publish this monograph. The issues discussed in this volume strive to shed light on critical issues to consider in the delivery of culturally responsive substance abuse treatment programs. The information contained in this document adds to the existing body of knowledge that examines the unique roles that race, ethnicity, language, and other sociocultural factors play in the delivery of culturally appropriate services for special populations.

Specifically, this document is a guide to service providers that sounds the clarion for the provision of substance abuse treatment services that acknowledge the patient's cultural strengths, values, and experiences while encouraging behavioral and attitudinal change. The provision of culturally competent service systems start with an organizational, mission-oriented approach and are aided by documents such as this one. It is hoped that this information will enhance service providers' knowledge about specific cultural issues relevant to the provision of substance abuse treatment services.

The intent of this monograph is to provide a tool to help providers and other substance abuse treatment professionals gain a greater understanding of the cultural, social, political, and economic forces affecting substance abuse treatment among the targeted populations. We hope this new knowledge will foster a better understanding of the unique dynamics these groups face in the already difficult substance abuse treatment continuum.

This publication is a product of the collaboration of many contributors. Among the principal writers are: Dharma E. Cortés, Ph.D., Davis Ja, Ph.D., Abdin Noboa, Ph.D., Vincent Perry, Ph.D., Robert Robinson, Dr. P.H., Domingo Rodríguez, and Jerry Stubben, Ph.D.. The secondary writers are: Evalina Bestman, Ph.D., Barbara Carey, Debra Claymore, Kim Oanh Cook, M.S.W., Ho'Oipo DeCambra, Raymond Dddexter, Ed.D., Ford Kuramotos, D.S.W., Cirilo L. Madrid, M.Ed., Mari Ono, L.C.S.W., Cheryl Reese, M.H.S., Gloria Rodríguez, M.S.W., Suzi Rodríguez, M.A., Pamela J. Thurman, and Tamara Watson-Wade, M.Ed..

CSAT gratefully acknowledges the assistance of the members of the Cultural Competence Advisory Network (CCAN) in the completion of this publication. A list of the names of the members of CCAN, who are experienced substance abuse researchers and treatment providers, is provided at the end of this document.

CSAT acknowledges the hard work of Nancy Ramos-Sayre who served as a Project Officer for this publication, and who worked tirelessly to see that its important messages was heard.

Camille, T. Barry, R.N., Ph.D.
Deputy Director
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INTRODUCTION

What sets worlds in motion is the interplay of differences, their attractions and repulsions. Life is plurality, death is uniformity.... Every view of the world that becomes extinct, every culture that disappears, diminishes a possibility of life.
Octavio Paz, Nobel Laureate

This monograph presents some tools to help providers of health services, primary care givers, medical and other allied health students in the substance abuse treatment area to understand the cultural, social, political, and economic forces affecting substance abuse among Hispanic Americans, African Americans, Asian Americans/ Pacific Islanders, and American Indians/Alaska Natives. These four racial and ethnic groups not only make up about a quarter of the total population in the United States, but constitute the fastest growing segments of the population. As members of these racial and ethnic groups continue to grow, providers face the task of providing substance abuse treatment to members of these groups more frequently than ever. Thus, the need to understand the sociocultural factors affecting substance abuse patterns among members of racial and ethnic groups is crucial for the provision of adequate treatment. This monograph attempts to shed light on some of those issues.

African Americans constitute the largest group with 12.1 percent of the population, followed by Hispanic Americans with 11.1 percent, Asian Americans and Pacific Islanders with 3.6 percent, and American Indians/Alaska Natives with 0.7 percent (U.S. Bureau of the Census, 1998). It should be acknowledged at the outset that there is a great deal of variation within racial and ethnic groups, as well as between groups, and that there is a complex relationship between racial/ethnic group membership and socioeconomic status. All of the major ethnic groups are heterogeneous and their members came to the United States from diverse regions over a long period of time and for a variety of reasons.

Cultural competency means more than speaking the language and recognizing the cultural icons of a people. It means changing any prejudgements or biases one may have of a people's cultural beliefs and customs. It is rooted in respect, validation, and openness towards someone with different social and cultural perceptions and expectations than one's own. Culturally competent care is provided with an understanding of and respect for the patients' cultural values and beliefs. This is accomplished through the efforts of a staff trained to understand and respect the attitudes, beliefs, and behaviors of culturally, ethnically and racially different individuals. Thus, cultural competency should improve the efficacy of treatment by offering services anchored in a culturally appropriate context.

Members of some minority groups have limited access to health care and are often at increased risk of substance abuse and its associated problems. This is so for a number of reasons, among them, the migration experience, poverty, unemployment, and cultural differences between members of minority groups and the large society. Within the U.S. socioeconomic context, some members of minority groups have sought economic and personal self-empowerment through the drug economy. Unfortunately, illusions of material wealth often end tragically in addiction, imprisonment, or death, and further the deterioration of a community's most valuable resource, its human potential.

We have known for some time that substantial differences in patterns of substance abuse exist among ethnic groups. Overall rates of alcohol and other drug use are high among members of American Indian and Alaska Native groups (U.S. DHHS, 1998), although the rates vary by age and gender across and within tribes. American Indian youth have very high rates of drug use compared to their non-American Indian counterparts (Beauvais, 1996). They also tend to begin using alcohol, illicit substances, cigarettes, and inhalants at a younger age, at higher rates, and in combination with one another (U.S. Government Office of Technology Assessment, 1994). School drop-out is highly correlated with substance abuse problems. About half of American Indian youngsters have tried marijuana. Substance abuse among American Indians has deleterious social and health consequences. They die more frequently from suicide, homicide and alcohol-related injuries than members of any other racial or ethnic group. Cirrhosis of the liver and alcoholism account for more than a third of all American Indian deaths.

Drug use patterns vary significantly between subpopulations of Hispanic Americans (Amaro et al., 1990; Delgado, 1997). Puerto Ricans, for example, are two to three times more likely to have ever used cocaine than Mexican Americans and Cuban Americans (Booth, Castro, and Anglin, 1990). Also, Latino youths start drinking at a later age, and boys drink more than girls (Alcocer, 1993). These data indicate the importance of information that analyzes

drug use within minority sub-populations. Caetano (1990) points out that higher rates of substance abuse may be due to acculturation (i.e, the process whereby immigrants change their behavior, attitudes and values for those of the host society's culture), a stress-producing event for immigrant groups.

Substance abuse has also taken a toll in the lives of African Americans. Despite the fact that a significant number of African Americans fall into the category of abstainers, there is also a significant number who use and abuse drugs (National Institute on Alcohol Abuse and Alcoholism, 1994). Many substance abuse problems African Americans face have been attributed to socioeconomic difficulties, stress, and discrimination (Jacobs, 1993).

The Asian American and Pacific Islander population poses intellectual and pragmatic challenges to providers of substance abuse treatment. First, it is the fastest growing group in the United States. Second, the population is characterized by huge ethnic, cultural, and sociodemographic heterogeneity. Third, until recently, this population's substance abuse problems have not received close attention. Asian Americans and Pacific Islanders have been underrepresented in most surveys because they do not reside in the areas sampled. Although it is largely agreed that Asian Americans and Pacific Islanders tend to have fewer substance abuse-related problems than the other groups, these problems are on the rise, particularly among specific subgroups.

HEALTH AND SOCIAL CONSEQUENCES OF SUBSTANCE ABUSE

Substance Abuse, HIV/AIDS and Other Infectious Diseases

Substance abuse carries high risk for contracting HIV/AIDS through injection drug use (IDU) and through the increased risk-taking behaviors associated with drug abuse. Injection drug use is a more significant factor in the transmission of HIV among Blacks/African Americans and Hispanics than among Whites. About one-half of reported AIDS cases among adult and adolescent Blacks/African Americans and Hispanics have been attributed to injection drug use, either directly or through heterosexual contact with an injection drug user (CDC, 1997).

Some low socioeconomic status (SES) minority individuals may engage in high-risk behavior for economic reasons. Lack of education or vocational training and the resulting limited access to employment may lead some to turn to prostitution and drug-dealing to support their families. Personal economic constraints may also lead to needle-sharing, not only among injection drug users but also among those who share sewing needles for do-it-yourself tattoos or ear-piercing.

HIV infection is most prevalent in both men and women in their late twenties and early thirties. Where data have been analyzed by race, African Americans and Hispanic Americans generally have higher prevalence rates than Whites. However, survey results from drug treatment centers have shown that HIV seroprevalence in injection drug users varies greatly by geographic location, with the highest rates found on the East Coast.

More than 100,000 American women are now infected with HIV. Three-quarters of these women are from minority populations — mostly African American and Hispanic American. Half of all American women with AIDS are injection drug users, and one-fifth are sexual partners of injection drug users. Women who use alcohol, cocaine, and noninjecting drugs also have high risk for HIV infection. Associated with crack cocaine abuse, for instance, are other factors for HIV risk, such as high rates of sexual encounters, unsafe sexual practices, and prostitution. Sexually transmitted diseases are common among women substance abusers and are linked with HIV infection rates. Alcohol abuse, furthermore, adversely affects the immune system, which exacerbates the progression from HIV infection to full-blown AIDS (U.S. DHHS, 1993b).

In addition to being associated with HIV/AIDS, substance abuse (i.e., injection drug use and alcohol abuse) is also directly related to other diseases such as hepatitis and cirrhosis of the liver. Both diseases are highly prevalent among American Indians and Hispanics (CDC, 1996).

Substance Abuse, Violence, and Crime

Substance abuse is frequently accompanied by problems with the law. For example, it is estimated that 95 percent of Asians and Pacific Islanders in California prisons are serving time for drug-related crimes (Kuramoto, 1994). Black/African American women in California prisons account for 35 percent of all women serving time for drug-related crimes (Reed and Reed, 1997). African American males in prison make up about 50 percent of all convicted drug offenders (Carr, 1996). Between 1986 and 1991, the number of African American males serving time in prison more than quintupled (Miller, 1997). Hispanic males are also disproportionately represented within the criminal justice system. Their entrance into the prison system is largely due to drug-related crimes. Similar to other groups, a strong relation exists between violence and substance abuse among American Indians/Alaska Natives (Gutierres and Todd, 1997).

CULTURE, HELP-SEEKING BEHAVIOR, AND ACCESS TO CARE ISSUES

General Barriers to Treatment

The 1991-1993 National Household Survey on Drug Abuse revealed that the percentage of Blacks/African Americans aged 18 and older is second to American Indians/Alaska Natives in need of illicit drug abuse treatment, followed by Puerto Ricans, Mexicans, and Cubans. Racial and ethnic populations face a number of problems that may impede their access to treatment services. Individuals with substance abuse problems from racial/ethnic groups tend to underutilize health care, prenatal care, mental health care, or substance abuse treatment, or they seek them as a last resort. Treatment may be sought only when the resources of the traditional family/social support network have been exhausted; at this point, problems may be so chronic and severe that treatment outcome may be poor. This pattern of utilization is the result of complex factors.

The individual's (or family's) economic status may serve as a deterrent to the purchase of services either out-of-pocket or through third-party reimbursement. Racial/ethnic populations are not only more likely to have lower incomes than those of the mainstream population, but to be uninsured (U.S. Bureau of the Census, 1997). For example, in 1996, Hispanics were the most likely group to have no health insurance coverage (U.S. Bureau of the Census, 1997). In that same year, about 30 percent of the total U.S. population received health insurance coverage through government sponsored programs (i.e., Medicare and Medicaid).

Those needing treatment may live in areas where access to health care providers is limited because of distance or transportation problems. Those with access often find that services are inadequate or inconveniently scheduled. Others may not realize that they are eligible or may not know what services a local program offers. Many treatment providers are not able to address treatment needs of individuals from cultural backgrounds different than their own even when they speak the client's language of origin. This is further compounded when trying to develop written materials for linguistic and culturally diverse populations. Issues such as literacy levels and regional language differences need to be taken into account when developing written treatment program materials.

Health and illness beliefs and attitudes may act as obstacles keeping racial and ethnic populations from seeking treatment for a substance abuse problem. More is known about the impact of health beliefs and attitudes on health and mental health than on drug treatment behavior. The literature on health and mental health has identified a number of factors that contribute to underutilization of services. Reliance on folk remedies may cause some underutilization of treatment services. Cultural stigma attached to psychiatric care, psychotherapy, counseling, and/or substance abuse treatment may invoke fear of losing status and of being judged a failure by the family and the community, and thereby contribute to underutilization. Cultures differ in their explanations, views, and acceptance of abnormal behaviors; what is defined as abnormal behavior in one culture may be sanctioned or encouraged in another. Abnormal behaviors may be attributed to physical or psychological causes or they may be viewed as the direct result of supernatural or spiritual forces.

Emergency rooms often serve as the sole primary care provider for members of racial and ethnic minority groups in urban areas. Individuals with long-standing drug problems are more susceptible to serious medical problems and more likely to use emergency rooms. The Drug Abuse Warning Network (DAWN) samples hospital emergency rooms for drug-related episodes. During 1996, 54 percent of all such episodes involved Whites; 27 percent, African Americans; and 10 percent, Hispanic Americans (U.S. DHHS, 1997c). However, emergency rooms often are unable to provide appropriate referrals to treatment and the follow-up necessary to assure that patients enter treatment for their substance abuse.

Barriers to Treatment Affecting Substance Abusers from Racial/Ethnic Groups

Regardless of the treatment model in use, racism on an institutional or individual level can be a barrier to treatment effectiveness. Institutional racism within a treatment system is evident when the program or treatment design is oblivious to the racial, cultural, or ethnic backgrounds, values, and mores of its patient population. Latent prejudice on the part of treatment staff as well as language and cultural differences undermine efforts to help patients achieve recovery from substance abuse (Private communication, Dr. B. Prim).

A community in social and economic distress may resent and mistrust treatment providers who are "outsiders." Negative experiences with service providers who may have lacked regard, awareness, or concern for cultural differences often reinforce unfavorable attitudes and distrust. Substance abuse treatments program may be rendered ineffective if the community has not been involved in their planning and implementation.

Many treatment professionals and community leaders believe that treatment staff who come from the same community are better suited to providing culturally responsive treatment since they are often knowledgeable about community networks and are able to design programs that address the belief systems, cultural values, attitudes, and behaviors of community members.

Gays, Lesbians, and Substance Abuse Treatment

Persons with gay, lesbian, or bisexual sexual orientations constitute a special population within racial/ethnic groupings. Research, however, has tended to focus on either sexual preference or ethnicity; thus, few studies address the interaction of sexual orientation and ethnicity. There is a paucity of research on the relationship between sexual orientation and effectiveness of specific treatment modalities; on the interaction of sexual orientation and ethnicity in treatment outcomes; and on how particular ethnic communities regard and treat their substance-abusing gay and lesbian members. Therefore, treatment for ethnic homosexual and bisexual people addicted to substances may be seriously flawed in most treatment systems. Treatment programs must make special efforts to find out as much as possible about the attitudes held toward gays and lesbians by the specific racial/ethnic group(s) to whom they provide treatment.

Much of the current literature on substance abuse and treatment issues affecting gays, lesbians, and bisexuals is written by practitioners based on their clinical observations. Their findings identify the need for special treatment services for gay substance abusers, and address the clinical issues specific to gay and bisexual substance abusers that must be understood by treatment professionals working with this population.

Factors that are central to the onset and maintenance of substance abuse for gay/lesbian individuals include: difficulties with self-esteem, relationships with others, isolation, alienation, and low self-efficacy (Holmes and Hodge, 1997). Clearly, these are some of the same causal factors that contribute to the prevalence of substance abuse in the general population. However, being homosexual or bisexual, or being a woman, or being a member of an ethnic minority group compounds the problems this seriously underserved population faces.

Treatment providers should be aware of local community resources (e.g., gay AA groups). Awareness of local gay groups and resources helps providers to ensure improved opportunities of retaining patients in treatment through the provision of culturally competent referrals appropriate to the needs of the gay/lesbian racial/ethnic minority patient. In addition, because poor coping skills are considered to be a major cause of relapse, providers treating gay/lesbian substance abusers should address issues such as: dealing with sex in recovery, codependency, same-sex couples issues, and issues related to HIV infection and AIDS.

The issue of sexual orientation should not be ignored in treatment, and treatment providers should be aware of the role it can play in defining attitudes and assumptions about patients. Staff training can ameliorate long-standing biases toward homosexuality and bisexuality.

Patients entering treatment are dealing with shame and fear of being rejected, not only for their substance abuse, but for their homosexuality. Many gay men report a history of nonacceptance, prejudice, and a lack of understanding in their encounters with treatment practitioners (Holmes and Hodge, 1997). Lesbians face reactions to their homosexuality, as well as issues specific to women in treatment. A counselor is an authority figure whose approval or disapproval typically carries a great deal of weight. Therefore, practitioners should consider carefully their own attitudes and beliefs about gay people. Their values and biases may influence the process of treatment. If prejudicial attitudes prevent staff members from providing the best possible treatment, it would be advisable for them to work with a different population.

Barriers to Treatment Affecting Substance-Abusing Individuals Living in Rural Areas, Including Migrant Farmworkers

Rural populations are plagued by a lack of readily accessible health and human services. The farmworker population in the United States is a multicultural mosaic of African Americans, American Indians/Alaska Natives, Asians/Pacific Islanders, Hispanic Americans, Whites and other racial and ethnic groups. The migrant and seasonal farm worker population is estimated at between 2 and 7 million people, with 4 million being the most common estimate (National Farmworkers Association, 1992). Contrary to popular belief, 81 percent of foreign-born farmworkers are legally authorized to work in the United States. About 27 percent of foreign-born farmworkers are either naturalized citizens (2 percent) or legal permanent residents (25 percent) (National Council of La Raza, 1992).

The farmworker population is an extremely disadvantaged sector of the nation's lower socioeconomic strata. The common problems of

farmworkers are well known: substandard housing, contaminated water supplies, and lack of access to health care. In addition, malnutrition, HIV, sexually transmitted diseases (STDs), and substance abuse are major problems. Migrant and seasonal farmworkers are chronically underemployed; roughly half have incomes below the poverty level, despite a high prevalence of families with multiple wage earners. The median family income for authorized farmworkers is between $7,500 and $10,000; for unauthorized workers it is between $2,500 and $5,000. Fewer than one-fifth (18 percent) are recipients of needs-based social services (food stamps are the type of assistance most often received). Married farmworkers without children are the least likely to live in poverty (30 percent) compared with farmworkers with children (54 percent) and single workers (53 percent). Foreign-born workers are twice as likely as U.S.-born workers to live in poverty (62 percent versus 31 percent) (National Farmworkers Association, 1992).

As a group, migrant farmworkers are subject to more accidents, dental disease, and mental health and substance abuse problems, and suffer a higher incidence of malnutrition than any other population group in the country. They also experience higher rates of diabetes, hypertension, tuberculosis, anemia, and parasitic infections than the national average. Forty percent of all farmworkers who visit migrant clinics have multiple and complex health problems. Because of the nature of their work, farmworkers have few financial resources and little time for medical treatment, much less for health prevention measures. Even when affordable primary health care facilities are available, migrant farmworkers face greater difficulties in accessing them than do other population groups. A clinic's location, financial constraints, language and cultural barriers, and operating hours all contribute to lack of access. Because of these factors, many farmworkers do not seek medical care. Thus, diseases remain undiagnosed and untreated (National Council of La Raza, 1992).

In serving substance abusers in rural areas, treatment providers must address the following issues:

- Development of innovative approaches to treatment.
- Inclusion of outreach, case finding, and referral through linkages with primary health care providers, law enforcement officials, schools, churches, and other community groups.
- Development of local, community-based support for treatment that may require reaching beyond conventional providers of health, human, and social services, and may include mobile treatment units that have been shown to be effective in certain settings for increasing access to treatment services.
- Provision of child care and transportation services so that substance abusers living in rural areas can avail themselves of existing health and human services.
- Use of community and migrant health centers (which often are culturally sensitive and bicultural) to provide substance abuse treatment and referral services.

ENGAGEMENT AND RETENTION ISSUES

Substance abuse problems are not only more prevalent among racial/ethnic minority populations, but substance abuse-related morbidity and mortality problems are more serious among them (Griffith et al., 1996). Many drug treatment programs face difficulties in attracting, retaining, and successfully treating racial/ethnic minority clients (Finn, 1996). There is a need to develop better methods for attracting and retaining minority populations in treatment, and providing continuing care for recovering substance abusers. Treatment providers and systems that are *culturally competent* are believed to be a means to this end.

Recognition that cultural factors may play an important role in treatment efficacy emerged in the mid-1970's. Cultural and racial characteristics of providers as well as patients became a focus of attention. Numerous theoretical perspectives were developed, including the concept of "fit" between counselor and patient in terms of background and environment. It became clear that patients with specific racial and ethnic characteristics were underutilizing treatment services (Sue and McKinney, 1975; Sue, 1976) and that failure-to-return rates were particularly high following a single session. Substantial evidence seemed to indicate that many of the factors accounting for service underutilization were related to whether or not treatment interventions were linguistically and culturally responsive to the needs of minority patients. Twenty years later, there is still much work to be done to make services available to those who need them.

WHAT IS CULTURAL COMPETENCE?

Culture permeates all life domains. The saliency of culture is heightened in the lives of those living in a sociocultural setting other than the one they come from. For those who have not experienced sociocultural change, cultural issues might come to the fore in interactions with individuals who do not

share the same culture of origin. These encounters prompt the realization that different cultures view the world in different ways. One way to bridge those differences is through the acquisition of knowledge about other cultures. Cultural knowledge not only enhances the understanding of different world views, but provides insight into the optimum approach to problem solution strategies (Mokuau, 1997).

Cultural competence is a set of academic and interpersonal skills that allow individuals to increase their understanding and appreciation of cultural differences and similarities within, among, and between groups (Woll, 1996). According to the Center for Substance Abuse Prevention (1994), a culturally competent program is one that demonstrates sensitivity and understanding of cultural differences in treatment and program design, implementation, and evaluation. Within the treatment setting, cultural competence is a fundamental ingredient that helps to develop trust, as well as an understanding of the way members of different cultural groups define health, illness, and health care (Gordon, 1994).

A culturally competent model of treatment acknowledges the patient's cultural strengths, values, and experiences while encouraging behavioral and attitudinal change. Treatment services that are culturally responsive are characterized by:

- Staff knowledge of the native language of the patient.
- Staff sensitivity to the cultural nuances of the patient population.
- Staff backgrounds representative of those of the patient population.
- Treatment modalities that reflect the cultural values and treatment needs of the patient population.
- Representation of the patient population in decision making and policy implementation.

These features, each by itself, do not constitute cultural competence, nor do they automatically create a culturally competent system. Culturally competent systems include professional behavioral norms for both treatment staff and the organization--norms that are built into the organization's mission, structure, management, personnel, program design, and treatment protocols. In other words, culturally competent systems need to implement cultural competence at various levels: attitude, practice, policy, and structure (Mason, 1995).

Approaches to Cultural Competence

Much of the literature on treating racial/ethnic minority patients advocates the use of culturally responsive treatments. Recommendations have been made to modify treatment modalities offered by mainstream programs by including racial/ethnic-specific features, as well as to develop new forms of culturally responsive treatment. Some have recommended increased use of ethnic paraprofessionals (Sue, 1976; Wu and Windle, 1980). Although Sue's recommendations focus primarily on Asians and Pacific Islanders, others report similar findings for Hispanic Americans (Barrera, 1978; Padilla, Ruiz, and Alvarez, 1975), African Americans (Vail, 1978; Sue, 1977), and American Indians (Colorado, 1986).

Research on the relationship between "racial or ethnic matching" of patients and counselors in a treatment context reveals complex dynamics on how the therapeutic alliance might affect treatment outcomes. It appears that although some individuals prefer providers of services from their same racial/ethnic/cultural background, that is not always sufficient to ensure client engagement and retention (Beutler et al., 1997). Similarities in sociodemographic variables and level of acculturation also appear to affect the nature of the therapeutic relationship. Flaskerud (1986) recommends that in addition to matching patient's and counselor's racial and ethnic backgrounds and language, careful and close attention should be paid to site accessibility with regard to location and hours, and the provision of comprehensive adjunct services, including medical, legal, social, educational and economic/vocational services.

In the past decade, numerous attempts have been made to develop a conceptual model of cultural relevance and appropriateness in treatment and counseling. In 1991, *The Journal of Counseling and Development* devoted an issue to cultural competence in training of treatment and counseling staff. Cultural competence was termed the "fourth force" of psychology in addition to humanistic, psychodynamic, and behavioral explanations of human behavior (Pedersen, 1991).

Cultural competence requires the willingness of treatment counselors and the treatment system under which they operate to conduct self-appraisals to develop an understanding of how they may differ from the community or patients they serve. Cultural competence also entails acknowledgment of existing inherent cultural biases and influences on one's attitudes and behaviors (Henderson and Primeaux, 1981). A counselor's comfort in relating to persons who are different is communicated in many

nonverbal and unconscious ways. Common factors that influence comfort include ethnic and racial characteristics, socioeconomic background, religious affiliation, and physical or mental handicaps (Axelson, 1985). However, cultural competence also requires effective communication that goes beyond mere language proficiency to focus on meanings and interpretations (Garcia, 1995). Within a culturally competent framework, knowledge of cultural beliefs, expectations and morals is crucial to effective communication (Moffic and Kinzie, 1996).

Similarly, an agency's program can be critically assessed by its institutional assumptions regarding services for specific ethnic communities. It can then address programmatic bias resulting from institutionalized misperceptions and cultural ignorance. It is advisable to include culturally appropriate and competent consultants to assist in this process.

A significant part of this self-assessment is training that examines not only personal beliefs but also prior interactions with the targeted patient population. The analysis of personal bias and worldview will allow staff to assess their strengths and weaknesses in order to build training priorities. According to Leong and Kim (1991), three areas of competency are required in this self-assessment and training process: beliefs/attitudes, knowledge, and skills.

Training can only begin to be meaningful when staff and management understand and accept the need for training and self-assessment. The most difficult element is gaining total program cooperation. All members must "buy in" to a process of reviewing and expanding their own worldview, including learning about the specific cultures of their patients. Training must be an ongoing process with "booster" sessions as well as retreats to discuss the policy and programmatic implications of any significant modality shifts. Using outside consultants is a more favorable and recommended alternative than relying upon agency ethnic staff to supply such training. By using consultants, all staff are given fair opportunity to participate and share in the learning process.

Once training begins, and new programmatic objectives and goals are established for the targeted patient population, ongoing support is required for the program objectives. However, program development and adaptation requires an ongoing and long-term commitment in planning and development of time, consultation, and supervision. One or two staff members alone cannot sustain such a process.

Evaluating Cultural Competence in Practice

Little is known about the proved effectiveness of specific cultural competent treatment modalities (Arroyo, Westerberg, and Tonigan., 1998). The time has come to not only assess the effectiveness of the few available services but to incorporate culturally competent elements in the evaluation of treatment programs. For example, evaluations need to incorporate clients' perceptions of what they consider adequate treatment; they should also consider how the social, cultural, economic and political contexts are incorporated into the treatment. In other words, treatment goals determine the outcome measures that should be used. If the treatment objectives fall under the rubric of cultural competence, outcome measures should correspond to those objectives. Some dimensions to evaluate should include: factors playing a role in determining who seeks treatment; differences between individuals who seek treatment and those who do not; the role of gender in treatment decisions, etc. (Mayers and Kail, 1993). The execution of these tasks will move the field of culturally competent treatment ahead and will foster the replication of programs that have proved to be effective.

UNIVERSAL CULTURAL THEMES IN THE DEVELOPMENT OF CULTURALLY COMPETENT TREATMENT PROGRAMS

Although every racial/ethnic minority group is characterized by unique cultural, migratory, social, economic, and political experiences, two themes relevant to cultural competence run across the groups: family structure and cultural healing and spiritual beliefs. They both should play prominent roles in the development of effective cultural competent substance abuse treatment services.

Family Structure

Kinship and family ties are extremely important to all racial/ethnic groups, since they form a network of mutual support that can provide material, emotional, and social resources to members in distress. However, a tight family structure can also serve to hide and prolong substance abuse problems. Family notions of propriety develop over generations and do not disappear when the family is transplanted to a new geographical location. Young people who attempt to abandon family standards often find in later life that they carry the values they had challenged earlier. Treatment providers must consider family attitudes and behaviors in the context of race, ethnicity, and culture. This will enable staff to include cultural characteristics in their efforts to restore or maintain family health.

Cultural Healing and Spiritual Beliefs

Folk beliefs strongly influence the behavior of many minority groups seeking health care and substance abuse treatment. Some Asians and Pacific Islanders consult traditional healers such as acupuncturists and herbalists, or use traditional remedies such as self-restraint and meditation to supplement Western medical interventions. Personal health is viewed as an individual's responsibility and requires balance between body and spirit. However, the extent of use and efficacy of traditional medicine among these cultures has not been adequately documented. Tribal healers and spiritual leaders play powerful roles in the health practices of American Indians. Coordination of health care, substance abuse treatment, and social programs with tribal healers and spiritual leaders is important since treatment outcomes are often strongly influenced by the Indian patient's spiritual beliefs and practices.

Hispanic Americans traditionally perceive illness as an imbalance of physical or mystical forces; illness is often attributed to God's will, magical powers, evil spirits, powerful human forces, or emotional upsets (Randall-David, 1989). There is little or no conceptual difference between physical and emotional illnesses. Spiritual healers and priests play an important role in managing crises and planning therapeutic interventions. Spiritual healing (e.g., *santería, espiritismo*) is practiced in different Hispanic communities.

Spirituality also plays a major role in the African American community. Voodoism, a type of spiritual healing, is a mixture of indigenous and Catholic beliefs. Hope and perseverance is maintained through voodoism, and serves as a unifying force for many Haitians in Haiti and in the United States.

MANAGED CARE AND CULTURALLY COMPETENT SUBSTANCE ABUSE TREATMENT

Managed care has been defined as "any health care delivery system in which various strategies are employed to optimize the value of provided services by controlling their cost and utilization, promoting their quality, and measuring performance to ensure cost-effectiveness. A managed care system actively manages both the medical and financial aspects of a patient's care" (Corcoran and Vandiver, 1996, p. 309). In recent years the health care delivery system in the United States has moved towards a managed care model including the Medicaid program that provides health care to individuals who live at, close to, or below poverty levels, and serves a significant number of members of minority groups.

The question to ask is how would managed care systems incorporate culturally competent treatment modalities within a structure that sets limits on treatment modality and duration? Some speculate that managed care threatens the flexibility required by culturally-based services (Moffic and Kinzie, 1996). In fact, models of mental health service delivery in managed care have evolved without considering the needs of racial/ethnic minorities in any systematic manner (Abe-Kim and Takeuchi, 1996). Corcoran and Vandiver (1996) indicate that few managed care programs are sensitive about approving treatment protocols that incorporate individuals — family, kin, elders — other than the patient.

In accordance with its precept of delivering quality services to consumers, and knowing that cultural ingredients play a crucial role in engaging and retaining racial/ethnic minority individuals in treatment, managed care systems have an obligation to provide the kind of treatment that works best for this population (Romero 1996). Services that do not take into account the cultural or clinical diversity of treatment needs will be destined for poor patient outcomes. A global, "one size fits all" mentality may ultimately lead to more costly and acute treatment needs down the road.

CONCLUSION

Designing culturally responsive substance abuse programs requires careful examination of the target population's unique characteristics and heritage. It is also important to consider the individual's cultural orientation and preferences when developing a treatment plan for a potential client. Thus, pre-treatment assessments should evaluate cultural dimensions that may impinge upon the treatment context. These assessments should include measures that evaluate the client's degree of acculturation to mainstream society, language and cultural preferences, level of stress caused by cultural differences (e.g., intergenerational conflict), as well as family and social support networks that influence the individual's beliefs, attitudes, and behavior toward both substance abuse and treatment, among others.

Trotter (1982) suggests that "language, values and ideals are not something to be taught wholesale — from a single perspective, and then called culturally sensitive treatment. Rather, they are a starting point on a broad cultural spectrum. The world is heterogeneous and knowledge of that spectrum allows the counselor to determine how best to provide an individual patient with the unique path for his or her recovery and reentry into society." Singer (1991) suggests that cultural differences between

program providers and recipients can significantly impede both program utilization and patient satisfaction. As Trotter (1982) points out, treatment programs need to "...reflect the total cultural complexity of the regions that they serve if they are to be successful."

The chapters ahead review important issues to take into account when delivering culturally appropriate services for Hispanic Americans, African Americans, Asian Americans/Pacific Islanders, and American Indians/Alaska Natives. They cover the following general areas: (1) population composition and sociodemographic profile; (2) substance abuse epidemiological data; (3) health and social consequences of substance abuse; and (4) culture, help-seeking behavior, and access to care issues, among others. The last chapter, briefly provides overarching recommendations for the incorporation of cultural issues into substance abuse treatment.

REFERENCES

Abe-Kim, J.S., and Takeuchi, D.T. 1996. Cultural competence and quality of care: Issues for mental health service delivery in managed care. *Clinical Psychology Science and Practice* 3:273-295.

Alcocer, A.M. 1993. Patterns of alcohol use among Hispanics. In R.S. Mayers, B.L. Kail, and T.D. Watts (Eds.), *Hispanic substance abuse* (pp. 37-49). Springfield, IL: Charles C. Thomas.

Amaro, H. Whitaker, R., Coffman, G., and Heeren, T. 1990. Acculturation and marijuana and cocaine use: Findings from HHANES 1982-84. *American Journal of Public Health* 80:54-60.

Arroyo, J.A., Westerberg, V., Tonigan, J.S. 1998. Comparison of treatment utilization and outcome for Hispanics and non-Hispanic Whites. *Journal of Studies on Alcohol* 59:286-291.

Axelson, J. 1985. *Counseling and Development in a Multicultural Society*. Monterey, CA: Brookes-Cole.

Bachman, J. G., Wallace, J. M., O'Malley, P. M., Johnston, L. D., Kurth, C. L., and Neighbors, H. W. 1991. Racial/ethnic differences in smoking, drinking, and illicit drug use among American high school seniors, 1976-1989. *American Journal of Public Health* 81:372-377.

Barrera, M. 1978. Mexican-American mental health service utilization. *Community Mental Health Journal* 14:35-45.

Beauvais, F. (1996). Trends in drug use among American Indians students and dropouts, 1975-1994. *American Journal of Public Health* 86(1): 1594-1598.

Beutler, L.E., Zetzer, H., dn Yost, E. 1997. Tailoring interventions to clients: Effects on engagement and retention. In L.S. Onken, J.D. Blaine, and J.J. Boren (Eds.), *Beyond the therapeutic alliance: Keeping the drug-dependent individual treatment* (pp. 85-109). NIDA Research Monograph 165. Rockville, MD: U.S. Department of Health and Human Services.

Booth, M.W., Castro, F.G., and Anglin. 1990. What do we know about Hispanic substance abuse? A review of the literature. In R. Glick & J. Moore (Eds.), *Drugs in Hispanic communities*. New Brunswick, NJ:Rutgers University Press.

Caetano, R. 1990. Hispanic drinking in the U.S.: Thinking in new directions. *British Journal of Addiction* 85:1231-1236.

Carr, R. 1996. Crime: A debate over punishment and prevention. *Congressional Quarterly* 54(40): 2810-2811.

Center for Disease Control (CDC). 1996. *Hepatitis Surveillance Report*. Atlanta: Author.

Center for Disease Control (CDC). 1997. *HIV/AIDS Surveillance Report*. Atlanta: Author.

Center for Substance Abuse Prevention. 1994. *Following specific guidelines will help you assess cultural competence in program design, application, and management*. Rockville, MD: U.S. Department of Health and Human Services.

Colorado, P. 1986. Native American alcoholism: An issue of survival. Doctoral dissertation. Brandeis University, The Heller Graduate School for Advanced Studies in Social Welfare.

Corcoran, K., and Vandiver, V. 1996. *Maneuvering the maze of managed care*. NY: The Free Press.

Delgado, M. 1997. Hispanics/Latinos. In J. Philleo, F.L. Brisbane, and L.G. Epstein (Eds.), *Cultural Competence in substance abuse prevention* (pp. 33-54). Washington, D.C.: National Association of Social Workers Press.

Ebona, A. 1984. Federal government policies and Indian goals of self-government. In L. Little Bear, Menn, Boldt, and J.A. Long (Eds.), *Pathways to self-determination*. Toronto: University of Toronto Press.

Finn, P. 1996. Cultural responsiveness of drug user treatment programs: Approaches to improvement. *Substance Use and Misuse* 31:493-518.

Flaskerud, J. H. 1986. The effects of culture-compatible intervention on the utilization of mental health services by minority patients. *Community Mental Health Journal* 22:127-141.

Garcia, M.H. 1995. An anthropological approach to multicultural diversity training. *Journal of Applied Behavioral Science* 31:490-504.

Gordon, J.U. (Ed.) 1994. *Managing multiculturalism in substance abuse services*. Thousand oaks, CA: Sage Publications.

Griffith, E.E.H., Chung, H., Foulks, E., Lu, F., Ruiz, P., Wintrob, R., and Yamamoto, J. (Eds.). 1996. *Alcoholism in the United States: Racial and ethnic considerations*. Report No. 141. Washington, D.C.: American Psychiatric Press.

Gutierres, S., and Todd, M. 1997. The impact of childhood abuse on treatment outcomes of substance abusers. *Professional Psychology: Research and Practice* 28(4):348-354.

Henderson, G., and Primeaux, M. (Eds.). 1981. *Transcultural Health Care*. Menlo Park, CA: Addison-Wesley.

Holmes, K.A. , and Hodge, R. H. 1997. Gay and lesbian people. In J. Philleo, F.L. Brisbane, and L.G. Epstein (Eds.), *Cultural Competence in substance abuse prevention* (pp. 153-176). Washington, D.C.: National Association of Social Workers Press.

Jacobs, J. (1993). Black America, 1992: An overview. In B. Tidwell (Ed.), *The state of black America* (pp. 1-10). New York: National Urban League.

Johnston, L. D., O'Malley, P. M., and Bachman, J. G. 1987. *National trends in drug use and related factors among American high school students and young adults, 1975-1986.* National Institute on Drug Abuse, Alcohol, Drug Abuse, and Mental Health Administration, Public Health Service, US Department of Health and Human Services, DHHS Publication No. (ADM) 87-1534. Rockville, MD: National Institute on Drug Abuse.

Kuramoto, F.H. 1994. Drug abuse prevention research concerns in Asian and Pacific Islander populations. In A. Cázares and L.A. Beatty (Eds.), *Scientific methods for prevention intervention research* (pp. 249-272). NIDA Research Monograph 139. Rockville, MD: U.S. Department of Health and Human Services.

Leong, F. T., and Kim, H. H. W. 1991. Going beyond cultural sensitivity on the road to multiculturalism: Using the intercultural sensitizer as a counselor training tool. *Journal of Counseling and Development* 70:112-118.

Mason, J.L. 1995. *Cultural competence self-assessment questionnaire: A manual for users.* Portland, OR: Portland State University Research and Training Center on Family Support and Children's Mental Health.

Mayers, R.S., and Kail, B.L. 1993. Hispanic substance abuse: An overview. In R.S. Mayers, B.L. Kail, and T.D. Watts (Eds.), *Hispanic substance abuse* (pp. 5-16). Springfield, IL: Charles C. Thomas.

Miller, E. 1997. Drugs, AIDS, and human rights. *Peacework* 275:7-9.

Moffic, H.S., and Kinzie, D.J. 1996. The history and future of cross-cultural psychiatric services. *Community Mental Health Journal* 32:581-592.

Mokuau, N. Pacific Islanders. 1997. In J. Philleo, F.L. Brisbane, and L.G. Epstein (Eds.), *Cultural competence in substance abuse prevention* (pp. 127-152). Washing ton D.C.: National Association of Social Workers Press.

National Council of La Raza. 1992. *State of Hispanic America 1991: An Overview.* Washington, DC: National Council of La Raza.

National Institute on Alcohol Abuse and Alcoholism. 1994. *Alcohol Alert* 23:1-3.

National Farmworkers Association. 1992. Personal communication with N. Ramos-Sayre, Center for Substance Abuse Treatment. Washington, DC.

Padilla, A. M., Ruiz, R. A., and Alvarez, R. 1975. Community mental health services for the Spanish-speaking sur-named population. *American Psychologist* 30:892-904.

Pedersen, P. B. 1991. Multiculturalism as a generic approach to counseling. *Journal of Counseling and Development* 70:6-12.

Randall-David, E. 1989. *Strategies for Working with Culturally Diverse Communities and Clients.* Bethesda, MD: The Association for Care of Children's Health.

Reed, D.F., and Reed, E.L. 1997. Children of incarcerated parents. *Social Justice* 24(3)152-169.

Romero, J.T. 1996. Operationalizing cultural competency in managed care environment. *Focal Point* 10:26-28.

Seale, J.P., and Muramoto, M.L. 1993. Substance abuse among minority populations. *Primary Care* 20:167-180.

Singer, M. 1991. Confronting the AIDS epidemic among IV drug users: Does ethnic culture matter? *AIDS Education and Prevention* 3:258-283.

Sue, S. 1976. Patients' demographic and therapeutic treatment: Differences that make a difference. *Journal of Consulting and Clinical Psychology* 44:864.

Sue, S. 1977. Community mental health services to minority groups. *American Psychologist* 32:616-624.

Sue, S., and McKinney, H. 1975. Asian Americans in the community mental health care system. *American Journal of Orthopsychiatry* 45:111-118.

Trotter, R.T. 1982. Ethnic and sexual patterns of alcohol use: Anglo and Mexican American college students. *Adolescence* 17(66):305-325.

U.S. Bureau of the Census. 1997. *Income, poverty, and health insurance.* Washington, DC: U.S. Government Printing Office.

U.S. Bureau of the Census. 1998. *Resident population of the United States: Estimates by sex, race, and Hispanic origin, with median age.* Washington, DC: U.S. Government Printing Office.

U.S. Department of Health and Human Services (DHHS). 1993b. *Substance Abuse Treatment Manual for Women (draft).* Rockville, MD: Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment.

U.S. Department of Health and Human Services (DHHS). 1997c. Data from the Drug Abuse Warning Network (DAWN), Annual emergency room data, 1996. *National Institute on Drug Abuse Statistical Series.* Rockville, MD: Alcohol, Drug Abuse, and Mental Health Administration.

U.S. Department of Health and Human Services (DHHS). 1998. *Prevalence of substance abuse among racial and ethnic subgroups in the United States, 1991-1993.* Rockville, MD: Substance Abuse and Mental Health Services Administration.

U.S. Government Office of Technology Assessment. 1994. *Technologies for understanding and preventing substance abuse addiction.* Washington, DC: US Printing Office.

Vail, A. 1978. Factors influencing lower-class Black patients' remaining in treatment. *Journal of Consulting and Clinical Psychology* 46:341.

Woll, C. 1996. What difference does culture make? Providing treatment to women different from you. *Journal of Chemical Dependency Treatment* 6:67-85.

Wu, I., and Windle, C. 1980. Ethnic specificity in the relative minority use and staffing of community mental health centers. *Community Mental Health Journal* 16:156-168.

POPULATION COMPOSITION AND SOCIODEMOGRAPHIC PROFILE

Hispanic Americans[1] constitute the second largest ethnic minority group in the United States. In 1994, Hispanics constituted 10.3 percent of the total U.S. population. As of 1997, they constitute 11.1 percent of the total population, numbering approximately 30 million (U.S. Bureau of the Census, 1998). This figure does not include the approximately 3.8 million people residing in Puerto Rico. At the current rate of growth, projections indicate that the Hispanic population will become the largest ethnic minority group in the United States by the year 2010 (U.S. DHHS, 1997a).

Hispanic Americans are the youngest group in the United States. Their median age is 26.5, which is ten years younger than that of the non-Hispanic White population (U.S. Bureau of the Census, 1998). Mexican Americans are the youngest subgroup (with a median age of 24.6), followed by Puerto Ricans (26.9 years of age). Cubans are the oldest subgroup with a median age of 43.6 years (U.S. Bureau of the Census, 1994).

Hispanic Americans are also diverse in terms of their country of origin and in their geographical location in the United States. Sixty-four percent of all Hispanics residing in the United States are Mexicans residing in the Southwest and West. Puerto Ricans living in the United States constitute 10.4 percent of the Hispanic population, most of whom reside in the Northeast, although a significant number have recently moved to the Southeast. Cubans account for 4.2 percent of the total Hispanic population in the United States and are located primarily in the Southeast. The remaining 21 percent comprise other Hispanic origins, including a large number of immigrants from Central and South America and the Dominican Republic. Dominicans are the fastest growing Hispanic subgroup in the United States. The vast majority of Hispanics (92 percent) live in urban areas (Delgado, 1997). Puerto Ricans and Cubans are the most urban of all subgroups (95 percent).

Hispanic subgroups also vary in terms of other socioeconomic and socio-demographic indicators. Hispanics, as a group, report an average household income of $31,124 (U.S. Bureau of the Census, 1994). Cubans have the highest average household income ($42,551 per annum) of all Hispanic subgroups (U.S. Bureau of the Census, 1994), but still lower than that of Whites ($51,471), Puerto Ricans have the lowest average household income ($27,917) of all Hispanic subgroups. Mexican Americans fall in between Cubans and Puerto Ricans with an average annual household income of $29,932. Hispanic migrant farmworkers are the poorest among all Hispanics. The annual salary of their vast majority does not reach $7,500. They rarely have access to workers compensation, occupational rehabilitation, or disability compensation benefits. Moreover, the large majority do not collect social security benefits due to their inability to prove past work history (National Advisory Council of Migrant Health, 1993).

Poverty overwhelmingly affects Hispanics in general. Census data from 1996 indicated that almost 30 percent of all Hispanic individuals lived below poverty levels (U.S. Bureau of the Census, 1997). This figure was almost four times the percentage of Whites and two times the poverty rate experienced by Asian Americans and Pacific Islanders. Blacks/African Americans have comparable poverty rates to those of Hispanics. For those Hispanic families that are headed by a female, the below-poverty rate ascends to almost 51 percent. Puerto Ricans are the poorest of the Hispanics. In 1993, almost 39 percent of all Puerto Ricans residing in the United States lived in poverty (U.S. Bureau of the Census, 1994). Considering this economic profile, it is not surprising to find that Hispanics are the most likely group to have no health insurance coverage (U.S. Bureau of the Census, 1997) and that one-third of them have no regular source of primary health care (U.S. DHHS, 1997a).

Although, as a group, Hispanics are affected by high poverty rates, this poverty is not necessarily the result of unemployment. Hispanics' labor force participation rates are comparable to those of Whites. In fact, the labor force participation rate for Hispanic males is higher (78.7 percent) than that of non-Hispanic males (73.1 percent) (U.S. Bureau of the Census, 1998). For Hispanic females, the labor force participation rate is 54.6 percent, compared to almost 60.3 percent for non-Hispanic females (U.S. Bureau of the Census, 1998). The differences in income are thus the result of differences in earnings rather than in labor force participation (Del Pinal, 1997).

[1] Hispanic Americans are defined as individuals of Mexican, Puerto Rican, Cuban, Central or South American or other Spanish culture or origin, regardless of race.

MIGRATION EXPERIENCE

Hispanics are heterogeneous not only in terms of their socioeconomic and socio-demographic profile but also in terms of their migration experiences. Some have arrived in the United States as political refugees; others have taken advantage of immigration policies favoring family reunification, and yet others have arrived through other legal and illegal channels.

Mexican Americans have been living in the United States since before 1848, when those residing in the annexed territories were given the option of citizenship as part of the peace treaty with Mexico. Later, the building of the U.S. railroads in the 1880's attracted Mexicans to the United States. In the 1940's the demand for farmworkers gave new impetus to Mexican migration to the United States. Current Mexican migration to the United States is mostly driven by economic forces and the physical proximity of the two countries.

Puerto Rican migration to the United States has been, in many ways, unique. In 1898, Spain ceded Puerto Rico to the United States after the Spanish-American war. In 1917, the United States granted U.S. citizenship to Puerto Ricans, since they were drafted and fought for the American flag even before being granted citizenship. Puerto Ricans had been migrating to the United States in search of better economic opportunities prior to becoming U.S. citizens. U.S. citizenship, however, has facilitated their entrance. The decades of the 1940's and 1950's witnessed one of the largest exodus of migrants in history, when Puerto Ricans arrived in the United States by the thousands, lured by job opportunities in the manufacturing industry. Subsequently, the decline in U.S. manufacturing prompted a return migration among many Puerto Ricans. However, they have continued to arrive and settle in the United States. Currently, more than one-third of the total Puerto Rican population resides in the United States.

The migration of Cubans to the United States has been more recent than that of Mexicans and Puerto Ricans. A large influx of Cubans arrived during the last days of Fulgencio Batista's dictatorship and in the early years of the revolution led by Fidel Castro. With the advent of the Cuban revolution, many Cubans, largely middle-class, sought political asylum in the United States. In the 1980's the United States opened its doors to more than 100,000 Cubans wanting to leave the island. More recently, a smaller but significant number of Cubans has arrived in the United States in search of, once again, political asylum. These migratory movements have each had different socioeconomic and political profiles. The first migration wave comprised mostly well-educated upper-class and professional middle-class Cubans who brought with them both monetary and human capital. The other two waves of migrants comprised mostly skilled workers.

The migration experience of Hispanics from other countries is very diverse. It includes individuals fleeing their war-torn countries, professionals, students, skilled and semi-skilled workers in search of a better life or family reunification.

SUBSTANCE ABUSE EPIDEMIOLOGICAL DATA

Although there are differences in the patterns of substance abuse across Hispanic subgroups, the pattern for the total Hispanic population indicates that they were slightly overrepresented in admissions for treatment episodes related to substance abuse (U.S. DHHS, 1995). Data from the 1996 National Household Survey on Drug Abuse (U.S. DHHS, 1997b) indicated that 1.1 million Hispanics (8 percent) were illicit drug users in 1996. In terms of the use of specific substances, the same survey revealed that Hispanics were current cocaine users at a higher rate (1.1 percent) than Blacks/African Americans (1.0 percent) and Whites (0.8 percent). Whites reported the highest rate of current alcohol use, 54 percent compared to 43 percent for Hispanics and 42 percent for Blacks/African Americans. Hispanics, however, reported the highest rate of binge drinking (16.7 percent), followed by Whites (16.1 percent) and Blacks/African Americans (13.1 percent). However, when it comes to those seeking alcohol treatment the differences in drinking practices between Hispanics and non-Hispanics are fewer (Arciniega et al., 1996).

Differences in substance abuse rates between Hispanics and other groups vary by age, subgroup, and gender. Hispanic youths between the ages of 12 and 17 use cocaine at a higher rate than their Black/African American and White counterparts (CDC, 1996). Mexican Americans aged 12 to 17 report higher levels of marijuana use than non-Hispanic youths. The 1995 Youth Risk Behavior Surveillance Study (CDC, 1996) reveals that Hispanic high school students outnumbered Whites and Blacks/African Americans in the percentage of those who have smoked, drank alcohol, and tried marijuana and cocaine before age 13. In terms of substance abuse patterns by subgroup, the Treatment Episode Data Set (DHHS, 1997c) reveals that, in 1995, a large proportion of Puerto Ricans and Mexicans were admitted for heroin-related episodes. Among Hispanics, Puerto Rican and Cuban youths appear to have the highest rate of cocaine use.

In terms of gender differences, Hispanic women report lower levels of substance abuse than their male counterparts (NCADI, 1997). However, Puerto Rican women tend to use cocaine at higher rates than women in any other Hispanic subgroup (Delgado, 1997). In general, it appears that acculturation plays an important role in substance use and abuse among Hispanic women. The more they adapt to the U.S. culture, the more their substance use patterns mirror those of women in the general population (NCADI, 1997). For example, the effect of acculturation upon alcohol use is the same for Cuban, Puerto Rican, and Mexican American women living in the United States. The more acculturated they are, the more alcohol they consume (Black and Markides, 1993). It is important to note that the relationship between acculturation and gender is stronger for Hispanic women than for men (Polednak, 1997).

Stress associated with level of acculturation, poverty, discrimination, and racism has been posited as an explanation for the high rates of substance abuse among Hispanics (Gloria and Peregoy, 1996; Leal, 1990). Illicit drugs and alcohol become a learned but maladaptive response to coping with the stress of adjusting to a new culture and environment. Hispanic youth are considered to be at high risk for involvement in substance abuse as well as for mental health problems. Many are surrounded by conditions that are detrimental to their well-being, such as poverty and violence, single-parent families, parents struggling with economic and assimilation problems of their own, prejudice, lack of educational and employment opportunities, and availability of drugs and alcohol (Botvin and Scheier, 1997). Mexican American and Puerto Rican teenagers have very high school dropout rates, a factor often correlated with substance abuse (NCADI, 1997). High-risk adolescent Hispanic Americans may become involved with gangs, the drug trade and its subculture, and with polysubstance abuse. They are likely to be underrepresented in national data sets, because the surveys fail to count those who have dropped out of school (Johnston et al.,1991).

The fact that alcohol and illicit drugs are readily available and that their consumption is embraced by some in the adolescent culture may influence their use and abuse by Hispanic adolescents as well as other adolescents. Research has shown that many parents believe that the widespread availability and acceptance of substance abuse in this country, unlike the situation in their own countries of origin, are major contributors to family disruption (Padilla et al., 1988). Children acculturate more rapidly than their parents through exposure to the American lifestyle in school, a source of cultural influence parents are not usually exposed to. Clashes in values within culturally traditional families create interpersonal stresses on family unity, in addition to the stresses that parents may already experience, such as unemployment, discrimination, and lack of community support.

The Border States

The States of Texas, California, New Mexico, and Arizona share several common features: approximately 2,000 miles of borders with Mexico, an intense drug smuggling trade across borders, large racial/ethnic minority populations, and high percentages of minority patients in treatment for substance abuse. Drug trafficking provides large volumes of drugs that are of high purity and sold at cheap prices. The Office of National Drug Control Policy has declared the Southwest border a national priority area for interdiction of illegal drugs. The information below describes the composition of the target minority groups in each of the Border States and the representation of racial/ethnic minority individuals in the Border States relative to their population in the U.S. Residing in the Border States are:

- 59.5 percent of all Hispanics in the U.S.
- 44.5 percent of all Asian Americans and Pacific Islanders in the U.S.
- 33 percent of all American Indians/Alaska Natives.
- 14.6 percent of Blacks/African Americans.
- Only 16.3 percent of all Whites in the U.S.
- These specific minority groups make up 24.8 percent of the total U.S. population, but constitute 41.5 percent of the population in the Border States.

Texas. The predominant minority groups in publicly funded treatment programs in Texas are Blacks/African Americans and Hispanics, representing 58.4 percent of clients. The development of a comprehensive treatment system for chemically dependent offenders is a progressive and necessary strategy for decreasing crime and the demand for illegal drugs; however, treatment must be culturally relevant, since 72 per-cent of Texas inmates represent minority populations. The primary cause for admission in 1992 was alcohol (42 percent), followed by cocaine (32 percent), and heroin (12 percent).

New Mexico. In the State of New Mexico, publicly funded drug and alcohol treatment programs in 1993 provided services to 11,638 adults. Slightly more than half were Hispanic (53.7 percent), with American Indians/Alaska Natives also dispro-

portionately represented (22.9 percent) with regard to their total population in the state. Overall, the minority population constituted 79.8 percent of the treatment population in state-funded programs in New Mexico, although the minority population comprised less than 50 percent of the state's population. Treatment admissions were primarily for alcohol (79 percent), followed by cocaine, marijuana, and heroin which together accounted for 15 percent of all admissions.

Arizona. In the State of Arizona, publicly funded drug and alcohol treatment programs in 1993 provided services to 24,425 adults, with minority patients comprising 31.1 percent of the treatment population. The largest single minority group represented in treatment was Hispanic (21.1 percent), followed by American Indians/Alaska Natives (8 percent) and Blacks/African Americans (7.6 percent). Treatment admissions in Arizona are primarily for alcohol (69 percent).

California. The State of California provided treatment services to 180,502 adults in 1993, and 46.6 percent (84,089) were minority individuals. While Hispanic representation in treatment and in the general population were roughly equivalent at 25 percent, Black/African American representation in treatment (18.7 percent) was more than double its representation in the state (7.4 percent). The primary illegal drugs abused in California in 1993 were heroin and cocaine/crack, accounting for 42.1 percent and 10.4 percent of all admissions to treatment, respectively. Alcohol admissions accounted for 31.6 percent.

HEALTH AND SOCIAL CONSEQUENCES OF SUBSTANCE ABUSE

Substance Abuse and HIV/AIDS

Data show that Hispanic Americans have a higher percentage of acquired immune deficiency syndrome (AIDS) cases related to injection drug use than the general population (Leshner, 1995). Furthermore, tuberculosis (TB) has become a serious community health concern that often parallels injection drug use and HIV infection in a community. In the period from 1985 to 1990, the number of Hispanic TB cases increased by 54.7 percent (NCLR, 1992a). In 1994, the rate of AIDS cases for Hispanics was almost 50 per 100,000 Hispanics, whereas the rate for the total population was almost 30 cases per 100,000 (U.S. DHHS, 1997a)

In 1995, AIDS/HIV-related infections were the fourth leading cause of death among Hispanic Americans. Figures compiled by the Centers for Disease Control (CDC) show that the risk of contracting HIV/AIDS is three times higher for Hispanic Americans than for Whites, and that the rates among persons born in Puerto Rico are as much as seven times higher than for Whites. High-risk sexual behavior and needle-sharing are the two behaviors that account for the majority of the AIDS cases among Hispanics. The most common routes of HIV transmission for Hispanic women are injection drug use or heterosexual transmission. As of June 1997, 37 percent of all Hispanic adolescent and adult males with AIDS reported injection drug use as the mode of transmission (CDC, 1997). Forty-three percent of Hispanic adolescent and adult females also reported injection drug use as the mode of transmission. Two other significant modes of transmission for Hispanic females were having sex with an injection drug user and with an HIV-infected person. Because of a cocaine or crack habit, women are likely to exchange sex for drugs, and they often do not use condoms. Thus, should they become pregnant, they risk transmitting the virus to the fetus. Prevalence rates of pediatric AIDS among Hispanic Americans are high. The HIV/AIDS Surveillance Report for mid-year 1997 indicates that Hispanics were second to African Americans in the number of pediatric AIDS cases (CDC, 1997). For the vast majority of these children, the mode of transmission was a mother with HIV infection.

There are several factors contributing to AIDS high-risk behaviors among Hispanics:

- Hispanic men who have sex with other men are still likely to have sex with women.
- Cultural attitudes may result in a reluctance to use condoms.
- Needles are shared or reused by injection drug users (Latkin et al., 1994), in tattooing, by curanderas (folk healers) and other non-medical persons who give vitamins or injections to members of the community, or in "blood brother" rites among gang members.
- Hispanic substance abuse subculture behavior has the highest utilization of "shooting galleries" for injection drug use. Schoenbaum (1986) found that Hispanic Americans used shooting galleries 31 percent of the time, compared to 18 percent among Blacks and 16 percent among Whites. The rate is as high as 51 percent among Puerto Ricans in the United States (Robles et al., 1993).

The magnitude of the difference in AIDS rates between Hispanics and Whites can be largely accounted for by injection drug use. Almost half of the Hispanic adults with AIDS are injection drug users (40 percent are reported to be injection drug users and another 6 percent are injection drug users who have engaged in homosexual or bisexual behavior). In comparison, fewer than one in eight White adult AIDS cases is an injection drug user. In terms of sexual orientation, almost 70 percent of homosexual/bisexual male AIDS patients are White, whereas 79 percent of heterosexual injection drug users with AIDS are Black/African American or Hispanic.

Among injection drug-using Hispanic Americans living in areas of the United States heavily populated by Hispanic Americans (i.e., New York, California, Texas, and Colorado), 74 percent never use bleach or alcohol to clean their drug-injecting equipment before injecting, which places them at serious risk for contracting and spreading HIV.

A study of Hispanic injection drug users in southern Arizona showed that 57 percent shared needles with three or more persons. Of those at risk for AIDS from sexual contact, 77 percent never used condoms, and 50 percent had three or more partners in the past 6 months. Very few were in drug treatment: 62 percent had never been in drug detoxification; 77 percent were never in a residential treatment program; and 88 percent were never in an outpatient, drug-free program (Estrada, 1991).

Substance Abuse and Crime

Hispanics are also disproportionately affected by drug-related crime. Homicide and legal intervention (i.e., deaths such as those caused by police officers in pursuit of criminals) are the fifth leading cause of death among Hispanic males (NHHS, 1997). It is believed that a large proportion of deaths due to homicide is related to substance abuse. The National Crime Victimization Survey (Ann Arbor News, 1993) indicates that Hispanics were among those affected the most by crime. Hispanics also experience high rates of incarceration due to drug-related activities. In recent years, the number of women in prisons has increased (Reed and Reed, 1997). Drug offenses are the main reason for women serving sentences in prison. In California, Hispanic women account for 17 percent of the total number of incarcerated women (Reed and Reed, 1997).

The interconnectedness between substance abuse and health and social consequences among Hispanics is further illustrated in a study (McCaughrin and Howard, 1995) comparing the clientele composition of outpatient substance abuse treatment units serving low and high numbers of Hispanics. The study revealed that clients attending clinics serving a high number of Hispanics were significantly poorer; more likely to abuse other drugs versus alcohol; more prone to turn to crime to support the drug habit; more likely to be ordered to treatment by the courts; and at a higher risk for HIV/AIDS. In addition, the treatment outcomes for clients at these clinics were poorer.

CULTURE, HELP-SEEKING BEHAVIOR, AND ACCESS TO CARE ISSUES

The more knowledgeable practitioners become about the sociodemographic and cultural characteristics of the populations they are trying to serve, the better they can understand the dynamics that lead to the use and abuse of alcohol and other drugs among members of specific Hispanic subgroups (Caetano, 1990; 1993 Langton et al., 1995). The diversity of Hispanic groups in the United States must be accounted for in the design of culturally appropriate programs. Some Hispanic Americans are descendants of the first inhabitants of territories that are now part of the United States, whereas others migrated from different Latin American countries. People from different circumstances and countries bring different cultural and traditional values with them, which often conflict with the prevailing social and cultural norms in the United States. However, since culture is not static, the length of time Hispanic individuals or subgroups have been in this country and the extent to which they have assimilated prevalent values and norms add another dimension to this group's diversity. For example, differences have been found between later-generation Hispanic Americans and recent immigrants. Later-generation adolescents score lower on self-esteem measures than do immigrant adolescents, and later-generation women are more likely to drink alcohol than their immigrant counterparts.

The success of any prevention or intervention program over the long term will also be determined by how well practices and principles will be developed and implemented to help Hispanics cope with the feelings of helplessness and alienation that come from lack of economic gain, discrimination, and social oppression without turning to alcohol, drugs, and the other high-risk destructive behaviors (Bernard, 1991). The following sections focus on important issues that reflect how cultural, sociodemographic, and institutional factors influence help-seeking behavior and access to care.

Appropriate Use of "Hispanic" or "Latino"

In designing culturally competent models of substance abuse treatment for Hispanic Americans, providers should be knowledgeable about the history and background of each target group. Treatment providers must show sensitivity when addressing their patients and should use the correct terms to gain confidence and credibility for the treatment program.

The origins of the word "Hispanic" are revealing. The term has different meanings in different geographical areas of the United States. A variety of places use the word "Hispanic" which is derived from the word "Hispania," which is the Latin name for the Iberian Peninsula. In Spanish, the word "hispanidad" translates as "Spanishness," Spanish world, and cultural community of Spanish-speaking nations. "Hispanismo" means Hispanism: interest in Spanish literature and culture. "Hispano" in Spanish means Hispanic, Spanish, Spanish-American, and Spaniard. "Hispanoamericano" is Spanish American. "Latinoamericano" is Latin American.

In communities where all Spanish-speaking residents are of the same origin, providers should investigate whether an even more specific name better describes and reinforces cultural origins. For example, in Colorado and Arizona some groups want to be called "Chicanos" in recognition of their racial mixture which includes indigenous roots. Those who recognize their Mexican roots and whose ancestors have been living in the United States in territories that were once part of Mexico call themselves Mexican Americans. Puerto Ricans are also known as "boricuas" or "borinqueños," which comes from the aboriginal name of Puerto Rico (Borinquen) before the first Spanish settlers renamed it.

Over the last 10 years the Federal government has established the use of the term Hispanic to classify all persons of Latin American origin residing in this country. Researchers conducting a Federally funded project will customarily use the term Hispanic to conform with the prevailing Federal classification. However, caution should be used in the use of this term when substance abuse treatment providers are beginning ongoing one-on-one relationships with patients. It is important to understand that not all communities identify with, or want to be categorized as Hispanic. This can depend on their geographic location or on deeply rooted emotions influenced by their history. The association of the term Hispanic with Spanish colonialism is offensive to some groups of Latin American origin. Also, there are some communities in New Mexico that want to be called Hispanic in honor of their Spanish ancestry because they recognize their Spanish heritage only. They do not recognize any racial mixture or admit to Latin American origins. "Latino" is preferred in many areas of the United States such as Chicago, New York City, and Miami. During the spring of 1990, for example, *The Los Angeles Times* informed its readers and the community at large that the accepted term for the Spanish-speaking population in Los Angeles would be Latino.

Using the correct term demonstrates the provider's sensitivity and respect for the patient population being served. This will help in establishing the credibility and trust required for a sound relationship between provider and patient.

Cultural, Socioeconomic and Institutional Barriers to Care

Many factors contribute to the lack of availability of treatment programs that are culturally competent and accountable to the Hispanic community. Because many existing treatment providers are not yet culturally focused, their outreach and recruitment strategies fail to consider the ways in which the traditional values of Hispanic Americans prevent them from seeking treatment for substance abuse problems. For example, mainstream treatment models fail to recognize the importance of the patient's family as an integral component of treatment and intervention.

A number of systemic problems may contribute to the underutilization of treatment programs by Hispanic Americans and members of other racial/ethnic groups. These include the following:

- Language barriers and a lack of bicultural treatment staff.
- Inability of treatment staff to gain the "*confianza*" (trust) needed to engage the Hispanic substance abuser in treatment.
- Prohibitive costs and lack of funding to enable poor Hispanic substance abusers to receive adequate treatment.
- Separation of the substance abuse treatment and health care systems.
- Overwork of substance abuse treatment professionals.
- Location of treatment programs.
- Physician's ethnic background.
- General lack of a continuum of care services that address the recovering Hispanic's treatment needs.

Even if culturally competent treatment with bilingual and bicultural staff were readily available and accessible, a number of financial obstacles impede obtaining and maintaining access to substance abuse treatment. Hispanic Americans receive less preventive health care, including prenatal care, than the total population. In 1996, Hispanic Americans were most likely to be without health insurance coverage (both private and government) (U.S. Bureau of the Census, 1997). Without health insurance, many Hispanic Americans are reluctant to seek health care and, consequently, use emergency rooms as primary health care providers. This overuse and misuse of emergency facilities escalates health care costs and, ultimately, impacts on funding for health services.

Working Hispanic Americans are more likely than non-Hispanics to have jobs in which employers do not offer insurance coverage. Even when insurance is available, third-party reimbursement to treatment programs provides partial payment, at best, with the remainder paid for by the patient. While indigent beds are occasionally available in residential chemical dependency (28-day) or therapeutic community (6-month) programs, these treatment modalities are least appropriate and least utilized by Hispanic substance abusers because of the confrontational nature of the treatment approach, which runs counter to Hispanics' preference for more personal interactions (i.e., *personalismo*) and the need to establish a level of trust or *confianza.* In addition to this, residential programs separate the patient from the family, another important element in the lives of Hispanic clients.

The separation of substance abuse treatment from the existing health care system has further hindered the ability of Hispanic Americans to utilize services (Delgado, 1988). Insofar as these systems have developed separate identities, each finds it difficult to refer patients to the other. This separation further complicates coordination and referral, since one program may be staffed to support Spanish-speaking Hispanic patients, but the other is not. Even in cases when staff is available and a referral can be made, treatment program and health care provider staff often are overworked and underpaid and have trouble relating to patients, resulting in a hesitancy among Hispanic Americans and others to utilize such services. In sum, Hispanics will benefit from programs that address:

- Language, socioeconomic, cultural, and geographical barriers to treatment.
- Immigration status (e.g., legal versus illegal) and length of time in the United States.
- Level of acculturation.
- Service integration.

Availability of Qualified and Culturally Competent Treatment Personnel

Underutilization of services and failure of treatment programs can also be attributed to lack of bilingual or bicultural personnel qualified to address the unique social, cultural, and linguistic life experiences of Hispanics in the United States. (Booth et al., 1990). A number of common misconceptions have hindered the ability of substance abuse treatment providers to deliver culturally competent treatment to Hispanic Americans. First, providers often assume that Hispanic staff are bilingual and/or bicultural. This is not always the case, since levels of acculturation vary among Hispanic Americans. Second, providers assume that the availability of bilingual staff and literature is sufficient to meet the needs of Hispanic patients. However, these are only perfunctory efforts at culturally competent treatment for Hispanic Americans. In fact, for later generation Hispanics, language issues are not necessarily the most salient deterrents to treatment. Finally, treatment providers' views of "culture" frequently are defined in the individual mind and are based upon literature that often presents biased discussions of Hispanic values and traditions. These biased interpretations create oppositional stereotypes between Hispanic Americans and other cultures that may be counterproductive to the therapeutic alliance (Morales, 1991). Frequently, stereotypical views do not allow for consideration of the role individual factors such as level of acculturation, ethnic identity, socioeconomic status, and life experiences also play in shaping an individual's personality and behaviors.

Several problems hamper efforts to employ bilingual, bicultural staff. First, there are few Hispanic health professionals to choose from, and not all of them are bilingual. Another problem in hiring Hispanic American treatment staff is that there are, generally, two types of people who enter the substance abuse field: professionals who come into the field following post-secondary education and training, and "indigenous workers," who come from the community that is being served, usually former patients or recovering persons (Rodriguez-Andrew, 1991). Professionals, while well educated and trained for a position in substance abuse treatment, often lack practical experience to understand the cultural nuances and treatment problems affecting the target patient population. They may come from

Hispanic communities far different from those in which they are working and may even have negative attitudes toward substance abusers. Indigenous workers, because of the fact that they come from the community, often relate to and work well with patients. However, many lack the formal education and training that provide the framework for substance abuse counseling and treatment.

System Fragmentation and Continuum of Care Services

Despite the considerable obstacles to accessing treatment and health services, some providers have been successful in delivering services to Hispanic American substance abusers. However, their service scope is limited. Considering the scarcity of appropriate treatment for Hispanic Americans and other racial/ethnic groups, the ability to refer patients or provide continuum of care services that address the recovering minority individual treatment needs is extremely limited. Further complicating the coordination of services are: (1) the fragmentation of the health care system, (2) lack of geographical access to services, (3) lack of communication among agencies, and (4) lack of communication among professionals.

Since the health care system is compartmentalized and fragmented, patients, especially those without adequate insurance coverage, often are forced to seek services from special needs clinics or providers. This complicated and confusing system is made even more so by the inability of some Hispanic Americans to speak English, as well as by the fact that some tend to access treatment and medical services only as a last resort. This picture is further compounded by the fact that the number of Hispanics obtaining advanced degrees in the social sciences, psychology, and medicine is significantly small. The small number of Hispanic professionals serving Hispanics are more likely to provide services in Hispanic communities. However, regardless of the residents' income, Hispanic communities suffer from a shortage of Hispanic providers (Matherlee and Burke, 1997).

Although training and experience in substance abuse treatment are crucial for effective interventions, there are other intervention strategies that are important to consider when dealing with Hispanic clients. For example, Hispanic cultural values that emphasize respect and the development of trusting interpersonal relationships run counter to confrontational therapies and approaches used in some substance abuse treatment programs. Many find it degrading and destructive to self-esteem. Thus, other treatment modalities should be employed.

In addition to culturally competent technology transfer efforts in treatment approaches, training should focus on holistic approaches that incorporate traditional values and beliefs and development of continuing care planning strategies that reintegrate patients back into their communities. At a minimum, various components must be considered when building a foundation for culturally competent treatment. Individualized patient assessment instruments need to be utilized not only to assess the patients' health needs but to assess the program's capacity to meet the needs of its patient population.

Conventional Treatment and Folk Medicine: Santería and Espiritismo

A culturally competent practitioner should be aware of belief systems that might play important roles in the way a substance abuse problem is both perceived and treated, such as *santería* and *espiritismo* among Hispanics. This is particularly important when patients use formal institutional service delivery systems along with traditional folk-healing methods.

Folk-healing traditions that combine the heritage of Spanish Catholic medical and religious practices with African and other belief systems are common within certain sectors of the Hispanic population. For example, *santería* is a religion that combines the beliefs of the Yorubans (Africans from South Nigeria) with those of Catholics. In Cuba, this religion is known as *lucumí* and in Brazil as *macumba*. *Espiritismo* is a faith-healing system that predominates in Puerto Rico and is also found in parts of Cuba (e.g., the Oriente region). *Santeros* and *espiritistas* are generally found in Cuban and other Hispanic communities throughout the United States. With some families, mobilizing the support systems available through *santeros* and *espiritistas* can serve as important resources that, when combined with family therapy, have powerful healing effects (McGlodrick, et al.,1982).

PRACTICES TO MEET TREATMENT NEEDS

Outreach and Public Relations

Wurzman and colleagues (1982) noted that favorable reports from Hispanic patients who were enrolled in treatment had a direct impact on treatment enrollment by other Hispanics, despite widespread doubt among Hispanics that available treatment programs do much good.

More specific outreach approaches, on the other hand, have focused on the "positive role model" approach to recruitment and retention in substance abuse treatment. These role models share their experience in treatment and describe how the treat-

ment has benefitted them. Successful role models persuade others to enter or remain in treatment because patients can identify with them. This approach supports the employment of indigenous workers as role models for Hispanic patients in substance abuse treatment. Indigenous workers come from the community and are frequently recovering substance abusers themselves. With proper training and supervision, the workers can use their life experience to engage the patient and relate to him/her in a manner consistent with the shared culture.

Treatment services should be organized around a cultural network to maintain an effective link between patient and community. One of the strengths of the Hispanic community is the richness and diversity of its natural support systems that can act as primary and secondary support for the patient and agency. Delgado and Delgado (1982) reported four significant resources that constitute a natural community-based support network:

1. Extended family, which will enhance the social and emotional support network.

2. Folk healers, who utilize culturally specific methods to diagnose and treat emotional, spiritual, and physical ailments.

3. Religious institutions, which offer additional social and psychological support services, emergency assistance in crisis, and spiritual advice.

4. Merchants and social/civic clubs, which traditionally are neighborhood based and could provide a wide variety of social activity and support.

Cultural Interpersonal Values

A qualitative study (Trepper et al., 1997) explored issues that interventionists need to take into account when developing cultural competent substance abuse treatment services for Hispanic women. One of the recommendations derived from the study is neither to exaggerate nor to underplay cultural issues in treatment. The study also highlighted the fact that not all Hispanics have similar cultural and behavioral values.

Mainstream society in the United States is predominately achievement-oriented and promotes individualism and competitiveness. In contrast, the Hispanic culture is generally allocentric, that is, it values group needs and objectives rather than personal goals and accomplishments (Marin and Marin, 1991). Hispanic Americans prefer nurturing and trusting interpersonal relationships, which are mindful that all persons, regardless of their social or economic status, should be treated with respect and dignity.

The significance of these characteristics is that only when trust (*confianza*) has been established in the therapeutic process or with the provider do Hispanic Americans commit to treatment and/or do well in counseling. Therefore, the introduction of therapy that treats the Hispanic American individual/family with *respeto, personalismo,* and *dignidad* should be the initial goal of all programs in developing trust and a commitment to treatment. The incorporation of the family in therapy must also respect cultural values of prime importance to Hispanics (Melus, 1980; California Hispanic Commission on Alcohol and Drug Abuse, 1983). Utilization of a wide variety of interventions that can be tailored to individual and family systemic needs must be an adopted strategy within the treatment system. It is this flexibility that research indicates is most effective in providing the best chance for recovery to high-risk individuals and their families (e.g., Lazarus, 1976).

Cultural factors and processes such as *personalismo*, trust, and acculturation are important to consider in efforts to retain Hispanics in treatment (Gloria and Peregoy, 1996). For Hispanics, *personalismo* or the preference for personal interactions is a very salient value that needs to be addressed in treatment. Within the therapeutic context, many Hispanic clients expect counselors to establish a kind of personal relationship (*personalismo)* that allows them to open up and trust (*"tener confianza"*) the counselor. Failure to accomplish this generally leads to early attrition from treatment (Gloria and Peregoy, 1996).

Culturally appropriate development efforts must also be based on a clear understanding of the antecedents of risk behaviors. For example, among Hispanic women, acculturation is an important predictor of many health-related behaviors, including cigarette smoking, alcohol use and early sexual initiation. In essence, acculturated Hispanic women are more likely than men to adopt high risk behaviors.

When it comes to treating women, providers need to be sensitive to their unique needs as women. In trying to determine the clinical needs of Hispanic women substance abusers and the impact of cultural factors upon treatment, Trepper and colleagues (1997) found that family plays an important role in the lives of Hispanic women. Thus, it is important to have a flexible enough treatment environment that (1) incorporates family members; (2) shows respect

for the family hierarchy; (3) validates the client's effort to work for the good of the family; (4) appreciates the family's strengths and competencies; and (5) accommodates needs of children. Trepper et al. (1997), however, wisely warn practitioners not to adopt these family notions as absolute truths for all Hispanics, but rather as questions to be addressed and figured out independently with each and every Hispanic client in treatment.

CONCLUSIONS AND RECOMMENDATIONS

Effective responses to the substance abuse problems Hispanics confront will require the identification of culturally specific barriers to treatment, prevention, and education, as well as an understanding of the impact of factors such as acculturation, socioeconomic condition, immigrant status, and cultural attitudes and values. Such obstacles can only be removed through the long-term intervention and cooperation of Hispanic community-based organizations. Approaches must be developed that take into consideration the following factors:

- Diversity of the Hispanic population.
- Language, economic, class, and cultural barriers.
- Immigration status, length of time in the United States, degree of acculturation.
- Impact of acculturation stress on family structure.
- Limited access to primary health care, health education and prevention programs, and substance abuse treatment programs.

In addition to these important issues, effective culturally competent interventions should:

- Foster strong community linkages to other community organizations to complement the overall scope of services.
- Promote a process of exchange among staff members. Current staff and newly recruited treatment staff should share their knowledge with each other. Staff should be balanced between those in recovery and those with professional training.
- Develop a trusting and respectful relationship with the community-at-large. This will firmly establish the credibility of the treatment program within the community.
- Be aware of normative behavior and communication styles, level of acculturation, political and socioeconomic background of the individuals served.
- Be guided by an integrative framework that incorporates cultural elements (i.e., language, norms, values, beliefs) into interventions, and also addresses health, social, psychological, and migration-related problems that compound the substance abuse problems Hispanics experience (Inclan and Hernandez, 1992; Santiago and Azara, 1995).

INFORMATION RESOURCES

Web Sites

Alcoholics Anonymous:
www.alcoholics-anonymous.org

America's Farmworkers Home Page:
www.ncfh.org/

Latino Link Home Page: www.latinolink.com/

LatinoWeb:
www.catalog.com/favision/latnoweb.htm

Office of Minority Health:
www.os.dhhs.gov/proorg/ophs/omh/

Resources for Diversity: www.nova.edu/inter-Link/diversity.html

Organizations

Latino Caucus of the American Public Health Association, P.O. Box 92198, Long Beach, CA 90809; 310-570-4016.

Marin Institute for the Prevention of Alcohol and other Drug Problems, 24 Belvedere Street, San Rafael, CA 94901; 415-456-5692.

National Coalition of Hispanic Health and Human Services (COSSMHO), 1501 16th Street, NW, Washington, DC 20005; 202-387-5000.

National Council of La Raza, 1111 19th Street, NW, Suite 1000, Washington, DC 20036; 202-785-1670.

National Hispanic Education and Communications Projects, 1000 16th Street, NW, Suite 603, Washington, DC 20036; 202-452-8750.

Publications

La Esperanza del Valle: A drama of family triumph over alcohol and substance abuse. Available from Novela Health Education, 1001 Broadway, Suite 100, Seattle, WA 98122; 1-800-677-4799.

Pasos Adelante (Steps Forward). A resilience enhancement curriculum for preschoolers and their parents. Available from Pasos Adelante, c/o The Hope Center, 260 S. Scott Avenue, Tucson, AZ 85701; 520-884-8470.

CSAP Implementation Guide: Hispanic/Latino Support Systems. Available from NCADI, P.O. Box 2345, Rockville, MD 20847-2345; 800-729-6686. Inventory number MS502.

Hoffman, F. 1994. **Cultural adaptations of alcoholic Anonymous to serve Hispanic populations.** *The International Journal of the Addictions* 29:445-460.

REFERENCES

Ann Arbor News. 1993. 1 in 10 Blacks crime victims. *Ann Arbor News* 158(319):2.

Arciniega, L.T., Arroyo, J.A., Miller, W.R., and Tonigan, J.S. 1996. Alcohol, drug use and consequences among Hispanics seeking treatment for alcohol-related problems. *Journal of Studies on Alcohol* 57:613-618.

Bernard, B. 1991. *Moving toward a "just and vital culture": Multiculturalism in our schools.* Portland, OR: Northwest Regional Educational Laboratory, Western Center for Drug-Free Schools and Communities.

Black, S.A., and Markides, K.S. 1993. Acculturation and alcohol consumption in Puerto Rican, Cuban-American, and Mexican American women in the United States. *American Journal of Public Health* 83(6):890-893.

Booth, M. W., Castro, F. G., and Anglin, M. D. 1990. What do we know about Hispanic substance abusers: A review of the literature. In: R. Glick and J. Moore, Eds., *Drugs in Hispanic Communities.* New Brunswick: Rutgers University Press.

Botvin, G.J., and Scheier, L.M. 1997. In D.K. Wilson, J.R. Rodriguez, and W.C. Taylor (Eds., *Health promoting and health-compromising behaviors among minority adolescents* (pp. 55-86). Washington, D.C.: American Psychological Association.

Caetano, R. 1990. Hispanic drinking in the U.S.: Thinking in new directions. *British Journal of Addiction* 85:1231-1236.

Caetano, R. 1993. Priorities for alcohol treatment research among U.S. Hispanics. *Journal of Psychoactive Drugs* 25:53-60.

California Hispanic Commission on Alcohol and Drug Abuse. 1983. *Health concerns of the Latino family,* Vol. 5, pp. 1-6.

Centers for Disease Control (CDC) 1996. Youth risk behavior surveillance, United States, 1995. *Mortality and Morbidity Weekly Review* 45.

Centers for Disease Control (CDC) 1997. *HIV/AIDS Surveillance Report.* Atlanta: Author.

Cervantes, R. 1991. Drug abuse and AIDS: Interventions in Hispanic American populations. In: *NIDA Conference Highlights.* Washington, DC: National Institute on Drug Abuse, p. 147.

Del Pinal, J. 1997. *The Hispanic Population.* Washington, D.C.: U.S. Census Bureau.

Delgado, M. 1988. Alcoholism treatment and Hispanic youth. *Journal of Drug Issues* 18:59-68.

Delgado, M., and Humm-Delgado, D. 1982. Natural support systems: Source of strength in Hispanic communities. *Social Work* 27(1):83-89.

Delgado, M. 1997. Hispanics/Latinos. In J. Philleo, F.L. Brisbane, and L.G. Epstein (Eds.), *Cultural Competence in substance abuse prevention* (pp. 33-54). Washington, D.C.: National Association of Social Workers Press.

Estrada, A. 1991. Drug abuse and AIDS: Interventions in Hispanic American populations. In: *NIDA Conference Highlights.* Washington, DC: National Institute on Drug Abuse, p. 183.

Gloria, A.M., and Peregoy, J.J. 1996. Counseling Latino alcohol and other substance users/abusers. Cultural considerations or counselors. *Journal of Substance Abuse Treatment* 13:119-126.

Inclan, J., and Hernandez, M. 1992. Cross-cultural perspectives and codependence: The case of poor Hispanics. *American Journal of Orthopsychiatry* 62(2):245-255.

Johnston, L. D., O'Malley, P. M., and Bachman, J. G. 1991. *Drug Use Among American High School Seniors, College Students, and Young Adults, 1975-1990.* Vol. I. DHHS Pub. No. (ADM) 91-1813. Washington, DC: US Government Printing Office.

Koetting, M.G., and Schiraldi, V. 1997. Singapore West: The incarceration of 200,000 Californians. *Social Justice* 249(1):40-53.

Langton, P.A., Epstein, L.G., and Orlandi, M.A. (Eds). 1995. *The callenge of participatory research: Preventing alcohol-related problems in ethnic communities.* Rockville, MD: Center for Substance Abuse Prevention.

Latkin, C., Mandell, W., Vlahov, D., Oziemkowska, M., Knowlton, A., and Celentano, D. 1994. My place, your place, and no place: Behavior settings as a risk factor for HIV-related injection practices of drug users in Baltimore, Maryland. *American Journal of Community Psychology* 22(3):415-430.

Lazarus, A. 1976. Multimodal behavioral therapy. *Journal of Nervous & Mental Disease* 156:404-411.

Leal, A. (1990). Hispanics and substance abuse: Implications for rehabilitation counselors. *Journal of Applied Rehabilitation Counseling* 21:52-54.

Leshner, A.I. (1995). *Hearing,* Department of Labor, Health and Human Services, Education. Washington, D.C.: Government Printing Office.

Marin, G., and Marin, B. V. 1991. *Research with Hispanic Populations*. Newbury Park, CA: Sage Publications.

Matherlee, K., and Burke, N. (1997). Cross-cultural competency in a managed care environment. *Issue Brief* 705. National Health Policy Forum. Washington, D.C.: The George Washington University

McGoldrick, Pearce, and Giordino. 1982. *Ethnicity and Family Therapy*. The Guilford Press.

McCaughrin, W.C., and Howard, D.L. 1995. Variation in outpatient substance abuse treatment units with high concentrations of Latinos versus White clients: Client factors, treatment experiences, and treatment outcomes. *Hispanic Journal of Behavioral Sciences* 17(4): 509-522.

Melus, A. 1980. Culture and language in the treatment of alcoholism: The Hispanic perspective. *Alcohol Health & Research World*, Summer.

Morales, A. 1991. Treatment research findings: Practical implications for the Hispanic community. Presented at the National Conference on Substance Abuse Prevention, Treatment, and HIV/AIDS, Los Angeles, CA.

National Center for Health Statistics (NCHS). 1997. *Health, United States, 1996-97 and Injury Chartbook*. Hyattsville, MD:USDHHS.

National Clearinghouse for Alcohol and Drug Information. 1997. *Prevention primer: Hispanic/Latino Americans*. Rockville, MD: Author.

National Council of La Raza (NCLR). 1992a. HIV/AIDS Fact Sheet. *AIDS in the Hispanic Community: An Update*. Washington, DC: National Council of La Raza, July 1992.

National Advisory Council of Migrant Health. 1993. *Recommendations of the National Advisory Council of Migrant Health*. Rockville, MD: U.S. Department of Health and Human Services, Bureau of Primary Health.

National Council of La Raza (NCLR). 1992b. *State of Hispanic America 1991: An Overview*. Washington, DC: National Council of La Raza.

Padilla, A. M., Cervantes, R. C., Maldonado, M., and Garcia, R. E. 1988. Coping responses to psychological stressors among Mexican and Central American Immigrants. *Journal of Consulting Psychology* 16:418-427.

Polednak, A.P. 1997. Gender and acculturation in relation to alcohol use among Hispanic (Latino) adults in two areas of the northeastern United States. *Substance Use and Misuse* 32911):1513-1524.

Reed, D.F., and Reed, E.L. 1997. Children of incarcerated parents. *Social Justice* 24(3)152-169.

Robles, R.R., Colon, H/M., Matos, T.D., Reyes, J.C. Marrero, C.A., and Lopez, C.M. 1993. Risk factors and HIV infection among three different cultural groups of injection drug users. In B.S. Brown and G.M. Beschner (Eds.), Handbook on risk of AIDS: Injection drug users and sexual partners, (pp. 256-274). Westport, CT: Greenwood Press.

Rodriguez-Andrew, S. 1991. Training treatment professionals to serve the Hispanic community. Presented at the National Conference on Substance Abuse Prevention, Treatment, and HIV/AIDS, Los Angeles, CA.

Santiago, R., and Azara, L. 1995. Developing a culturally sensitive treatment modality for bilingual Spanish-speaking clients: Incorporating language and culture in counseling. *Journal of Counseling and Development* 74:12-17.

Schoenbaum, E. E., et al. 1986. Risk factors for human immunodeficiency virus infection in intravenous drug users. *New England Journal of Medicine* 321:874-879.

Trepper, T.S., Nelson, T.S., McCollum, E.E., and McAvoy, P. 1997. Improving substance abuse service delivery to Hispanic women through increased cultural competencies: A qualitative study. *Journal of Substance Abuse Treatment* 14:225-234.

U.S. Bureau of the Census. 1994. *Current Population Survey*. Washington, DC: U.S. Government Printing Office.

U.S. Bureau of the Census. 1997. *Current Population Survey*. Washington, DC: U.S. Government Printing Office.

U.S. Bureau of the Census. 1998. *Current Population Survey*. Washington, DC: U.S. Government Printing Office.

U.S. Bureau of the Census. 1998. *Resident population of the United States: Estimates by sex, race, and Hispanic origin, with median age*. Washington, DC: U.S. Government Printing Office.

U.S. Department of Health and Human Services (DHHS). 1995. *National Drug and Alcohol Treatment Unit Survey* (Advance Report no. 9). Rockville, MD: Substance Abuse and Mental Health Administration.

U.S. Department of Health and Human Services. 1997a. *Healthy People 2000* (Progress Review/Hispanic Americans). Rockville, MD: Alcohol, Drug Abuse, and Mental Health Administration.

U.S. Department of Health and Human Services (DHHS). 1997b. National Household Survey on Drug Abuse:Highlights 1996. Rockville, MD: Substance Abuse and Mental Health Administration.

U.S. Department of Health and Human Services (DHHS). 1997c. *Treatment Episode Data Set* (Advance Report no.12). Rockville, MD: Substance Abuse and Mental Health Administration.

Wurzman, I., Rounsaville, B., Kleber, H. D. 1982. Cultural Values of Puerto Rican Opiate Addicts: An Exploratory Study. American Journal of Alcohol Abuse 9:141-153.

POPULATION COMPOSITION AND SOCIODEMOGRAPHIC PROFILE

According to late 1997 U.S. Census Bureau figures, non-Hispanic Blacks/African Americans[1] make up about 12.1 percent of the total U.S. population and number approximately 32.5 million (U.S. Bureau of the Census, 1998), compared to about 29 million in 1990. The population growth for this group is mostly attributed to natural increase. Blacks/African Americans are largely concentrated in metropolitan areas (Gray, 1997).

The median age for the total Black/African American population is 30 years, which is 7.5 years younger than the White population. In general, Blacks/African Americans 18 years old and older are less likely to be married and living with their spouses. In 1997, only 34.1 percent reported being married and living with his/her spouse (U.S. Bureau of the Census, 1997). The remaining 66 percent include those married with an absent spouse, separated, widowed, divorced, never married, and "other" category. It is estimated that close to half of all Black/African American families are headed by a female with no husband present (Beatty, 1994). Household composition has clear economic repercussions for members of this group. Among those who live in a married-couple household, only 9.1 percent lived below the poverty level in 1996, compared to Whites and Hispanics for whom the percentages were 5.1 and 18, respectively (U.S. Bureau of the Census, 1997). Almost 44 percent of Blacks/African Americans living in households headed by a female with no husband present are harshly affected by poverty. This figure compares to 27 percent among Whites and 51 percent for Hispanics. In terms of poverty rates for the Black/African American population in general, 28.4 percent of this population reported living below poverty levels in 1996, second to Hispanics with 29.4 percent living below poverty levels. Among Asians and Pacific Islanders, poverty affects 14.5 percent of their population, and among Whites it affects almost 9 percent. Thus, Blacks/African Americans are three times as likely to live in poverty than Whites.

Per capita income for Black/African American families in 1995 was $10,982, almost $7,000 below that of the general population and almost $9,000 below that of the White population (U.S. Bureau of the Census, 1997). Black/African American males are twice as likely to be concentrated in the $1 to $19,999 income category than White males. The latter are twice as likely to be concentrated in the $30,000 and over category than their Black/African American male counterparts. For women, the picture is different. The incomes for both Black/African American and White women are comparable in almost all categories.

In terms of educational attainments, approximately 73 percent of all Blacks/African Americans age 25 and older have a high school diploma. About 13 percent of Blacks/African Americans age 25 and older have completed a bachelor's degree. To a large extent, educational attainments determine earning potential. This is clearly illustrated in the differences in earnings between those with a high school diploma and those holding a bachelor's degree. Figures from 1993 reveal that the median earnings of full-time, year-round employed Blacks/African Americans with a high school diploma were $18,460, compared with $32,360 for those with at least a bachelor's degree. The differences in socioeconomic indicators between Blacks/African Americans and Whites suggest that educational attainments and employment have protected White Americans against poverty more effectively than Blacks/African Americans (Robinson et al., 1992).

MIGRATION EXPERIENCE

The vast majority of the first Blacks/African Americans to arrive in the United States were forced from their homeland, Africa, brought to this country and forced into slavery. After the emancipation, and between the late 1880's and the late 1960's, hundreds of thousands of Blacks/African Americans left the South for the North, in search of better life and economic opportunities, in what has been called the "Great Migration." This internal migration has

[1] In accordance with the final decision on the revision of Federal standards for racial and ethnic data (Directive No. 15) taken by the Office of Management and Budget (OMB) in October 1997, this chapter utilizes the category "Black or African American." This nomenclature will be used for the Year 2000 census, and will also be phased in by other Federal data systems by January 1, 2003. "Black or African Americans" includes individuals who have origins in any of the black racial groups of Africa. Thus, it is inclusive of individuals from the Caribbean, Africa, and the United States (generally referred to as African Americans). This chapter is largely devoted to this latter group. When appropriate, a distinction will be made when addressing issues pertaining to specific groups such as African Caribbeans. In order to be consistent with the sources used in this chapter, the terms used in such sources will also be the ones used in this chapter.

determined, to a large extent, the geographical distribution of the Black/African American population throughout the United States.

The 1970's witnessed not only a decrease in the number of African American moving North, but also a significant number of them returning to the South. By the decade of the 90's, several cities in the South reported net increases of Blacks/African Americans arriving from the Northeast, Midwest and the West, spurred on by the region's industrial growth and development. According to the U.S. Census (Frey and Scommegna, 1997), 65 percent of the nation's Black/African American population growth occurred in the South, principally in Atlanta, Washington, D.C., Houston, Miami, Dallas-Fort Worth, Norfolk, and Orlando.

Texas appears to be the preferred destination for California Blacks/African Americans, whereas Blacks/African Americans leaving New York seem to prefer several southeastern states (i.e., Florida, North Carolina, Virginia, Georgia, South Carolina, and Maryland). It is predicted that by the year 2025, New York, Illinois, California, Michigan, and Massachusetts will lose the largest number of Blacks/African Americans while the western and mid-western states will gain the most, particularly Black/African American professionals, blue-collar workers, and retirees (Frey and Scommegna, 1997).

SUBSTANCE ABUSE EPIDEMIOLOGICAL DATA

Substance abuse patterns among Blacks/African Americans are intrinsically challenging for students, researchers, and practitioners in the field of substance abuse. A significant number of Blacks/African Americans abstain from alcohol and other substances, but another significant number use and abuse alcohol and other substances (Gray, 1997). To make an already complex picture more complicated, substance abuse patterns vary by age groups. Blacks/African Americans tend not to use and abuse substances at an early age (CDC, 1996), but there is a high prevalence of alcohol and other substance use among those aged 21 and over (U.S. Government Office of Technology Assessment, 1994). The 1995 Youth Risk Behavior Surveillance studies (CDC, 1996) indicate that, with the exception of current marijuana use, Black/African American high school students consistently report lower lifetime, current, and frequent use of tobacco, alcohol, marijuana, cocaine and other illegal substances than Whites. Some have argued that, considering the high rate of high school dropout among Black/African American youths, figures from the Youth Risk Behavior Surveillance studies might underestimate their substance abuse problems. However, the fact that high school dropouts among Blacks/African Americans have decreased in recent years (Bennett and DeBarros, 1997) reduces that possibility.

It has been found that marijuana is one, if not the most, commonly used substance and that Black/African American drug users show a tendency to progress from marijuana to heroin (Gray, 1997). However, recent data from the Treatment Episode Data Set, 1992-1995 (U.S. DHHS, 1997) indicate that crack cocaine is the drug prompting the largest number of admissions to treatment among young or early middle-aged Black/African American males and females.

In terms of past-year prevalence rates of illicit drug use, the 1991-1993 National Household Survey on Drug Abuse (U.S. DHHS, 1998) found that the rate for Blacks/African Americans was somewhat higher (13.1 percent) than that for Whites (11.9 percent), but lower than American Indians'/Alaska Natives' (19.8 percent) and Puerto Ricans' (13.3 percent). These rates vary across age groups. For example, Blacks/African Americans between ages 12 and 17 had the second lowest level of illicit drug use, whereas their 18 and older counterparts had the second highest level. Black/African American women consistently have lower rates of use and abuse of substances than their male counterparts and about the same or lower rates than their White female counterparts (Barr et al., 1993; U.S. DHHS, 1997).

There are no universally accepted theoretical perspectives that explain the causes for the high incidence of substance abuse among Blacks/African Americans. There is agreement that poverty, overcrowding, illiteracy, unemployment, the breakdown of two-parent families, and environmental stressors associated with both structural and interpersonal racism may be causative factors or strongly associated with substance abuse in this population (Jones-Webb et al., 1997).

Risk and Protective Factors

Risk factors refer to cognitive, psychological, attitudinal, social, environmental, pharmacological, physiological and developmental characteristics that promote initiation of substance abuse. Conversely, protective factors are those that both reduce the risk of substance abuse and addiction and promote positive development (i.e., role models, participation in peer groups, high self-esteem, environmental messages).

Many African American adolescents are surrounded by factors that place them at a high risk of developing substance abuse problems: low self-

esteem, low family pride, a history of family alcohol and/or drug abuse, peer pressure, and involvement in delinquent behavior (Vega et al., 1993). Protective factors that counteract the effects of risk factors among Blacks/ African Americans include family support, religion, community involvement, and spirituality (Brooks et al., 1992; Gray, 1997; Johnson and Jennison, 1994; Kleinman and Lukoff, 1978). There are many ways in which the family can shield their members from drug abuse, among them, dependence on helpful extended relatives, transmission of child rearing values and a religious world view (Stevenson and Renard, 1993). It has been suggested that the effectiveness of culturally competent interventions can be boosted by addressing the risk factors that plague the lives of Blacks/African Americans (Gray, 1997) and by simultaneously reinforcing protective factors, such as resiliency, self-esteem, and reliance on the family and community (Logan, 1996; Long, 1993; U.S. DHHS, 1997; U.S. Government Office of Technology Assessment, 1994).

HEALTH AND SOCIAL CONSEQUENCES OF SUBSTANCE ABUSE

Substance Abuse and HIV/AIDS

As is the case with members of other racial/ethnic groups, the health and social repercussions of substance abuse problems are magnified in the lives of Blacks/African Americans. Blacks/African Americans have higher rates of alcohol-related medical problems and mortality rates than their White counterparts (Goddard, 1993; NIAAA, 1994), despite the fact that the latter group has higher rates of alcohol use and abuse (U.S. DHHS, 1998).

An examination of the leading causes of death among Blacks/African Americans in the United States also points to the deleterious consequences of substance abuse. HIV infection is the fourth leading cause of death among the Black/African American population, with homicide and legal intervention (i.e., deaths such as those caused by police officers in pursuit of criminals) the sixth leading cause (NCHS, 1997). Nonetheless, it is estimated that half of all homicides among Blacks/African Americans are related to alcohol use and 10 percent or more to use of illegal drugs.

HIV/AIDS disproportionately affects Blacks/African Americans in general and Black/African American injection drug users in particular. Half of AIDS-related deaths among African Americans are due to injection drug use (Day, 1995). Among those who inject drugs, Blacks/African Americans are almost five times as likely as Whites to be diagnosed as having AIDS (Day, 1995). Blacks/ African Americans who inject drugs are also seven times more likely to die from AIDS than from a drug overdose. Figures from 1997 indicate that Black/African American adolescent and adult males are three times as likely as Whites to contract HIV through injection drug use or through sex with an injection drug user (CDC, 1997). For adolescent and adult Black/African American women, the most frequent modes of transmission were drug use and heterosexual contact with an injection drug user or an HIV-infected man (CDC, 1997). Although, across all racial/ethnic groups, the most predominant mode of transmission among pediatric AIDS tends to be a mother with HIV the cumulative number of pediatric AIDS cases among Blacks/African Americans is four times greater than Whites' (CDC, 1997). It is believed that this difference is the result of several factors such as drug use coupled with unprotected sex.

Substance Abuse and Crime

Substance abuse also has serious social repercussions within the Black/African American community. It is estimated that about half of the 1.4 million Black/African American men in prison are serving drug-related sentences (Abramsky, 1997; Carr, 1996). Abramsky (1997) attributes this not to the fact that Blacks/African Americans use more drugs than Whites, but to the fact that the large majority of the crimes committed by Blacks/African Americans are crack cocaine-related crimes, which are punished more severely than powder-cocaine crimes (more prevalent in White middle-class suburbs). Black/African American women are not that different in this respect from their male counterparts. About 35 percent of all the women incarcerated in California are Blacks/African Americans, and the large majority of them are also serving time for drug-related crimes (Reed and Reed, 1997). In terms of arrests, Blacks/African Americans are more likely than Whites to be arrested for illicit drug use(Mosher and Yanagisake, 1991).

The most prevalent treatment model used among Blacks/African Americans and members of other ethnic/racial groups in prison is incarceration without specialized services (Brown, 1992). However, although a significant number of Black/African Americans entering the correctional system has some kind of substance abuse problem, in those prison facilities with substance abuse programs, they are underrepresented (De Leon et al., 1993).

Blacks/African Americans are also more likely to be affected by drug-related crimes at the other end of the violence spectrum, namely as victims. They are among those affected the most by crimes directly and

indirectly connected to drugs (Ann Arbor News, 1993). The high concentration of Blacks/African Americans in poor neighborhoods often plagued by drug activities puts them at a higher risk of being a victim of crime.

CULTURE/RACE, HELP-SEEKING BEHAVIOR, AND ACCESS TO SERVICES ISSUES

Although racial/ethnic minorities, for the most part, tend to be overrepresented among those with substance abuse problems, the large majority of individuals abusing substances and receiving treatment for those problems are Whites (U.S. DHHS, 1997). Cultural, racial, social, and economic forces come to play when individuals from racial/ethnic minority groups with substance abuse problems seek treatment services. Among the first issues they must deal with concerns knowledge about availability of services. Other important factors impinging upon help-seeking efforts relate to affordability. Assuming that services are available, that the potential client knows about them and that he/she can afford them, issues about the adequacy of the services may surface. Thus, although structural barriers (e.g., lack of services) might be insurmountable for many, availability of services does not necessarily translate into successful treatment for others. This section presents some of the issues that come to play when Blacks/African Americans seek substance abuse treatment services.

Cultural Competence in Treatment Delivery

Development of trust between a non-Black/African American clinician and a Black/African American patient is core to service delivery problems. However, the issue in question is not simply the color of the skin of the clinician. In those instances in which a Black/African American therapist has been trained using theoretical models based on the class and social values of the dominant culture, chances are that he/she may not be successful in working with a large number of Blacks/African Americans. Any clinician, regardless of race, who cannot identify with the patient's needs nor understands where the patient is coming from is likely to engender mistrust.

Without a culturally and racially specific knowledge base for working with Black/African American patients, negative racial attributions may be combined with stereotypes about substance abusers that influence interactions with these patients. For many Blacks/African Americans, negative experiences with society at large have made them resistant to the idea of being treated by providers who represent the society they have learned to resist. This has a detrimental effect in the therapist-client relationship, and ultimately drives many patients away from what could be an opportunity for a successful treatment experience.

The Distinction Between African Americans and Black Americans in the Context of Services

Grouping people of color into a homogeneous category results in an inaccurate understanding of the patient's background. This will ultimately lead to a less effective therapeutic alliance between the provider of services and the consumer. In order to better serve patients of color, it is important to understand some of the nuances between those who identify with the term "African American" and those who do not.

The term "African American" is a term used by some people to affirm their roots in the continent of Africa. The identification with the African continent, "the mother continent," is essential in grounding and reattaching some African American people to their origin. The term "Black," which is a designation of preference by many people of color, relates to the Black American in the diaspora. The term relates to Black Americans whose self image is defined more by the beginning of their ancestors forced arrival in the United States than by a cultural connection to Africa.

The Black experience in America has been diverse and wide-reaching. It has produced a varied cultural range of experiences and expressions. Individuals seeking substance abuse treatment have lived many of these experiences. It is paramount to the success of treatment that providers carefully listen to the expression of who their patients are, so that they can ascertain their treatment needs and interact with the patients as they are and according to how they see themselves.

One dimension of the African American experience that may be especially difficult for clinicians to grasp is the historical context of slavery. There may be a tendency to relegate this experience to the past and to overlook its consequences in the present, especially in the case of a practitioner whose self-image and personal experience relative to race are positive. For many African Americans, however, the impact of slavery remains current and is manifested in racism at both individual and institutional levels.

The issues of slavery and institutional racism are constant and prevalent facts in the lives of many Black Americans. These issues must be addressed early in any treatment experience, so as to be

acknowledged and accepted as part of the personal dynamic of treating African Americans and being culturally competent in all treatment environments, private or publicly funded.

African American Families

Frequently, uninformed attitudes about the predominance of female-headed households among urban Black/African American families has resulted in categorizing them as dysfunctional. A greater number of African American families today (as other families) are composed of one parent living alone with young children (U.S. Bureau of the Census, 1997).

Blacks/African Americans have characteristically practiced a communal form of child rearing. The Black/African American family shares with its church the concept of inclusive community. They rely on relatives and community members to help in the process of rearing their children. The African American extended family has been described as a kinship network that extends beyond a household into communities and indeed into different cities and states (Nobles, 1972). Bonds of "reciprocal dependence or communal alliance" knit these extended families together and serve to meet basic family functions (Brisbane and Womble, 1992). The African proverb, "It takes a whole village to raise a child," speaks to the communal form and the collective responsibility of the "village" to instill values in all the children of their "village."

Racism and its Impact on Treatment

The term "racism" is commonly used to describe a social dynamic that impedes the possibility of all positive relations among races of people. It is a constellation of presumptions, beliefs, attitudes, and behaviors triggered by the sole perception of another person's race. In practice, it takes the form of automatically attributing certain social and behavioral characteristics to the race of another person. "Race" is used as shorthand for summarizing the attributes of a group and responding to all members of the group as if no further distinctions among individuals of that race existed.

Institutional racism has a profound effect on access to treatment, capacity to complete treatment, and the benefits that can be expected from treatment. The effectiveness of a treatment system is shaped by the quality of interactions within the system, i.e., interactions among its policies, employees, and patients, and the degree to which the patient is assured the right to the "expectation of benefit" (Sullivan, personal communication, 1993) from the treatment-providing institution.

Institutions that seek to have treatment staff reflect the demographics of the patient population have only just begun to make an inroad into cultural competence. Unless the administrative staff, the board of trustees, and the organization's policies and procedures reflect the cultural components of the populations they seek to treat, they may be viewed by the Black/African American patient as manipulative and hypocritical.

Racism and experiences with welfare and other social systems have made Black families particularly sensitive to situations in which they are asked to provide personal information. Often, these requests are perceived as prying, particularly when they take place before a bond of trust has been established.

The Role of the Church

The church can play an instrumental role in the treatment and recovery of Black/African American drug users. For centuries, the church has played a caring and healing role in the Black/African American community, and, to a great extent, it has become a surrogate extended family. As the recoverer makes his or her way back into the community, church support can serve to improve the individual's chances of recovery and lessen the chance of relapse.

Lessons Learned from CSAT-Funded Programs

CSAT has funded a number of substance abuse treatment programs that have incorporated culturally competent interventions and treatment approaches for Blacks/African Americans. They have provided valuable information about strategies to implement when treating African Americans for substance abuse problems.

Some programs, like a mental health center in Miami Florida, combined basic social service and treatment principles with anthropological fieldwork in the local catchment area. This fieldwork assisted the program in building a conceptual framework that enhanced cultural competence in the delivery of treatment.

The Center's treatment approach was developed around the following areas:

- An annual community-based needs assessment survey in which neighborhood residents are asked for their perception of the services needed in their communities.
- Case-management services focused on family reunification and linkage with and advocacy for appropriate community resources and support systems.

- Onsite Twelve-Step programs (e.g., Narcotics Anonymous, Alcoholics Anonymous) attended by members from the ethnic groups in the area served by the Center.
- Child-care services.
- Patient participation in establishing social and recreational activities.
- Encouragement of church attendance and advocacy as well as education among church youth groups around the areas of self-esteem, HIV/AIDS, family relations, and depression.
- Employment of appropriate ethnic staff at all levels of the treatment program in order to facilitate communication, rapport-building, identification, role modeling, and the development of trust.
- The use of ethnically appropriate assessments of patient behaviors, symptoms, and treatment needs.
- Involvement of professional and paraprofessional counselors from the recovering community, including former patients of the program, as peer counselors and outreach workers.
- Implementation of a food program in which patients can volunteer at a food bank and earn exchange credits for foods of their own choosing (often ethnic foods).
- Counseling support with regard to home remedies, folk healers, spiritual and religious treatments specific to particular cultural groups, and herbal and other alternative health practices.
- Seminars in leadership training that are often led by African American celebrities.
- Links with local African American newspapers which provide culturally relevant articles for their readers on substance abuse issues.
- The use of focused skill-building groups on parenting which include grandparents, aunts, and uncles.

Other programs developed an Afrocentric treatment approach that combined mainstream substance abuse treatment with an African value system (Afrocentricity) to create a unique philosophy for achieving recovery goals. African American philosophers suggest that the search for one's roots begins with an exploration of African American history and mythology and proceeds to an in-depth look at East Africa as the origin of all African people. Afrocentricity reflects a committed attitude or way of being. It is fully presented in the African American value system, the *Nguzo Saba*, promulgated by Karenga. It emphasizes oneness of spirit between people and nature. The program's philosophy embodies the idea of multidimensional relationships among its residents.

In addition to the use of an Afrocentric approach African proverbs have been used to further enhance the development of a broader spectrum of perspectives, styles of thinking, and insight in treatment. Some of the proverbs used are:

- The ruin of a nation begins in the homes of its people. (Ashanti)
- Even an ant may harm an elephant. (Zululand)
- A roaring lion kills no game. (Tanzania)
- He who is being carried does not realize how far the town is. (Nigeria)
- One camel does not make fun of another camel's hump. (Guinea)
- He who conceals his disease cannot expect to be cured. (Ethiopia)
- A brother is like one's shoulders. (Somalia)

CONCLUSIONS AND RECOMMENDATIONS

Culturally competent principles and guidelines are important in the design and implementation of effective programs that will meet the treatment needs of Black/African American patients. It is clear that social, economic, political, and cultural contexts are so intertwined in the lives of Blacks/African Americans that ignoring these contexts in the treatment arena constitutes a disservice to this community (Pena and Koss-Chioino, 1992).

Evaluations should take into account the kinds of outcomes that should be measured in cultural competent services. Some dimensions to evaluate should include: factors playing a role in determining who seeks treatment; differences between individuals who seek treatment and those who do not; the role of cultural sensitivity and programming on treatment outcomes, etc. (Mayers and Kail, 1993). The execution of this task will move the field of cultural competence treatment ahead and will foster the replication of programs that have proved to be effective.

INFORMATION RESOURCES

Web sites

Alcoholics Anonymous World Services:
www.alcoholics-anonymous.org

Minority Health Network:
www.pitt.edu/!ejb4/min

Office of Minority Health:
www.os.dhhs.gov/proorg/ophs/omh

Resources for Diversity:
www.nova.edu/Inter-Links/diversity.html

Substance Abuse and Mental Health Administration: www.samhsa.gov/

The Universal Black Pages:
www.gatech.edu/bgsa/blackpages.html

Organizations
African American Family Services, 2616 Nicollet Avenue South, Minneapolis, MN 55498; 612-871-7878.

Black Congress on Health, Law, and Economics, 1025 Connecticut Avenue, NW, Suite 308, Washington, DC 20036; 202-659-4020.

Publications
Rowe, D., and Grills, C. 1993. **African-centered drug treatment: Alternative conceptual paradigm for drug counseling with African-American clients**. *Journal of Psychoactive Drugs* 25:21-33.

Johnson, K.A., and Jennison, K.M. 1994. **Stressful loss and the buffering effect of social support on drinking behavior among African-Americans: Results of a national survey**. *Journal of Alcohol and Drug Education* 39:1-24.

REFERENCES

Abramsky, S. 1997. Gulag American style. *Toward Freedom* 46(2):10-11.

Ann Arbor News. 1993. 1 in 10 Blacks crime victims. *Ann Arbor News* 158(319):2.

Barr, K.E., Farrell, M.P. Barnes, G.M., and Welte, J.W. 1993. Race, class, and gender differences in substance abuse: Evidence on middle-class/underclass polarization among Black males. *Social Problems* 40(3):314-327.

Beatty, L.A. 1994. Issues in drug abuse prevention intervention with African Americans. In A. Cázares and L.A. Beatty (Eds.), *Scientific methods for prevention intervention research* (pp. 171-201). NIDA Research Monograph 139. Rockville, MD: U.S. Department of Health and Human Services.

Bennett, C.E., and DeBarros, K.A. 1997. *The Black Population*. Washington, D.C.: U.S. Census Bureau.

Brisbane, F. L., and Womble, M. 1992. *Working with African Americans: The Professional Handbook*, 1992, Chicago: HRDI International Press.

Brooks, J.S., Whiteman, M., Balka, E.B., and Hamburg, B.A. 1992. African-American and Puerto Rican drug use: personality, familial, and other environmental risk factors. *Genetic, Social, and General Psychology Monographs* 118(4):417-438.

Brown, B. 1992. Program models. In C. Leukefeld, and F. Tims (Eds.), *Drug abuse treatment in prisons and jails* (NIDA Research Monograph 118, pp. 31-37). Rockville, MD: Department of Health and Human Services.

Carr, R. 1996. Crime: A debate over punishment and prevention. *Congressional Quarterly* 54(40):2810-2811.

Centers for Disease Control (CDC) 1997. HIV/AIDS Surveillance Report. Atlanta: Author.

Day, D. 1995. *Health emergency: The spread of drug-related AIDS among African Americans and Latinos*. Princeton, NJ: The Lindesmith Center.

DeLeon, G., Melnick, G., Schoket, D., and Jainchill, N. 1993. Is the therapeutic community culturally relevant? Findings on race/ethnic differences in retention in treatment. *Journal of Psychoactive Drugs* 25:77-86.

Frey, W., and Scommegna, P. 1997. *Black migration to the South reaches record highs in 1990s*. Washington, D.C.: Population Reference Bureau.

Goddard, L. 1993. Background and scope of the alcohol and other drug problems. In L. Goddard (Ed.), *CSAP technical report 6: An African centered model of prevention for African-American youth at high risk* (pp. 11-18). Rockville, MD: Department of Health and Human Services.

Gray, M. 1997. African Americans. In J. Philleo, F.L. Brisbane, and L.G. Epstein (Eds.), *Cultural competence in substance abuse prevention* (pp. 55-81). Washington D.C.: National Association of Social Workers Press.

Johnson, K.A., and Jennison, K.M. 1994. Stressful loss and the buffering effect of social support on drinking behavior among African-Americans: Results of a Natinal Survey. *Journal of Alcohol and Drug Education* 39(2):1-24.

Jones-Webb, Snowden, L., Herd, D., Short, B., and Hannan, P. 1997. Alcohol-related problems among Black, Hispanic and White men: The contribution of neighborhood poverty. *Journal of Studies on Alcohol* 58(5):539-545.

Kleinman, P., and Lukoff, I. 1978. Ethnic differences in factors related to drug use. *Journal of Health and Social Behavior* 19:190-199.

Logan, S.L. 1996. *The Black family: Strengths, self-help and positive change*. Boulder, CO: Westview Press.

Long, L. 1993. An Afrocentric intervention strategy. In L. Goddard (Ed.), *CSAP technical report 6* (pp. 87-92). Rockville, MD: U.S. Department of Health and Human Services.

Mayers, R.S., and Kail, B.L. 1993. Hispanic substance abuse: An overview. In R.S. Mayers, B.L. Kail, and T.D. Watts (Eds.), *Hispanic substance abuse* (pp. 5-16). Springfield, IL: Charles C. Thomas.

Mosher, J. F., and Yanagisake, K. 1991. Public health, not social warfare: A public health approach to illegal drug policy. *Journal of Public Health Policy, Inc.* 12:278-323.

National Center for Health Statistics (NCHS). 1997. *Health, United States, 1996-97 and Injury Chartbook*. Hyattsville, MD:USDHHS.

National Institute on Alcohol Abuse and Alcoholism. 1994. *Alcohol Alert* 23:1-3.

Nobles, W. 1972. African philosophy: Foundations for Black psychology. In: Jones, R. H., Ed., *Black Psychology*. New York: Harper & Row, pp. 103-104.

Pena, J., and Koss-Chioino, J. 1992. Cultural sensitivity in

drug treatment research with African-American males. In J. Pena and J.Koss-Chioino (Eds.), *Ethnic and multicultural drug abuse* (pp. 157-179). Binghampton, NY: The Haworth Press.

Reed, D.F., and Reed, E.L. 1997. Children of incarcerated parents. *Social Justice* 24(3)152-169.

Robinson, R. G., Pertschuk, M., and Sutton, C. 1992. Smoking and African Americans: Spotlighting the effects of smoking and tobacco promotion in the African American community. In: S.E. Samuels and M.D. Smith, Eds., *Improving the Health of the Poor: Strategies for Prevention.* Menlo Park, CA: The Henry J. Kaiser Family Foundation.

Stevenson, H.C., and Renard, G. 1993. Trustin ole'wise owls: Therapeutic use of cultural strengths in African-American families. *Professional Psychology Research and Practice* 24(4):433-442.

Sullivan, H. S. 1993. Personal communication.

U.S. Bureau of the Census. 1997. *Current Population Survey.* Washington, DC: U.S. Government Printing Office.

U.S. Bureau of the Census. 1998. *Resident population of the United States: Estimates by sex, race, and Hispanic origin, with median age.* Washington, DC: U.S. Government Printing Office.

U.S. Department of Health and Human Services (DHHS). 1997. *Treatment Episode Data Set* (Advance Report no.12). Rockville, MD: Substance Abuse and Mental Health Services Administration.

U.S. Department of Health and Human Services (DHHS). 1998. *Prevalence of substance abuse among racial and ethnic subgroups in the United States, 1991-1993.* Rockville, MD: Substance Abuse and Mental Health Services Administration.

U.S. Government Office of Technology Assessment. 1994. *Technologies for understanding and preventing substance abuse and addiction.* Washington, D.C.: U.S. Printing Office.

Vega, W., Zimmerman, R., Warheit, G., Apospori, E., and Gil, A. 1993. Risk factors for early adolescent drug use in four ethnic and racial groups. *American Journal of Public Health* 83:185-189.

POPULATION COMPOSITION AND SOCIODEMOGRAPHIC PROFILE

Asian American and Pacific Islanders constitute the fastest growing ethnic minority group in the United States (Bennett and Martin, 1997). Census figures from 1997 estimate that about 9.6 million Asian Americans and Pacific Islanders reside in the United States. This figure represents an increase of 2.6 million since 1990. Asians and Pacific Islanders comprise 3.6 percent of the total U.S. population. Although their median age is 31.4, much of this population's growth is not due to natural increase but to immigration, which accounted for 86 percent of the total increase (Bennett and Martin, 1997). It is projected that by the year 2000, 12.1 million Asians and Pacific Islanders will reside in the United States, still representing 4 percent of the total population. By 2050, this population is expected to reach 41 million (U.S. Census Bureau, 1997).

Chinese are the largest Asian subgroup residing in the United States (23 percent), followed by Filipinos (19 percent) Korean Americans and Asian Indians (11 percent each) (Zane and Kim, 1994). Vietnamese represent 8 percent of all Asians and Pacific Islanders in the United States, followed by Cambodians and Laotians with 2 percent each and Hmong and Thai with one percent each. A significant number of individuals from these subgroups are foreign born. Among Chinese, 63 percent are foreign born. For Filipinos and Korean Americans, the percentages of foreign born are 64 percent and 80 percent, respectively (Zane and Kim, 1994). Hawaiians, the Pacific Islander population indigenous to the Hawaiian islands, make up the largest subgroup (66 percent) of the Pacific Island group, followed by Samoans (15 percent), Chamorros (12 percent), and other Pacific Island groups (Mokuau and Browne, 1994). Other Asians/Pacific Islanders include Tongans, Thai, and Burmese, among others. The large majority (67 percent) of Asians and Pacific Islanders residing in the United States speak a language other than English at home (U.S. Census Bureau, 1997). Samoans have the highest proportion of non-English speakers (64 percent) (U.S. Census Bureau, 1993).

Sixty percent of Asians and Pacific Islanders reside on the West Coast of the United States (Bennett and Martin, 1997), largely in metropolitan areas. As a group, Asians and Pacific Islanders have attained high educational levels. Census data from 1994 indicate that about 9 out of 10 Asian and Pacific Islander males 25 years old and over and 8 out of 10 female counterparts have obtained at least a high school diploma. There are, however, significant educational differences across Asian and Pacific Islander subgroups.

In terms of household/family median income, Asians and Pacific Islanders fare better than any other group in the United States. For example, data from 1993 indicate that the median income for Asian and Pacific Islander families was $44,460, compared to $41,110 for White families, the group which traditionally has the highest household income in the United States. However, a close examination of other family variables uncovers factors responsible for these apparently favorable numbers. First, Asian and Pacific Islander households tend to be larger than White families (3.8 and 3.1, respectively) and to include members of the extended family. Most of the members of the household work, and thus contribute to the family/household income (Kuramoto, 1994). Second, Asian and Pacific Islander males and females had lower earnings than their comparably educated White counterparts. Thus, higher median income might be an artifact of the number of earners contributing to the overall family income.

The overall economic success of Asians and Pacific Islanders in the United States, however, does not hold true for all members of the groups. In fact, poverty has been on the rise for Asians and Pacific Islanders (Kuramoto, 1997; Mokuau, 1997). In 1997, 14.5 percent of the total Asian and Pacific Islander population in the United States lived below poverty level, as compared to 8.6 percent of the White population and 28.4 and 29.4 percent of Blacks and Hispanics, respectively (U.S. Census Bureau, 1997). Of those Asians and Pacific Islanders living at the poverty level, about a third were working.

MIGRATION EXPERIENCE

Asians and Pacific Islanders are a group characterized by racial, ethnic, cultural and sociodemographic heterogeneity. They also vary in terms of their migratory experience and history. The Philippines, China, India, Vietnam, and Korea accounted for the largest number of this group's immigrants between 1990 and 1996. Reasons for immigration vary. For the vast majority of immigrants arriving in the United States from China, Korea, and the Philippines, both family reunification and their high levels of education and skills have largely motivated their coming to the United States. For those arriving from Vietnam, Laos, and

Cambodia, policies designed to help war refugees provided the impetus to moving to the United States (Kuramoto, 1994).

The number of years living in the United States also varies by group. Some groups have lived in the United States for significantly more years than other groups. For example, many Japanese and Chinese families have lived in the United States for generations, as compared to Vietnamese, Koreans, Asian Indians, and Filipinos who are mostly first-generation (U.S. Government Office of Technology Assessment, 1994). These differences have repercussions in terms of their settlement experiences as well as their language, ethnic identity, and acculturation levels. All of these factors have shaped the development of substance abuse problems and thus need to be taken into account when providing appropriate treatment.

SUBSTANCE ABUSE EPIDEMIOLOGICAL DATA

Three major roadblocks have delayed progress in the understanding and treatment of substance abuse problems among Asians and Pacific Islanders. The first one is the persistent finding that, compared to other populations, Asians and Pacific Islanders tend to use and abuse drugs and alcohol at lower rates than Whites, Hispanics, and Blacks/African Americans. This finding has promoted the notion that substance abuse is not an issue of concern among Asians and Pacific Islanders. The second roadblock is the lack of comprehensive substance abuse incidence data among Asians and Pacific Islanders. Since many members of these groups are consistently left out of substance abuse epidemiological studies, the tendency has been to conclude that their problems with substance abuse are, if any, minimal (Kuramoto, 1997; Mokuau, 1997). The third obstacle in understanding and providing substance abuse treatment among Asians and Pacific Islanders is the challenge this population's cultural and sociodemographic heterogeneity poses to understanding the full extent of the substance abuse problems they face (Cheung, 1989; Kuramoto, 1994). The complexity of different cultural norms, languages, traditions, values, and beliefs translates into varying patterns of substance abuse across subgroups (Kuramoto, 1994; 1997). Each subgroup may differ not only in terms of the drugs they abuse but also in the manner in which they abuse substances.

The combined effect of these three obstacles has resulted in Asians and Pacific Islanders being continually relegated "invisible," when it comes to acknowledging and resolving critical service needs. The uneven quality of current research appears to reflect this failure to recognize substance abuse problems within these communities. It is worth noting that, although slow and limited, some progress has been made in removing these roadblocks.

Incidence Data Research

Over the past years, the number of studies on substance abuse among Asians and Pacific Islanders has grown. However, studies in the area still show some limitations. For example, the studies' sample sizes tend to be small and are generally restricted to specific geographical areas. As already mentioned, early research on Asians and Pacific Islanders suggested relatively low rates of substance abuse (Wolff, 1973). Those findings raised questions about the factors contributing to those low rates. Thus, subsequent studies were launched to find explanations for those relatively low rates. Those studies generated an extensive body of information regarding biophysiological factors related to genetic and metabolic differences between Caucasians and Asians as possible explanations for the lower rates of alcohol abuse. The data concluded that there were no differences in alcohol tolerance among Asians, Pacific Islanders, and Caucasians (Chan, 1986; Newlin, 1989; Johnson and Nagoshi, 1990; Morales, 1991; Zane and Sasao, 1992), and that the differences in substance abuse rates were largely due to sociocultural factors (Cheung, 1993; Li and Rosenblood, 1994).

Other studies of Asians and Pacific Islanders showing lower incidence of substance abuse and chemical dependency (Kitano, 1982; Cohen, 1979; Johnson et al., 1987; Sue and Morishima, 1982; Sue, Zane, and Ito, 1979) present serious methodological weaknesses (e.g., underestimation of levels of use and abuse of alcohol and other drugs). A summary of the research literature determined that, in many cases, sampling of student groups excluded those at greater risk for substance abuse, such as recent immigrants and adolescents not in school (Zane and Sasao, 1992). In addition, validity of results can be questioned with regard to inadequate sample size, lack of control data for demographic and cultural factors, inadequate translations of survey instruments, and measurement bias in the use of self-reporting procedures.

Studies undertaken by community-based organizations (Wong, 1985; Morales, 1991) have tried to obtain more representative samples of the at-risk population in non-student settings. These results provide evidence that equivalent or higher levels of specific substance abuse exist for certain Asian and Pacific Islander groups than for other ethnic groups.

In addition, there is strong evidence of the diverse types of substance abuse patterns among Asian and Pacific Islander groups (Kitano and Chi, 1987).

Non-inclusion or underrepresentation in the national drug abuse surveys and other data collection efforts is another significant factor contributing to lack of information on patterns of use and abuse of substances by Asians and Pacific Islanders. For example, African Americans and Hispanics were heavily represented in the National Household Survey on Drug Abuse conducted in 1988-89 (DHHS, 1990a). However, Asians and Pacific Islanders were not represented. The Drug Abuse Warning Network (DAWN) fails to present reliable incidence information on Asians and Pacific Islanders primarily because reporting occurs in major metropolitan areas where Asians and Pacific Islanders are not necessarily highly concentrated (DHHS, 1990a). Among the few comprehensive Asian and Pacific Islanders needs-assessment studies are the statewide studies, *Special Services for Groups* (Morales, 1991) and *Statewide Asian Drug Service Needs Assessment* (Sasao, 1991), funded by the California Department of Alcohol and Drug Programs. Also, the 1991-1993 National Household Survey on Drug Abuse collected data on Asians/Pacific Islanders. It revealed that they had the second lowest level of past-year use of any illicit drug. They also had a very low need of illicit drug use treatment. However, the survey does not provide information on specific sub-groups.

Heterogeneity of the Population and Substance Abuse Epidemiology

The relatively few studies that have systematically examined substance abuse patterns and issues among Asian Americans and Pacific Islanders have pointed to two facts, namely, that this population does confront substance abuse problems and that the sociocultural factors impinging upon substance abuse vary across sub-groups. Nevertheless, findings are far from conclusive. As a general pattern, Asians and Pacific Islanders tend to have lower prevalence rates of substance abuse (NIDA, 1995) than any other groups. However, studies focusing on specific Asian and Pacific Islander subgroups shed light on how the patterns vary across subgroups.

Although, as a general pattern, Asian and Pacific Islanders use drugs at lower rates than other groups, the inclusion of variables such as age, immigration status, geographical residence, and type of substance abuse adds new dimensions to the complexity of establishing patterns of substance abuse among subgroups. For example, adolescent Asian Americans consistently have the lowest prevalence of alcohol and drug use across all groups (U.S. Government Office of Technology Assessment, 1994). Pacific Islander students in California reported the highest rate of alcohol consumption followed by Koreans, Filipinos, Japanese, Southeast Asians, and Chinese (Austin and Gilbert, 1994). Native Hawaiians report comparable drink rates to those of Whites, whereas among those residing in the United States, Japanese Americans tend to drink the most followed by Koreans and Chinese Americans (U.S. Government Office of Technology Assessment, 1994). In New York, Asians and Pacific Islanders were found to use cocaine at the same rate as Black/African Americans and inhalants at higher rates than Black/African Americans (Austin and Gilbert, 1994). Their use of inhalants was similar to that of Latinos but lower than that of Whites. For Asians and Pacific Islanders residing on the West Coast, their risk for using illicit drugs, in general, and in sequence with alcohol and tobacco is high (Ellickson, Hays and Bell, 1992).

In terms of alcohol use among Chinese, Japanese, Koreans, and Filipinos residing in Los Angeles, Kitano and Chi (1987) found that Japanese had higher rates of heavy drinking episodes (25 percent), followed by Filipinos (20 percent), Koreans (15 percent), and Chinese (10 percent). Another prevalence study revealed that Chinese Americans and Filipino Americans used fewer drugs than the general population, whereas Japanese reported similar rates to those of the general population (Trimble, Padilla, and Bell, 1987). In a survey of 204 Asian and Pacific Islander Driving-Under-the-Influence cases, alcohol consumption differed significantly between ethnic subgroups (Morales, 1991). Japanese Americans reported heavy alcohol consumption at twice the frequency rate of Koreans and over three times the rate of Pacific Islanders. Yet, Pacific Islanders reported heavier consumption levels at each occurrence. Moreover, they reported twice the number of instances of heavy drinking than Japanese and over six times more than Filipinos.

As part of an ambitious and comprehensive needs-assessment study conducted in California, Sasao (1991) organized community forums with members of Asian and Pacific Islander subgroups (i.e., Chinese Americans, Japanese Americans, Koreans, Filipinos, Vietnamese, Cambodians, Laotians, Hmongs, and Thai). Those forums provided a picture of the substance abuse problems the subgroups confront and the factors that shape and compound those problems. The study revealed that members of all groups confront problems with alcohol. Tobacco was a close second followed by marijuana, crack cocaine, and opiates (particularly among Laotians, and Hmongs). Across all groups,

adolescents, young adults, recent immigrants, and males were reported to be the most affected by substance abuse problems.

Findings from these community forums illustrate the multi-layered and interlocked issues involved in substance abuse. The substance abuse problems confronted by each group can be viewed as the by-product of the unique way in which cultural, economic, social, political, and migratory factors fuse for each group.

HEALTH AND SOCIAL CONSEQUENCES OF SUBSTANCE ABUSE

Substance abuse has been related to AIDS among Pacific Islanders (Mokuau, 1995) and other groups. The AIDS epidemic began to affect Asians and Pacific Islanders in the late 1980's. As of June 1997, there have been 4,370 AIDS reported cases among Asians and Pacific Islanders in the United States (CDC, 1997). The three main modes of transmission among members of these groups are injection drug use, heterosexual and homosexual intercourse (Sy et al., 1998). In 1994, Asians and Pacific Islanders reported the highest proportion of HIV/AIDS cases in Hawai`i (Department of Health, 1994). Since substance abuse problems have been increasing among Asians and Pacific Islanders, it is expected that substance abuse will play a significant role in the emergence of new HIV/AIDS cases within this population.

A relationship between crime and substance abuse has consistently been strong (Ichiho, DeLisio, Sakai, and Maritsugu, 1990). For Asians and Pacific Islanders this is not an exception. Hawaiians and Samoans show high rates of substance abuse-related crimes (Crime Prevention Division, 1994). It is estimated that 95 percent of Asian and Pacific Islanders in California prisons are serving time for drug-related crimes (Kuramoto, 1994).

CULTURE, HELP-SEEKING BEHAVIOR, AND ACCESS TO CARE ISSUES

Although the large majority of the studies reveal relatively low levels of substance abuse among Asians and Pacific Islanders when compared to Whites, Blacks/African Americans, and Hispanics, substance abuse problems among this population are on the rise (Ja and Aoki, 1993; James et al., 1997). This is particularly true for Southeast Asians (i.e., Cambodians, Mien, Hmongs) (Amodeo et al., 1996). It is argued that adaptation to Western culture alters the hierarchical family structure, interdependence, and self-identity, which consequently predisposes young Asian Americans to substance abuse problems (James et al., 1997).

Despite the increase in substance abuse problems among Asians and Pacific Islanders, culturally-appropriate treatment and intervention programs have lagged behind (D'Avanzo, 1997).

The diversity of Asians and Pacific Islanders has made the challenge of culturally competent substance abuse treatment services a complex one for providers. Mainstream services rarely recognize the substance abuse issues of Asians and Pacific Islanders, and give little consideration to the impact of cultural values, language, and socioeconomic history on individuals within treatment interventions. Creating innovative models for attracting and retaining Asian and Pacific Islander patients in treatment requires ongoing focus on the following issues:

- Diversity of Asian and Pacific Islander groups.
- Language, socioeconomic, cultural, and geographical barriers to treatment.
- Immigration status (e.g., immigrant, refugee) and length of time in the United States.
- Level of acculturation.

Family, Community and Culture

In order to understand how the worldview of Asian and Pacific Islander people might affect help-seeking behavior and access to care, several factors need to be considered. Substance abuse is not easily discussed within many of these ethnic communities. Illicit substance abuse and dependency are considered serious breaches of acceptable behavior. In Asian families, as well as in families of other racial/ethnic groups, acknowledging a substance abuse problem often leads to a significant loss of face and shame for both the individual and the family. In response, the family may inadvertently isolate the individual, and avoid or deny the existence of problems.

In Pacific Islander families, a person's substance abuse problems can be felt as shameful and hurtful to one's family. The individual can be viewed as losing his/her sense of spirituality and, ultimately, jeopardizing important family relationships. Conceivably, as an outcome of this deep-felt personal and familial pain, when asked for self-report data on substance abuse, actual behaviors may often be substantially under-reported. In an alcohol needs assessment survey, Chinese, Japanese, Koreans, Pacific Islanders, Filipinos, and Southeast Asians overwhelmingly responded that denial of substance abuse was the primary barrier to seeking recovery services (Morales, 1991). Consequently, mobilizing these communities toward prevention and treatment strategies is not an easy task.

Many Asian and Pacific Islander families embody the cultural perspective of prioritizing one's identity within the context of the larger group, be that one's community, family or other affiliations. This group focus fosters a unique appreciation of family interdependence and promotes a sense of group cohesiveness. A family's response to the presence of illicit substance abuse and addiction may seem confusing to mainstream practitioners who are unaware of the cultural dynamics at play. Too often families are labeled "dysfunctional" and "enabling" for behaving in culturally prescribed ways that may paradoxically escalate or prolong the addictive process. It is important to understand that these family responses in most other life circumstances are appropriate and effective for maintaining vital family cohesiveness. From a practitioner's viewpoint, ill-timed introduction of interventions that exclude or totally separate the individual from the family (e.g., "tough love" strategies), may be met with fierce resistance. Likewise, intervention strategies that attempt to diffuse the power of family relationships or imply parental blame for the child's problems are culturally inappropriate and will likely result in failed therapeutic relationships not only among Asian Americans/Pacific Islanders but among other groups.

In Asian families, if internal means of resolution to the individual's addiction problems fail, interventions are often initiated from within the extended family network. Relatives may be asked to intervene and attempt rationalizing with the substance abuser or appealing to his/her sense of familial obligation. The problem is thus contained within a small portion of the community, beginning with the family, then the extended family, and finally moves outward to include friends, elders, and others in the extended network. As a last resort, families may attempt relocating the individual from the current environment to live with extended family elsewhere or returning the individual to the native country.

It is generally at the point where all other means of familial or community problem-solving has failed that social and human service providers within established organizations are contacted for assistance. Patients referred by their families are likely to be highly resistant to treatment. Since the family has gone outside normal acceptable parameters, the patient's personal shame and reluctance to enter treatment will be difficult to overcome.

In Pacific Islander families, members may not have any idea about how to resolve the problem of the substance abuser and will avoid any intervention until the judicial system or family court becomes involved. For the family to reach out to social service agencies implies an expectation by the family that the agency has the answer to the problem. Since most agencies are staffed by people who are not familiar with the individual's culture or may offer services that are culturally inappropriate, there is no guarantee that the agency will be of assistance.

Most families do not understand the nature of the substance abuse process and consequently have different expectations of service providers. They may assume that the individual can be quickly fixed and returned to "normal." Practitioners should understand that concepts such as chemical dependency or mental illness are defined by Euro-Western ideologies that treat an individual's emotions, behaviors, physical functioning, and spirituality as separate non-related entities. In contrast, Eastern and indigenous cultures view health from a more holistic perspective of body, mind, and soul integration. Consequently, treatment providers may find themselves in a double bind with conflicting family expectations on one hand, and a reluctant patient, on the other.

Gender Issues

In general, Asian and Pacific Islander women report low levels of substance use and abuse. Therefore, if Asians and Pacific Islanders, as a whole, suffer from a lack of visibility and treatment accessibility, women within these groups are given even less consideration for service. Thus, when a woman develops a chemical dependency problem, there are even fewer avenues of seeking recovery that will address her multiple needs. In fact, there are numerous additional barriers to engaging her in appropriate services than those previously mentioned in this chapter.

It is important to note that the role of Asian and Pacific Islander women within their family systems, similar to women in other cultures, is a pivotal one. Traditionally, women play a primary caretaking role within the family. It is generally the woman's responsibility to nurture, protect and promote the family's survival. Additionally, in Pacific Islander families, the matriarch is responsible for major decision-making. Yet, in these difficult times, her role has increased in complexity and challenges.

In addition to caretaking, many women carry a major financial responsibility in supporting their families. For example, in immigrant and refugee families, the woman may secure new employment sooner than her spouse while also maintaining responsibility for family caretaking. Increasingly, women are raising their families without the presence

of a partner. In the case of Hawaiian homes, 21.3 percent were female householders with no husbands, a rate higher than that of other ethnic groups in Hawai`i (Blaisdell and Mokuau, 1991).

Availability of Culturally Competent Treatment

Underutilization of services among Asians and Pacific Islanders is more due to a lack of culturally competent services and treatment than to low levels of substance abuse among members of the group (Kuramoto, 1994). Culturally competent treatment, including the organization's credibility in the community, bilingual and bicultural staff, emphasis on culture, ethnic pride, language issues, and multiservice approach, (Kuramoto, 1994; Mokuau, 1991; 1995) can minimize shame and loss of face.

Community-based service organizations often are the only source of treatment services available to Asian and Pacific Islander groups. Many community organizations are willing but are often ill-trained and unequipped to provide substance abuse treatment services. Few facilities are prepared to provide culturally responsive services for Asians and Pacific Islanders. Most have no linguistic capability attached to their services, whether outpatient, inpatient, or residential. Often, waiting lists are established, with waiting periods as long as six months to a year. Longer established U.S.-based ethnic communities such as Chinese, Japanese, and Hawaiians may be more able to provide a greater range and variety of health and social service options within their communities.

Emerging immigrant groups such as Cambodians, Laotians, and Thai, as well as Pacific Islander groups like Samoans and Tongans, often have only a single organization as a source for continuing care services. These overburdened community-based organizations are often the only resource for treating substance abuse in the community.

Providers find themselves working in a crisis-oriented environment where primary needs often take precedence over addressing substance abuse issues. Treatment providers must be ready and willing to handle basic living issues such as shelter, food, childcare, legal constraints, employment, and medical needs, among others, if substance abuse interventions are to be successful. Most patients will not be able to give their substance abuse problems attention until these fundamental needs are resolved. Moreover, these needs must be addressed before treatment can be effective in reducing the patient's potential for relapse.

Availability of Qualified and Culturally Competent Treatment Personnel

The staff at treatment centers servicing Asians and Pacific Islanders has received their education and experience primarily within Western-oriented universities and organizations. Consequently, only a small number of trained professionals have acquired cultural competence through program models that are a blend of Western approaches and Eastern or Polynesian cultural ideology and background. Most treatment approaches at the few existing treatment programs for Asians and Pacific Islanders are a hybrid of Western, Eastern, and/or Polynesian concepts. More commonly, these populations are serviced by mainstream professionals or staff in recovery who have not been exposed to relevant cultural experiences or applicable models of effective treatment for these populations. Not surprisingly, patients who strongly identify with their cultural background will find "fitting in" to mainstream models of treatment enigmatic and conflicting. Ultimately, the costly results of such dissonance in service provision can be harmful for patients unable to find alternative avenues for treatment. This might not be the case, however, among more acculturated patients.

Role of Culture

As a result of the shortage of services, the tendency is to locate services in organizations that already serve the community and which are easily identified by this population (Mokuau, 1997). Thus, treatment is sought through Asian and Pacific Islander social services, primary care health care and mental health clinics, private physicians, clergy, community-based organizations, and native healers, among others. Therefore, the importance of collaborating with community leaders, churches, temples and schools to attract individuals to services cannot be overemphasized (Kuramoto, 1994).

The design of substance abuse treatment services needs to take into account cultural factors such as family involvement, immigration status and its accompanying risks for substance abuse as well as acculturation (Ja and Aoki, 1993; Varma and Siris, 1996). For example, since Asians and Pacific Islanders view the family as an extension of the self, close family members should also be incorporated into the treatment program (Kuramoto, 1994). Cultural themes related to substance abuse that should also be addressed are moderation, family reputation, humility, negative community sanctions on excessive

drinking and behavior, needs of the family, sharing, generosity, and extended family. Other ingredients should be incorporated when treating members of specific groups. For example, important cultural themes for Vietnamese, Cambodian and Hmong refugee populations include kinship solidarity and the search for equilibrium (Frye, 1995).

Staff and Training

Perhaps one of the most important factors determining a program's ability to provide culturally appropriate and accountable treatment and consequently retain consumers of services is the program's staff. Many programs attempt to make their treatment viable through a process commonly known as "staff osmosis," i.e., hiring staff with one or both of two elements — language and ethnicity congruent to the clientele.

Hiring a staff member who speaks the language of the targeted group is the first step used to service recent immigrants. Often, the staff member may not even be from the same ethnic group, but perhaps has learned the required language in school. Although this affords the patient a common language with which to communicate, it does not necessarily facilitate the process of treatment if the treatment setting is operating from an Euro-Western perspective.

The second element, hiring staff of the same ethnic group, is very common in establishing relevant services for Asians and Pacific Islanders. Unfortunately, simply having the same ethnic background of the target population is not a guarantee of cultural competence (Dobbins and Skillings, 1991). For example, even if the staff person speaks Chinese, the cultural assumptions of a third- or fourth-generation Chinese American may be far more similar to those of a Caucasian than of a recent Chinese immigrant. Again, there is an attempt to intervene with a cultural approach based on ethnicity per se but without appropriate consideration of the patient's worldview.

It is critical to note that Asian and Pacific Islander professionals can also benefit from cultural competency training, particularly if their experience is primarily based on Euro-Western-oriented approaches. Bilingualism, although an important relevant skill, does not in itself impart cultural competency to treatment. Culturally competent practice addresses the appropriate integration and utilization of treatment approaches that are inclusive of the patient's cultural worldview and understanding of quality life.

Recruitment of culturally competent staff is predicated on the experience the candidate has with the population to be served and with substance abuse treatment modalities. Often life experience with the population to be served is a more pragmatic foundation than having only education or experience in substance abuse treatment. The ideal goal is for the professional to be able to balance cultural life experience with substance abuse expertise.

Culturally competent staff recruitment and retention, however, is more than simply matching language or ethnicity. Staff members must also undergo a process of understanding their own perspectives regarding treatment and the effects on the patient population. This means examining their own perceptions and biases towards particular Asian and Pacific Islander ethnic groups in order to recognize the limitations of their personal world view. This process is critical for promoting increased self-awareness and addressing practitioner bias. For example, a Japanese or Chinese American staff member may be asked to work with a recent refugee or immigrant from Laos. The experiences and perspectives of this patient will significantly differ from that of a third- or fourth-generation Asian American practitioner.

Continuum of Care

In some communities where substance abuse has become a significant and growing problem, a larger range of services has been established. For example, in major metropolitan areas with large Asian and Pacific Islander populations, such as San Francisco, Los Angeles, or New York, a continuum of services is now available in the areas of social services, mental health, and health care. A significant issue is the economic feasibility for local communities to fully develop the entire range of substance abuse services, particularly if they are addressing the needs of specific Asian and Pacific Islander ethnic groups.

In most instances, for the emerging immigrant groups and some Pacific Islander communities, development of an organizational infrastructure consists primarily of self-help community organizations such as mutual aid societies and association groups. In many cases, traditional village or tribal ties are primary sources of support. For others such as Filipinos and Koreans, clubs and associations serve as a social network, with churches the primary organizational vehicles for assistance. Generally, assistance and support are offered through volunteer services.

PRACTICES USED TO MEET TREATMENT NEEDS

Effective culturally competent interventions for Asian American and Pacific Islanders and members of any other racial/ethnic groups should:

- Foster strong community linkages to other community organizations to complement the overall scope of services.
- Promote a process of exchange among staff members. Current staff and newly recruited staff can share their knowledge with each other. Staff in recovery should be complemented by those professionally trained.
- Develop and foster a trusting and respectful relationship with the community-at-large. This will firmly establish the credibility of the treatment program within the community.
- Be aware of normative behavior and communication styles, level of acculturation, political and socioeconomic background of the individuals served.
- Be willing to explore the effectiveness of currently available treatment models from Western, Eastern and Polynesian perspectives.

Acupuncture, an Eastern healing approach, has been tested at some site for substance abuse treatment. The exploration of different treatment models presupposes that different ones would be viewed as "legitimate" within the framework of current funding and policy making sources in city, State, and Federal bureaucracies. Combinations of Eastern, Polynesian and Euro-Western treatment approaches continue to be explored for efficacy. For example, the Asian American Residential Recovery Services (AARRS) in San Francisco has utilized a fairly conventional therapeutic community model but has also incorporated acupuncture, a focus on family, vocational and recreational activities, community support and counseling, Asian ethnic staff, and appropriate languages.

Suggested Treatment Modalities

An effective treatment program approach reflects cultural characteristics, norms, and values (Mokuau, 1997). It also requires substantial planning and development. As mentioned earlier, despite serving multicultural populations, most treatment programs follow conventional outpatient peer group and/or therapeutic community approaches or a Twelve-Step model. These models have important strengths and usefulness, but they are not culturally grounded in addressing Asian and Pacific Islander issues, nor have they been widely accepted by these populations. The most common approach for Asian and Pacific Islander patients has been to modify the Euro-Western approaches utilized by most treatment programs.

Programs have at least three options in establishing program approaches. First, simply utilizing current and existing treatment theories and approaches is the most convenient treatment regime but fails to consider the traditional perspectives of Asian and Pacific Islander patients. A second option is adapting and revising Euro-Western treatment approaches, then incorporating creative Asian and Pacific Islander interventions within the overall context of the treatment regime. Although this has a narrow conceptualization of the treatment focus, it may help expand program relevance for some Asian and Pacific Islander patients. For example, second- or third-generation Chinese or Japanese Americans might relate better to an English-speaking program with a more mainstream approach. More recent arrivals to this country, and those individuals who continue to hold traditional values and beliefs of their ethnic culture might be less likely to succeed with such a program. An example of this approach could be the use of individual- rather than group-therapy approaches in order to avoid issues of "losing face" and thus retain individuals in treatment (Kuramoto, 1994).

A third option is utilizing only culturally based approaches that match specific cultural beliefs. Although difficult to establish and legitimize within our current system of treatment, this approach provides culturally relevant services for those with strong traditional values. Acupuncture, herbal medicine, religious and familial approaches are examples of this treatment type.

In the Thai community for instance, prayer and spiritual belief, growth, and development under Buddhism have been advocated as viable alternatives to the current methods of treatment for this population. Techniques such as, *ho`oponopono* (culturally prescribed family sessions), receiving guidance through *nā kūpuna* (elders), working in the Hawaiian *lo`i* (taro patches), and using storytelling and myths as avenues to personal insight and learning life's lessons, are being utilized successfully in the treatment of Hawaiian patients.

Treatment Alternatives: A Community-Based Approach

In reviewing treatment alternatives, the following are suggestions for approaches on a community level. The ideal range of treatment services for the Asian and Pacific Islander community includes prevention,

outreach, outpatient, detoxification and methadone maintenance, day treatment services, inpatient and residential care for both youths and adults, family services, and continuing care.

Local communities need to determine the level and range of services predicated on community parameters established by local groups and organizations. These parameters can be based on degree of need, population size, parity, existing organizations and resources, socioeconomic factors, severity of substance abuse problems, available staffing or expertise, etc. Established community-based organizations with a critical mass of funding, staffing, and experience may take the lead in offering substance abuse treatment services. For most, the first step is the establishment of prevention services for youth and families, followed by treatment services for youth on an outpatient basis.

Developing potential models of care in substance abuse treatment can depend on the level of treatment required. Included are services such as education, preventive medicine, outreach, short-term crisis counseling, case management, and referrals. These services are often within the organizational framework of most human service agencies. As such, organizations can utilize existing expertise and community relationships to develop programs for educating the community, youth, young adults, and families. Often, prevention and education services will bring attention to cultural needs that would otherwise remain "hidden." The history, level of trust, experience, and capabilities of an agency will influence the community's willingness to overlook the stigma of substance abuse and utilize treatment programs.

Within this approach, language capabilities and cultural sensitivity are essential. Furthermore, the level of services is impacted by the quality of expertise available among different Asian and Pacific Islander groups. Organizations with existing expertise within their own ethnic communities can establish substance abuse treatment services with minimal costs and resources. For example, a Filipino youth organization could develop its own levels of care for Filipino youth; an existing Vietnamese social service agency could develop such services for Vietnamese adults and families.

Provision of treatment services to the late-stage addict is more complicated and requires sophisticated levels of expertise including detoxification, medical care, psychiatric care, and possibly pharmacological care including methadone maintenance. This treatment regimen can be made available through comprehensive outpatient care or through inpatient or residential treatment services.

Instituting an organizational mission and vision that affirms cross-cultural competency requires a multilevel approach that is integrated throughout the agency infrastructure. This process includes developing relevant administrative and programmatic design, policies, and evaluation. In this context, organizations that have programs dedicated to treatment intervention for Asians and Pacific Islanders must first define the structure and hierarchy in which the program operates. Logistically, the program must be accessible to community members, and the organization and its program must have a positive presence within the community. Organizational credibility and accessibility includes recruiting the active participation of community-based individuals and leaders in initial development of the program and on its board of directors. Board membership should include individuals with treatment experience, people in recovery, community leaders and providers, and family members of clients and individuals in recovery. The agency's policies should include and address the diverse needs of their clientele.

Several CSAT demonstration projects have attested to the importance of considering all the elements discussed above when implementing treatment programs. For example, the United Cambodian Community program demonstrated the relevance of providing multiple services in a cultural competent setting under one roof. As previously mentioned, ties with the community of racial/ethnic groups and recruitment of recovering para-professionals to work along professionals tend to facilitate the delivery of effective treatment. Various CSAT demonstration projects (The Asian American Residential Recovery Services program, Micronesia Bound, Inc., Pohnpei Community Action Agency , Asian American Drug Abuse Program) effectively used those strategies, among others, in the implementation of treatment interventions. Others, such as Ho`omau Ke Ola, in Wai`anae, Hawai`i, have successfully combined traditional cultural concepts and Eastern techniques with the aforementioned components in the treatment they provide to their clients.

The Asian American Residential Recovery Services (AARRS) in San Francisco has used different sources of motivation to bring potential clients to treatment (Ja and Aoki, 1993). A structured treatment approach in which the potential client is given clear guidelines and procedures, preferably in writing, so a message of stability is delivered at the outset of the first encounter with the treatment program is recommended.

As mentioned earlier, the experiences preceding the arrival of Southeast Asians in the United States often include war related trauma which compound their process of adapting to the new sociocultural environment. Recent times have witnessed an increase in mental health problems with co-occurring substance abuse problems among South East Asians (O'Hare and Tran, 1998). Based upon the experiences of members of this group, suggestions have been made about how to assess and address substance abuse problems among them. For example, a multivariate approach is recommended to assess South East Asians' substance abuse problems. Such an approach allows to assess substance abuse problems in a context that examines causes, course and consequences of substance abuse in relation to co-occurring health, mental health, and other psychosocial problems (O'Hare and Tran, 1998). In addition to this, it is important to address the cultural context in which these problems occur. This cultural context includes losses suffered as the result of war (for those that apply), migration, and the process of acculturating to a new sociocultural environment.

Treatment providers serving Southeast Asians should focus on multiple losses, stress-related somatic issues, and problems of adaptation (O'Hare and Tran, 1998). In terms of intervention models, psycho-educational approaches, role-modeling and coping skills approach are also recommended. Practitioners should avoid insight oriented therapy with Southeast Asian substance abusers. Cognitive-behavior therapy approaches have shown positive results among Southeast Asian substance abusers (O'Hare and Tran, 1998). These approaches focus on learning new skills to reduce or eliminate consumption of alcohol and drugs, prevent relapse, and reduce negative consequences of substance abuse. The application of these approaches to this group should be cognizant of issues of guilt, shame, roles of family members, and the role of the community in reducing or eliminating substance abuse. However, any approach used to address substance abuse problems among Southeast Asians should recognize the role factors such as ethnic identity, trauma and losses, assimilation and acculturation-related stresses, psychosocial and mental health problems play in the development and maintenance of substance abuse problems (O'Hare and Tran, 1998).

CONCLUSIONS AND RECOMMENDATIONS

The ability to organize multicultural treatment programs for Asians and Pacific Islanders is an ideal toward which the treatment community needs to strive. However, it may be prohibitively expensive to provide the full range of comprehensive, culturally competent treatment services to Asians and Pacific Islanders.

Epidemiological data on substance abuse reveal that the group's diversity plays a major role in the way they use and abuse substances. The population's sociodemographic profile also points to the vast differences that exist across subgroups in terms of English-language use and income. There are also differences in the way members of different subgroups view the use of drugs and the services provided to deal with substance abuse problems. For example, those who are not proficient in English will confront difficulties in receiving treatment at facilities where their native language is not spoken. The same situation exists for those who have limited economic resources and cannot pay for services.

As reviewed earlier, the migratory experience also varies by subgroup. Some have arrived to reunite with relatives. For others, their educational attainments and occupational skills have given them the opportunity to move to the United States. Still others have arrived in the United States as political refugees escaping war, imprisonment and torture. The migratory experiences add another dimension to their socio-psychological idiosyncrasies. In some cases it might make them more vulnerable to develop substance abuse problems. Acculturation also plays an important role in both the recognition of a substance abuse problem and help-seeking efforts to deal with it. A highly acculturated individual might be more prompt to recognize the problem, will be more familiar with available treatment services, and might confront fewer obstacles in obtaining it, as opposed to a less acculturated individual.

However, focusing on these issues is only the first step. Development of substance abuse treatment services for Asian and Pacific Islander must also address:

- Knowledge and utilization of cultural strengths and values in treatment design.
- Recruitment and retention of bilingual/multi-ethnic and multicultural staff.
- Ongoing training to address issues of cultural diversity and competency.
- Culturally competent evaluative research and database design.

INFORMATION RESOURCES

Web sites

Alcoholic Anonymous World Services: www.alcoholics-anonymous.org

Asian and Pacific Islander American Health Forum Programs: www.igc.org/apiahf/

Asian Community Mental Health Service(ACMHS): www.acmhs.org

Asian Health Service: www.ahschc.org

Asian Pacific American Network: www.apanet.org

Association of Asian Pacific Community Health Organization: www.aapcho.org

Hmong Homepage: www.stolaf.edu/people/cdr/hmong

Khmer Health Advocates: www.hartnet.org/~khmer

National Asian Pacific American Families Against Substance Abuse: www.igc.org/apiahf/hapafasa.html

Office of Minority Health Resource Center: www.omhrc.gov or 1-800-444-6472

Orange County Asian and Pacific Islander Community Alliance: www.ocapica.org

University of Washington, Cambodian Ethnic Medical Guide: www.washington.edu/clinical/ethnomed/cambodia.html

University of Washington, Vietnamese Ethnic Medical Guide: www.washington.edu/clinical/ethnomed/vietnam.html

Thai culture: http://sunsite.au.ac.th/thailand/culture.html

Publications

This A.A.: An Introduction to the A.A. Recovery Program. Available in Cambodian, Chinese, Korean, Vietnamese and other languages through A.A. World Services Inc., General Service Office, PO Box 459, Grand Central Station, NY, NY 10163; 212-870-3400.

Storytelling: Culture as Prevention - Korean Folktales. 45-minute videotape. Available from Conference Recording Service, 1380 Gilman Street, Berkeley, CA 94706; 1-800-647-1110.

New Land, New Choices: A Culturally Specific Curriculum on Alcohol, Tobacco, and Other Drugs for Southeast Asian Students. Available from Metropolitan Indochinese Children and Adolescent Services, Southeast Asian family Empowerment Project, 254 Adams Street, Dorchester, MA 02212; 617-825-1861.

Opening Doors: Techniques for Talking with Southeast Asian Clients about Alcohol and Other Drug Issues. Available from Metropolitan Indochinese Children and Adolescent Services, Southeast Asian family Empowerment Project, 254 Adams Street, Dorchester, MA 02212; 617-825-1861.

References

Amodeo M., Robb N., Peou S., and Tran H. 1996. Adapting mainstream substance-abuse interventions for Southeast Asian clients. *Families in Society: The Journal of Contemporary Human Services* 77: 403-412.

Austin, G., and Gilbert, M. *1994. ATOD Use Among American Youth.* Unpublished manuscript.

Bennett, C.E., and Martin, B. 1997. *The Asian and Pacific Islander Population.* Washington, D.C.: U.S. Census Bureau.

Blaisdell, K., and Mokuau, N. 1991. Kanaka Maoli: Indigenous Hawaiians. In N. Mokuau (Ed., *Handbook of social services for Asian and Pacific Islanders* (pp. 131-154). New York: Greenwood Press.

Center for Disease Control (CDC). 1997. *HIV/AIDS Surveillance Report.* Atlanta: Author.

Chan, A. 1986. Racial differences in alcohol sensitivity. *Alcohol and Alcoholism* 21:93-104.

Cheung, Y. 1989. Making sense of ethnicity and drug use: A review and suggestions for future research. *Social Pharmacology* 3:55-68.

Cheung Y.W. 1993. Beyond liver and culture: A review of theories and research in drinking among Chinese in North America. *International Journal of the Addictions* 28:1497-1513.

Cohen, S. 1979. The oriental syndrome. *Drug Abuse and Alcoholism Newsletter* 8(10):1-3.

Corcoran, K., and Vandiver, V. 1996. *Maneuvering the maze of managed care.* NY: The Free Press.

Crime Prevention Division. 1994. *Crime in Hawai'i 1993.* Honolulu: State of Hawaii Department of the Attorney General.

D'Avanzo, C.E. 1997. Southeast Asians: Asian-Pacific Americans at risk for substance misuse. *Substance Use and Misuse* 32:829-848.

Department of Health. *1994. AIDS surveillance quarterly report.* Honolulu: State of Hawaii.

Dobbins, J. E., and Skillings, J. H. 1991. The utility of race labeling in understanding cultural identity: A conceptual tool for the social science practitioner. *Journal of Counseling and Development* 70:37-44.

Ellickson P., Hays R., and Bell R. 1992. Stepping through the drug use sequence. *Journal of Abnormal Psychology* 101 (3):441-451.

Frye B.A. 1995. Use of cultural themes in promoting health among Southeast Asian refugees. Special issue: Underserved populations. *American Journal of Health Promotion* 9:269-280.

Ichiho, H., DeLisio, G., Sakai, T., and Moritsugu, S. 1990. The Hawaii State Department of Corrections substance abuse strategy. *Hawai'i Medical Journal* 49: 200-204.

Ja, D.Y., and Aoki, B. 1993. Substance abuse treatment: Cultural barriers in the Asian-American community. *Journal of Psychoactive Drugs* 25:61-71.

James, W.H., Kim G.K., and Moore D.D. 1997. Examining racial and ethnic differences in Asian adolescent drug use: The contributions of culture, background and lifestyle. *Drugs: Education, Prevention and Policy* 4(1):39-51.

Johnson, R. C., and Nagoshi, C. T. 1990. Asians, Asian-Americans, and alcohol. *Journal of Psychoactive Drugs* 22(1):45-52.

Kitano, H. L. L. 1982. Alcohol drinking patterns: The Asian Americans. In: *Special Population Issues, Alcohol and Health Monograph 4.* Washington, DC: National Institute on Alcohol Abuse and Alcoholism.

Kitano, H. L. L., and Chi, I. 1987. Asian Americans and alcohol abuse: Exploring cultural differences in Los Angeles. *Alcohol Health and Research World* 11:41-53.

Kuramoto, F.H. 1994. Drug abuse prevention research concerns in Asian and Pacific Islander populations. In A. Cázares and L.A. Beatty (Eds.), *Scientific methods for prevention intervention research* (pp. 249-272). NIDA Research Monograph 139. Rockville, MD: U.S. Department of Health and Human Services.

Kuramoto, F.H. 1997. Asian Americans. In J. Philleo, F.L. Brisbane, and L.G. Epstein (Eds.), *Cultural competence in substance abuse prevention* (pp. 83-125). Washington D.C.: National Association of Social Workers Press.

Li H.Z., and Rosenblood L. 1994. Exploring factors influencing alcohol consumption patterns among Chinese and Caucasians. *Journal of Studies on Alcohol* 55:427-433.

Mokuau, N. (Ed.). 1991. *Handbook of Social Sciences for Asian Pacific Islanders.* New York: Greenwood Press.

Mokuau, N., and Browne, C. 1994. Life themes of Native Hawaiian female elders: Resources for cultural preservation. *Social Work* 39(1):43-49.

Mokuau, N. Pacific Islanders. 1995. In R.L. Edwards (Ed.-in-Chief), *Encyclopedia of social work* (19th ed., Vol 3, pp. 1795-1801). Washington, DC: National Association of Social Workers.

Mokuau, N. Pacific Islanders. 1997. In J. Philleo, F.L. Brisbane, and L.G. Epstein (Eds.), *Cultural competence in substance abuse prevention* (pp. 127-152). Washington D.C.: National Association of Social Workers Press.

Morales, R. 1991. *Alcohol Abuse and the Asian American.* Presentation at the NIDA National Conference on Drug Abuse Research and Practice, January 21, 1991, Washington, DC.

National Institute on Drug Abuse. *1995. Drug Use Among Racial/Ethnic Minorities.*

Newlin, D. B., 1989. The skin-flushing response: Autonomic, self-report, and conditioned responses to repeated administrations of alcohol in Asian men. *Journal of Abnormal Psychology* 98:421-425.

O'Hare, T., and Tran, T.V. 1998. Substance abuse among Southeast Asians in the U.S.: Implications for practice and research. *Social Work in Health Care* 26:69-80.

Sasao, T. 1991. *Statewide Asian drug service needs assessment.* Sacramento: California Department of Alcohol and Drug Programs.

Sue, S., and Morishima, J. K. 1982. *The Mental Health of Asian Americans.* San Francisco: Jossey-Bass.

Sue, S., Zane, N., and Ito, J. 1979. Alcohol drinking patterns among Asian and Caucasian Americans. *Journal of Cross-Cultural Psychology* 10(1):41-46.

Sy, F.S., Chng, C.L., Choi, S.T., and Wong, F.Y. 1998. Epidemiology of HIV and AIDS among Asian and Pacific Islander Americans. *AIDS Education and Prevention*:10.

Trimble, J., Padilla, A., and Bell, C. 1987. *Drug abuse among ethnic minorities.* Rockville, MD: National Institute on Drug Abuse.

U.S. Bureau of the Census. 1993. *We the American.... Pacific Islanders.* Washington, DC: U.S. Department of Commerce.

U.S. Bureau of the Census. 1997. *Current Population Survey.* Washington, DC: U.S. Government Printing Office.

U.S. Department of Health and Human Services (DHHS). 1990a. *Data from the Drug Abuse Warning Network (DAWN): Annual Data 1989.* U.S. Department of Health and Human Services, Public Health Service, Alcohol, Drug Abuse, and Mental Health Administration, National Institute on Drug Abuse. DHHS Pub. No. (ADM) 90-1717, Rockville, MD.

U.S. Government Office of Technology Assessment. 1994. *Technologies for understanding and preventing substance abuse and addiction.*

Varma S.C., and Siris S.G. 1996. Alcohol abuse in Asian Americans: Epidemiological and treatment issues. *American Journal of Addictions* 5: 136-143.

Wolff, P. 1973. Vasomotor sensitivity to ethanol in diverse Mongoloid populations. *American Journal of Human Genetics* 25:193-199.

Wong, H. Z. 1985. *Substance Use and Chinese American Youths: Preliminary Findings on an Interview Survey of 123 Youths and Implications for Services and Programs.* San Francisco: Youth Environment Services.

Zane N.; and Kim J. Substance use and abuse. 1994. In N. Zane, D. Takeuchi, and K. Young (Eds.), *Confronting critical health issues of Asian and Pacific Islander Americans.* Thousand Oaks, CA: Sage Publications.

Zane, N., and Sasao, T. 1992. Research on drug abuse among Asian Pacific Americans. *Drugs and Society* 6(3-4):181-209.

AMERICAN INDIANS AND ALASKA NATIVES

INTRODUCTION

Development of culturally competent substance abuse treatment programs for American Indians/Alaska Natives[1] should take into account the history of such programs for this population. American Indian/Alaska Native communities are cognizant of the fact that they have severe substance abuse problems (Colorado, 1986). The high rate of alcoholism has been the main stimulus for the first alcohol treatment programs for American Indians. Alcohol treatment clinics for American Indians were first funded in the 1970's by the National Institute on Alcohol Abuse and Alcoholism (NIAAA) (Rhoades et al., 1988).

Immediately after the inception of substance abuse programs for American Indians, the American Indian Movement (AIM) began to question the motives of the Federally and State-funded substance abuse treatment programs that served both reservation and non-reservation populations. The AIM viewpoint was that such treatment programs alienated American Indian patients from their traditions and religion by attempting to mold them in the image of White culture (Akwesasne Notes, 1973; Churchill and Larsen, 1981). Treatment programs not based on native traditional practices and ceremonies were believed to be more interested in revenues than in the best treatment modalities for American Indian patients (Barta, 1991; Colorado, 1986; Poor Thunder, 1991).

In 1978, 36 of these treatment programs were transferred to the Indian Health Service (IHS). Realizing that American Indian communities were encountering additional difficulties this time with illegal drugs, especially abuse of inhalants among youth, IHS began to implement substance abuse treatment programs that were not alcohol specific. By 1988, there were 300 substance abuse treatment programs supported by the IHS. In redeveloping these programs, IHS used a substance abuse treatment model similar in nature to the CSAT Comprehensive Treatment Model. This model recognizes that addiction to drugs and alcohol has many causes and can be a chronic condition. Therefore, substance abuse treatment must first assess the multiple bio-psycho-social needs of each individual substance abuser. These needs must then be met through long-term comprehensive services selected specifically for the individual. IHS's treatment model requires (1) ensuring a permanent, coordinated effort to combat the serious health problem of alcohol and substance abuse among American Indians and Alaska Natives; (2) restructuring activities permanently, rather than providing a time-limited campaign; (3) providing training of health professionals, especially American Indians; and (4) involving lay efforts within the tribes, including the tribal government, schools, elders, and all sections of the community (Rhoades et al., 1988).

POPULATION COMPOSITION AND SOCIODEMOGRAPHIC PROFILE

Indian populations occupied most of the area of the continental United States when Europeans first arrived some 400 years ago. American Indians were and still are an extremely culturally and linguistically diverse group. This diversity evolved partly because of geographical barriers. American Indian tribes are subdivided into the following categories: Plains, Southwest, Eastern Woodlands, Great Basin, California, Plateau, and Northwest Coast. American Indians are currently the smallest minority group in the United States, constituting 0.7 percent (about 2.0 million) of the population in 1997 (U.S. Bureau of the Census, 1998). Figures from 1995 reveal that 13 percent of American Indians live in Oklahoma (Collins, 1997). Other States with high numbers of American Indian residents include Arizona, California, New Mexico, and Alaska.

The Federal government recognizes about 400 American Indian tribes; such official recognition confers rights to services, reservation land, and self-government. Many other tribal groups are either recognized by the State or not recognized (Beauvais, 1992; Ebona, 1984). Individual identity as an American Indian requires Federal or tribal certification. Normally, the Federal government, through the Bureau of Indian Affairs, requires a person to have at least one-quarter Indian blood before he/she is recognized as an American Indian. Many individual tribes certify their tribal members through their own blood quantum requirements (e.g., one-sixty-fourth to full blood) and/or descendency requirements.

It is important to recognize that American Indian tribes cannot be placed into a large "melting pot," because tribally-specific differences must be acknowledged. Each tribe, whether from the Plains, Plateau, or Coastal Regions, has separate and often vastly different beliefs, ceremonies, cultures,

[1]This chapter is limited to a discussion of culturally competent substance abuse treatment for American Indians in general and does not address such issues for specific tribes.

governments, practices and traditions. Differences also may occur within a tribe, since the bands and clans within it often possess practical and theoretical differences. Issues, practices, and ceremonies discussed in this chapter are mainly those of Plains tribes —amongst the largest in size— and must be adapted to the cultural patterns of the specific tribe that wishes to apply them.

SUBSTANCE ABUSE EPIDEMIOLOGICAL DATA

Until the arrival of the European, fermented beverages were unknown to Indians in the area now covered by the continental United States. Interest in alcohol varied greatly as tribes were introduced to it; some tribes rejected it, others incorporated its use into tribal practices, and still others were ravaged by it (Heath, 1985). Although substance use is a serious problem among American Indians today, the extent of substance abuse related problems varies across tribes.

Alcohol is the drug of choice among American Indians (Mail and Johnson, 1993). Overall rates of alcohol and other drug use are high among members of American Indian and Alaska Native groups (Mail and Johnson, 1993; U.S. DHHS, 1998). In 1995, the large majority of admissions (77 percent) to substance abuse treatment among American Indians was due to alcohol (U.S. DHHS, 1997). American Indians also begin using alcohol, illicit substances, and cigarettes at a younger age, at higher rates, and in combination with one another (U.S. Government Office of Technology Assessment, 1994) than any other group. However, the use of specific drugs among American Indians varies. According to the National Household Survey on Drug Abuse: 1991-1993, American Indians'/ Alaska Natives' past-year alcohol use was a close third to whites, whereas past-year use of cigarettes, marijuana, and cocaine were significantly higher than any other group's (U.S. DHHS, 1998). They also had the highest level of need of illicit drug abuse treatment compared to any other group.

As mentioned earlier, American Indians/Alaska Natives use and abuse substances from an early age. American Indian youths frequently abuse inhalants (Beauvais et al., 1985; Wingert, 1982). It has been estimated that by eighth grade, 25 percent of American Indians had tried an inhalant (U.S. House Committee on Appropriations, 1989). Moreover, it is believed that predisposing factors to inhalant use are already in place by the fourth and fifth grades (Beauvais and Oetting, 1988). As they grow older, the use of inhalants decreases, but the rate continues to be much higher than for any other group. A recent longitudinal study (Beauvais, 1996) confirms the conspicuous abuse of substances among American Indian youths. Over time, they still report very high rates of drug use compared to non-Indian counterparts. Those who have dropped out of school are at a higher risk of developing substance abuse problems. Estimates indicate that about half of American Indian youngsters have tried marijuana.

HEALTH AND SOCIAL CONSEQUENCES OF SUBSTANCE ABUSE

Similar to the experience of other racial/ethnic minority groups, substance abuse has highly deleterious effects in the lives of American Indians. However, the negative health and social consequences they suffer because of substance abuse problems are quantitatively and qualitatively harsher than any other group's (Indian Health Service, 1995; Wing et al., 1995). Alcohol plays a direct and prominent role in the health problems American Indians suffer: heart disease, cancer, diabetes, injuries, and death. They die more frequently from suicide, homicide and alcohol-related injuries than members of any other racial or ethnic group (Moran and May, 1997). Cirrhosis of the liver and alcoholism account for more than a third of all American Indian deaths (May, 1996). In 1985, for example, half of all American Indian deaths were related to alcohol abuse (U.S. DHHS 1985). Alcohol-related trauma and disease among American Indians frequently lead to disability (Hisnanick and Erickson, 1993; Indian Health Service, 1993).

Substance abuse has also been related to HIV and AIDS among American Indians/Alaska Natives. Although the most common mode of exposure among American Indian/Alaska Native males diagnosed with HIV/AIDS is men who have sex with men (MSM), a significant number of AIDS cases has been attributed to a combination of MSM and injecting drug use (CDC, 1998). For females, injecting-drug use is the most common mode of exposure, followed by heterosexual contact.

Both American Indian adolescents and adults are more likely to be involved in alcohol-related offenses than members of any other ethnic or racial group (U.S. Government Office of Technology Assessment, 1994). Alcohol also tends to be the leading cause for arrests. Youngsters are three times more likely to be involved in alcohol-related offenses than Whites or Hispanics. American Indian adults are ten times more likely to be arrested while under the influence of alcohol and/or other drugs than their White counterparts.

Alcohol and substance abuse among American Indians also has adverse health and social repercussions on the lives of American Indian women. They tend to die at higher rates than other women due to alcohol-involved causes (Moran and May, 1997). Also, it appears that physical abuse plays a prominent role in the lives of American Indian women who abuse substances (Gutierres and Todd, 1997; Robin et al., 1997). They also suffer more comorbid symptomatology (i.e., substance abuse and psychiatric symptoms) than their male counterparts (Novins et al., 1996; Robin et al., 1997).

CULTURE, HELP-SEEKING BEHAVIOR, AND ACCESS TO CARE ISSUES

Traditionally, substance abuse treatment in the United States has been predominantly targeted toward White middle-class males, and has been designed to meet their needs. This orientation has been and continues to be a barrier to effective multicultural substance abuse treatment of American Indians (Churchill and Larsen, 1981; Katz, 1985; Colorado, 1986; Pedersen, 1988; Ponterotto, 1988; Ponterotto and Casas, 1991).

Counseling, psychotherapy, or referral to Twelve Step programs, while effective mainstream treatment modalities, may not appeal to American Indian patients. Psychotherapy often does not work with American Indian substance abusers because of the need for personal disclosure, the requirement of patient-doctor trust, and a Western-oriented definition of antisocial behavior. American Indian clients tend to take longer to disclose sensitive issues in their lives to another and do so only after a trusting relationship is established. But continual disclosure as often required in confrontation therapy may diminish or end the established trust relationship (Colorado, 1986; Red Horse, 1982; Stubben, 1992b; Wilbur, 1994).

Geographic Distance from Providers

Lack of access to local providers who are culturally competent is problematic. Urban American Indians have a very difficult time obtaining culturally competent substance abuse treatment because of lack of funding for urban-based American Indian treatment programs; lack of American Indian treatment staff in urban areas; and a lack of understanding by many urban treatment centers of culturally competent treatment modalities.

The resources available for reservation treatment programs are often severely impacted upon by heavy use on the part of off-reservation American Indians, especially from urban areas, who return to their reservations for such services. Use of tribal and IHS services by off-reservation American Indians diminishes the level of service for those living on the reservation who depend on the availability of such services. Thus, expansion of current services is crucial to fulfill this population's needs.

Culturally relevant substance abuse treatment modalities documented by the NIAAA have identified specific cultural attributes that affect substance abuse treatment among American Indians (NIAAA, 1986). Research conducted through the National Institute of Mental Health (Manson, 1986) describes particular traditional practices, such as the *Talking Circle*, *Sweat Lodge*, and *Four Circles*, that can be used in the treatment of American Indians.

American Indian inmates in Nebraska identified such tribal ceremonies as the *Sweat Lodge*, *Vision Quest*, and the *Sun Dance* ceremony as important factors in an alcohol and drug-free life, and suggest the promotion of these activities including for those in prison and after their release (Grobsmith, 1989).

A recent study focusing on Alaska Natives, revealed that implementation of culturally sensitive approaches that incorporate and reinforce their lifestyles increased the retention of Alaska Native patients (Fisher et al., 1996). The strategies used to engage and retain them in treatment included spirit groups, cultural awareness activities, and urban orientation in addition to individual counseling.

Some successful American Indian treatment programs are receiving requests for treatment from non-Indian substance abusers who have undergone treatment in Western-oriented programs and have not recovered. Dissemination of information on American Indian substance abuse treatment techniques, practices, modalities, and research findings on the efficacy of these culturally competent programs can be found through the IHS (See also sub-section "American Indian Treatment Practices" in this chapter).

PRACTICES USED TO MEET TREATMENT NEEDS

A holistic approach that includes traditional values, beliefs, ceremonies, and processes is essential to the effectiveness of a culturally competent American Indian substance abuse treatment program (Red Horse, 1982; Colorado, 1986; Ponterotto and Casas, 1991; Poor Thunder, 1991). This may include spiritual beliefs and values, enhanced awareness of what it is to be an American Indian, and acknowledgment of a shared history of prejudice and oppression.

In the early and mid-1980's, research indicated that treatment programs incorporating American Indian culture and religious beliefs were meeting

with greater success (Churchill and Larsen, 1981; Colorado, 1986; Hall, 1986; Mail and McDonald, 1980). The conclusion was that American Indians need substance abuse prevention and treatment programs with a high degree of cultural or even tribal understanding and sensitivity (Colorado, 1986; Hall, 1986; LaFromboise and Rowe, 1983).

A significant number of American Indian substance abuse treatment programs have been developed across a wide array of treatment modalities. Most have concentrated on alcohol abuse, but many have a drug treatment component. Programmatic control and treatment development are contained and responsive to local forces, whether political, medical, psychological, spiritual, or economic. Some drug treatment approaches that are effective among members of society at large may have little or no success among American Indians. Cultural norms often govern the use and abuse of substances. In the Lakota world, for example, many women abstain from drug and alcohol use when they become grandmothers (Medicine, 1983). Many tribes believe that people abuse substances because they have strayed from the natural order of things, or the right path of life. Return to this right path requires "recovery of self and of autonomous dignity" through specific individual actions and traditional behaviors and ceremonies (Colorado, 1986; Poor Thunder, 1991). Inclusion of these linkages to traditional behaviors and associated ceremonies is key to any culturally competent substance abuse program that treats American Indian patients (Hand, 1991; 1992; Poor Thunder, 1991).

Substance abuse treatment programs for American Indians must include American Indian staff, especially of the same tribe. American Indian staff should contribute significantly to the intake process and to the development of an appropriate and effective treatment plan. Specific tribal healing practices are beneficial in the treatment of the substance abuser, and interviews with the patient by American Indian staff will reveal the attitudes and beliefs crucial to the effective use of traditional healing practices in the treatment plan (Red Horse, 1982; Colorado, 1986; Manson, 1986; Poor Thunder, 1991; Ponterotto and Casas, 1991). The following sections address these and other culturally competent treatment delivery issues.

Establishing Culturally Competent Treatment Programs

American Indian treatment programs require personnel who understand the different value systems of the American Indian and the non-American Indian or Western world. Most American Indians, particularly the young and middle-aged, are expected to learn to cope in both worlds on a daily basis (Nieto, 1992). When the acculturation process is stressful, alcohol and drug use may offer relief and escape as part of the coping response (Beauvais and LaBoueff, 1985; Bobo, 1985; Trimble, Bryan, and Padilla, 1985; Walker and Kivlahan, 1984). Culturally competent staff members have the ability to blend the adaptive values and roles of both the culture in which they were raised and the culture with which they are surrounded (LaFromboise and Rowe, 1983). Staff members in an American Indian substance abuse treatment program must understand both American Indian and non-American Indian worlds in order to deal with the impact of these competing value systems on a patient's substance use.

Qualified, culturally competent staff should be recruited from the American Indian communities themselves. Until recently, the use of tribal peoples as staff for drug treatment programs raised the issue that professionally trained clinicians often had difficulty integrating these culturally competent members of the community into the treatment process and involving them in treatment decisions. However, IHS has played an instrumental role in integrating these individuals through the development of programs designed to increase the numbers of American Indian health professionals in tribally managed services (IHS, 1996).

It is essential that the community be included in the treatment process and that community members such as tribal healers, elders, and holy persons serve as counselors and support staff. Although community is important, in some tribes the aforementioned community members may not be available or, in the beginning of the treatment program, may not be willing to be involved. Others in the community may do more harm than good because of tribal factionalism, political infighting or because of denial of a substance abuse problem by the community (Stubben, 1992a; Wilbur, 1994). Thus, an assessment of community resources is important in the developmental stages of a treatment program; continual communication with the community must be maintained along with ongoing substance abuse education of the community.

Disclosure and Confrontational Interventions

Several factors identified through research need to be considered in the treatment of American Indians. There is wide variation in the willingness of American Indians to disclose personal sex history, childhood experiences, family secrets, finances, and other routine details of social history or of a psychological nature. Also identified has been the

high value that American Indians place on respect for the individual, suggesting that the decision and responsibility to correct behavior lie within the individual. At the same time, an American Indian seeking to separate himself or herself from the family or reservation to attend a substance abuse program may suffer chastisement, imposed feelings of guilt, and physical abuse (Colorado, 1986; Poor Thunder, 1991; Red Horse, 1982).

Confrontation therapy, if used at all, should be carefully reviewed for its effectiveness with American Indian patients. As successful as this treatment technique may be with some populations, to many American Indians it is degrading and destructive to self-esteem (Ponterotto and Casas, 1991; Red Horse, 1982). Interviews with American Indians who underwent confrontation therapy revealed that they could accept confrontation on such issues only from their elders or from a similarly respected tribal person. Furthermore, confrontation of this type from an elder would be much more subtle, humorous, or teasing in nature (Stubben, 1992a, b).

The Cultural Network

To overcome the problem of separation from family, community, and tribe, many tribally based treatment programs use a cultural network that integrates the patient's indigenous community into the treatment plan. This mechanism serves to empower the community by being involved in determining programs that will impinge upon their future. The cultural network includes family and community members from all age cohorts and can serve patients from any age group. Culturally competent treatment programs reaffirm the cultural and structural integrity of American Indian extended kin systems.

In the culturally competent model, treatment services are organized around the cultural network. This structural model not only brings patients together as a collective for therapeutic support, but also incorporates immediate and extended family members, other individuals from the community, and community organizations to maintain an effective link between the patient and the community. This cultural network makes the existing mental health therapies much more acceptable to the patient because of the family and community support and input. The model also offers reality-based treatment. Through daily social contacts between patients and family, community, and tribal members, the professional staff keep abreast of emerging patient needs. Common pitfalls in the care continuum, such as inadequate staff outreach and follow-up, are avoided. Engaging individuals from allied community programs helps to meet the developmental needs of patients through informal relationships rather than through sterile clinical procedures. With all age cohorts involved, a true family development principle prevails that accentuates extended kin systems and maintains valued features of the culture (Red Horse, 1982).

Formal Linkages with Other Community Resources

The health and human service systems an American Indian person encounters vary greatly from tribe to tribe and from American Indian community to American Indian community. Although several urban areas have American Indian centers and culturally competent health and social service personnel, many more do not. The lack of cultural competence in the agencies may affect the American Indian patient's view of the substance abuse treatment process and of treatment facilities in general. Thus, the culturally competent substance abuse treatment program must be a catalyst in educating the health and human service agencies within its organizational network. All staff of service agencies with which a treatment facility interacts should be included in culturally competent education efforts: social workers, psychologists, judges, probation officers, police personnel, juvenile authorities, and housing personnel. Cooperative education efforts strengthen the bond between the cultural network and a drug treatment program.

American Indian Treatment Practices

Traditional American Indian approaches to substance abuse treatment vary among communities and tribes. The following treatment practices have been studied and found effective for patients from Plains tribes.

The *Talking Circle* or *Talking Stick meeting* is a form of group therapy in which participants are typically seated in a circle. Sweetgrass, sage, or cedar may first be burned and passed around the circle as a purification ritual. The rising smoke represents the vehicle by which the participants' intentions and subsequent messages are carried to the Creator. This act ritually connects the individual, physically and psychologically, to the source of the Circle's power. A leader begins the meeting by introducing the meaning of the talking stick (or feather) and, holding the stick, shares his or her innermost feelings with everyone in general, but no one in particular. The stick is then passed to the person seated on the leader's left. As each participant receives the stick, he or she is licensed to

speak freely without fear of rejection or contradiction. No interruptions are permitted and each participant may speak as long as desired. The Talking Circle is closed by a joining of hands and brief prayer (Manson, 1986).

The *Sweat Lodge* usually is a small, circular, dome-shaped structure made of willow poles that are arched, tied together, and covered tightly with blankets, a heavy tarpaulin, or animal skins. Heated rocks are placed at the center of the lodge, upon which water is poured to produce steam during the course of the ceremony. The participants sit within the lodge at its outer edge facing the center. The ceremony lasts several hours and is divided into "rounds." A round begins with the sprinkling of water on the rocks and continues with prayer, which is initiated by the sweat leader and often involves prayers by the other participants. Once the prayers have been completed, the sweat leader signals the end of the round and the participants may leave the Sweat Lodge if they wish. Another round then begins. The ritual itself may vary, but the central purpose of the Sweat Lodge is to bring each participant closer to the Creator and to the elemental forces that give meaning to life. The Sweat Lodge ceremony reaffirms human kinship with all living beings and the universe in general (Manson, 1986).

Other examples of culturally competent American Indian substance abuse treatment approaches that incorporate ancient American Indian traditions and teachings include the following: Good Way (Colorado, 1986; Sanderson, 1991), Sacred Circle (Crossbear, 1991), Red Road (Hand, 1991; Poor Thunder, 1991), and the Peyote Road of the Native American Church (Hill, 1990; Lawson and Morris, 1991). These promote the traditional idea that the individual who follows the right path will be healed. Thus, by adapting one's path of life to the beliefs and values of these ways of living, the substance abuser will overcome not only the substance abuse problem but also many other problems in his or her life. The patient will regain the positive identity as an Indian person that non-American Indian treatment modalities often try to replace through assimilation of the values of Western culture (Barta, 1991; Churchill and Larsen, 1981; Colorado, 1986; Poor Thunder, 1991).

The *Good Way* promotes spiritual healing and often utilizes traditional culture through interpretation of Twelve Step programs in both tribal language and philosophy. The Good Way also incorporates tribal ceremonies to a limited degree, particularly purification sweats and prayer. But the Good Way, although culturally sensitive, still relies heavily on the Twelve Step philosophy of NA or AA.

An example of the adaptation of the NA and AA philosophies to tribal culture can be found in the English version of the "Lakota Twelve Steps Toward a Drug-Free Life" (Sanderson, 1991):

1. I admit that because of my dependence on alcohol I have been unable to care for myself and my family.

2. I believe that a greater spirit can help me to regain my responsibilities and model the life of my forefathers (ancestors).

3. I rely totally on the ability of the Great Spirit to watch over me.

4. I strive every day to get to know myself and my position within the nature of things.

5. I admit to the Great Spirit and to my Indian brothers and sisters the weaknesses of my life.

6. I pray daily to the Great Spirit to help me.

7. I pray daily to the Great Spirit to help me correct my weaknesses.

8. I make an effort to remember all those that I have caused harm to and with the help of the Great Spirit achieve the strength to try to make amends.

9. I do make amends to all those Indian brothers and sisters that I have caused harm to whenever possible through the guidance of the Great Spirit.

10. I do admit when I have done wrong to myself, those around me, and the Great Spirit.

11. I seek through purification, prayer, and meditation to communicate with the Great Spirit as a child to a father in the Indian way.

12. Having addressed those steps, I carry this brotherhood and steps of sobriety to all my Indian brothers and sisters with alcohol problems and together we share all these principles in all of our daily lives.

The *Peyote Road*, a contemporary religion as opposed to religions of tribal groups, of the Native American Church is a blend of Christian and Indian beliefs. Peyote, a hallucinogenic cactus bud and highly controlled substance, is used sacramentally to attain visions. Prayers and songs to Jesus are a major part of the ceremony, which normally lasts from

sunset to sunrise. The four basic rules of life on the Peyote Road are (1) brotherly love, (2) care of one's family and abstinence from adultery and extramarital affairs, (3) self-reliance and hard work at one's job, and (4) avoidance of alcohol and drugs (Blackbird, 1981; Burnette and Koster, 1974; Hill, 1990).

The concept of the *Red Road* is often used to describe the difference between being drunk and sober, between using drugs and being straight. Unlike NA, this approach does not state that one is either a drug user or drug free, because both conditions are portrayed as part of reality. To "walk the Red Road" is to know the difference between being drunk and sober and to exist with that knowledge. The *Black Road*, on the other hand, represents self-gratification, disharmony, and imbalance. The decision to walk the *Red* or the *Black Road* is a matter of free will that exists in every human being.

Similarly, both sides of the *Sacred Circle* have consequences that must be recognized. The individual must choose one side of the circle or in the case of substance abuse, choose to be drug free or to use drugs. Persons "walking the Red Road" know the consequences of both sides of the *Sacred Circle* and choose the way that holds the greatest appeal. A person on the *Red Road* realizes that he or she must be drug free in order to choose the best way (Hand, 1991). Individual responsibility in the *Red Road* approach is a common characteristic among many American Indian cultures— to respect individual autonomy within the group society. Thus, the decision to be drug free or a user and the responsibility to act lie solely with the individual (Poor Thunder, 1991; Red Horse, 1982).

The incorporation of elders into treatment interventions has also been used as a cultural competent strategy in substance abuse treatment. In the Oneida Drug Abuse Treatment Improvement Project on the Oneida Reservation in Wisconsin (a CSAT-funded demonstration project) elders from the community served as hosts to the patients when they enter the facility. The underlying assumption for this practice is that elders possess years of experiential cultural knowledge that can be of great value to both the treatment program and its patients. Other American Indian treatment programs utilize elders in "circles of wisdom," incorporating tribal stories and philosophies into the treatment. Tribal elders have also served as a valuable resource in the traditional "blessing" or "smoking" of treatment facilities and programs.

The Native American Health Center of the Oakland Community Counseling, another CSAT-funded demonstration project, incorporated a public health perspective into its treatment delivery approach. By so doing, the individual's situational, social, cultural, and economic contexts were addressed. This project was designed within the philosophical framework that the individual's interaction with all of these contexts determines drug behavior and subsequent drug-related problems. With these factors in mind, treatment was approached from a wide spectrum of service components: health, mental health, social, and vocational.

The practices identified above are only a few examples of tribally-specific techniques utilized among American Indian peoples in the United States. Non-American Indian treatment programs may want to identify and develop linkages with American Indian substance abuse treatment programs in their geographic area that were developed and are run by American Indians so that tribally or culturally competent treatment approaches can be replicated.

Alaska Native Treatment Practices

There is no one generic "Alaska Native." The State Division of Alcoholism and Drug Abuse lists seven distinct groups of natives as "races." These vary from the Tlingit, Haida, and Tsim-shian (the totem builders) in Southeast Alaska to the Aleuts in the Aleutian Chain four time zones distant. The Inupiat and Yup'ik (commonly called Eskimo) inhabit the northern and western regions, respectively, and the Athabascan are located in the central region. Each has its own language and culture.

Within this diverse population a few common characteristics stand out that have implications for treatment. The typical drinking pattern is "binge drinking," in which all of the alcohol available is consumed. It is interesting to note that the introduction of the native population to alcohol was by groups notorious for this type of drinking (Russian explorers, traders, miners, whalers). This occurred at the same time as the native culture was being actively destroyed. The resultant low self-esteem and powerlessness so often exhibited must be looked on as culturally connected.

From a treatment perspective, the Salvation Army Clitheroe Center in Anchorage, Alaska (a CSAT demonstration grant project), revealed that confrontational methods not only are ineffective but also have a negative impact. For example, direct eye contact is negatively viewed as challenging. Situational role modeling, however, was found to be an effective relapse prevention technique.

As mentioned earlier, a main barrier affecting access to substance abuse treatment among American Indians/Alaska Natives is the lack of local service

organizations. This barrier becomes almost unsurmountable for those living in remote communities who often resist leaving their community to seek treatment somewhere else. In response to the needs of geographically isolated communities, a mobile treatment program was developed by Hanki (1987). The purpose of this community mobile treatment is not to merely establish a temporary treatment facility but to also overcome social (e.g., lack of social support groups), individual (e.g., fear about leaving the community), and cultural (e.g., treatment programs that do not take into account the cultural milieu) barriers that deter substance abusers from seeking help (Wiebe and Huebert, 1996). The implementation of this treatment intervention requires expertise and the interplay of several actors and entities: the community, the treatment team, and other agencies involved. Although comprehensive evaluations of the use of community mobile treatments have not been conducted, preliminary information reveals an increase in the number of individuals receiving treatment, high levels of abstinence, and involvement in after care programs among treatment participants (Wiebe and Huebert, 1996).

CONCLUSIONS AND RECOMMENDATIONS

This chapter delineated the problems American Indians/Alaska Natives confront in relation to substance abuse: highest prevalence of illicit drug use and need for substance abuse treatment than any other group. These problems are further compounded by the limited number of treatment facilities available to them as well as by lack of access to the ones that are readily available.

Effective treatment services for American Indians/Alaska Natives require an understanding of the factors and circumstances surrounding this population's use and abuse of substances. For example, American Indians/Alaska Natives begin using and abusing substances at an early age. Therefore, treatment modalities should be developed to address the needs of American Indian youth. In addition to this, many American Indians living in reservations are resistant to the idea of traveling long distances to receive services. Also, current reservation treatment facilities cannot absorb this population's demands for treatment. Establishment of treatment facilities for American Indians/Alaska Natives need to take into account these factors in the early stages of development. Along with this, it is important to integrate the use of traditional ceremonies and practices to promote sobriety among American Indians. However, it will also be crucial to identify those individuals who are highly acculturated or assimilated for whom emphasis on traditional ceremonies might not be appropriate.

INFORMATION RESOURCES

Web Sites

Aboriginal Youth Net Solvent Abuse Module: www.ayn.ca/modules/solvent/index.html

AIDS Prevention and Education Network Contacts for Native American and Aboriginal Populations: www.health.org/na.htm

Indian Health Services: www.ihs.gov/

The National Center for Cultural Healing: www.cultural-healing.com

Native American Voices: www.umc.org/naco/

Naturally Native Production: www.umc/org/naco/redhorse.htm

Organizations

Indian Health Service (IHS), Alcoholism and Substance Abuse Program, Room 5A-25 5600 Fishers Lane, Rockville, MD 20857; 301-443-4297.

National Association for Native American Children of Alcoholics (NANACoA), 1402 Third Avenue, Suite 1110, Seattle, WA 98101-2118; 206-467-7686; 1-800-322-5601. Web site: www.nanacoa.org/

Northern Plains Native American Chemical Dependency Association (NPNACDA), P.O. Box 1153, Rapid City, SD 57709; 603-341-5360. Web site: www.rapidnet.com/npna/welcome.html

REFERENCES

Akwesasne Notes. 1973. *"B.F. I'm not your Indian anymore."* Rooseveltown, NY.

Barta, G. 1991. Director, Native American Alcohol Treatment Program, Inc. Sergeant Bluff, IA. Personal interview.

Beauvais, F. 1992. An integrated model for prevention and treatment of drug abuse among American Indian youth. *Journal of Addictive Diseases* 11(3):63-80.

Beauvais, F. 1996. Trends in drug use among American Indians students and dropouts, 1975-1994. *American Journal of Public Health* 86(1): 1594-1598.

Beauvais, F., and LaBoueff, S. 1985. Drug and alcohol abuse intervention in American Indian communities. *International Journal of Addictions* 20:139-171.

Beauvais, F., and Oetting, E.R. 1988. Indian youth and inhalants: an update. *NIDA Research Monograph* 85:34-48.

Blackbird, E. 1981. *Native American Church Ceremony.* Macy, NE: Omaha Indian Reservation.

Bobo, J. K. 1985. Preventing drug abuse among American Indian adolescents. In L. D. Gilchrist and S. P. Schinke (Eds.), *Preventing Social and Health Problems Through Life Skills Training.* Seattle: University of Washington.

Burnette, R., and Koster, J. 1974. *The Road to Wounded Knee.* New York: Bantam Books.

Center for Disease Control. (1998). HIV/AIDS among American Indians and Alaskan Natives— United States, 1981-1997. *Mortality and Morbidity Weekly Review* 47: 154-160.

Churchill, W., and Larsen, D. 1981. *American Indian Substance Abuse: A Familial Solution.* Arlington, VA: Center for Multicultural Awareness.

Collins, L.V. 1997. *Census facts for Native American month.* Washington, D.C.: U.S. Census Bureau.

Colorado, P. 1986. *Native American alcoholism: An issue of survival.* Doctoral dissertation. Brandeis University: The Heller Graduate School for Advanced Studies in Social Welfare.

Crossbear, T. 1991. Sacred Circle Philosophy. Ames, IA. Personal interview.

Ebona, A. 1984. "Federal Government Policies and Indian Goals of Self-government." In L. Little Bear, M., Boldt and J.A. Long (Eds.), *Pathways to Self-determination.* University of Toronto Press: Toronto.

Fisher, D.G., Lankford, B.A., and Galea, R.P. 1996. Therapeuic community retention among Alaska Natives: Akeela House. *Journal of Substance Abuse Treatment* 13:265-271.

Grobsmith, E. 1989. The relationship between substance abuse and crime among American Indian inmates in the Nebraska Department of Corrections. *Human Organization* 48:285-298.

Gutierres, S., and Todd, M. 1997. The impact of childhood abuse on treatment outcomes of substance abusers. *Professional Psychology: Research and Practice* 28(4):348-354.

Hall, R. 1986. Alcohol treatment in American Indian populations: An indigenous treatment modality compared with traditional approaches. *Annals of the New York Academy of Sciences* 472:168-178.

Hand, F. 1991. *The role of the spiritual people in recovery.* Paper presented at American Indian Substance Abuse Conference, Des Moines, IA, May 1991.

Hand, F. 1992. *Red Road.* Presentation at Second Annual Iowa Governor's American Indian Substance Abuse Conference, Des Moines, IA, October 1992.

Hanki, P. 1987. *Report of the Mobile Treatment Program for the Ulkatcho Reserve at Anahim Lake.* Nechako Centre: Prince George, British Columbia.

Heath, D. B. 1985. American Indians and alcohol: Epidemiological and sociocultural relevance. In *Alcohol Use Among U.S. Ethnic Minorities. III. Alcohol Use Among American Indians and Alaska Natives.* Proceedings of a Conference on the Epidemiology of Alcohol Use Among Ethnic Minority Groups. NIAAA Research Monograph No. 18, 207-222.

Hill, T. 1990. Peyotism and the control of heavy drinking: The Nebraska Winnebago in the early 1900s. *Human Organization* 49(3).

Hisnanick, J., and Erickson, P. 1993. Hospital resource utilization by American Indians and Alaskan natives for alcoholism and alcohol abuse. *American Journal of Drug and Alcohol Abuse* 19:387-396.

Indian Health Service. 1993. *Trends in Indian health.* Rockville, MD: U.S. Department of Health and Human Services.

Indian Health Service. 1995. *Trends in Indian health.* Rockville, MD: U.S. Department of Health and Human Services.

Indian Health Service. 1996. *Trends in Indian health.* Rockville, MD: U.S. Department of Health and Human Services.

Katz, J. H. 1985. The sociopolitical nature of counseling. *The Counseling Psychologist* 13.

LaFromboise, T. D., and Rowe, W. 1983. Skills training for bicultural competence: Rationale and application. *Journal of Counseling Psychology* 30:589-595.

Lawson, P. E., and Morris, C. P. 1991. The Native American Church and the new court: The Smith case and Indian religious freedoms. *American Indian Culture and Research Journal* 15(1): 79-91.

Mail P.D., and Johnson, S. 1993. Boozing sniffing, and toking: An overview of the past, present, and future of substance abuse by American Indians. *American Indian and Alaska Native Mental Health Research* 5(2):1-33.

Mail, P. D., and McDonald, D. R. 1980. *Tulapai to Tokay: A Bibliography of Alcohol Use and Abuse Among Native Americans of North America.* New Haven, CT: HRAF Press, Inc.

Manson, S. M. 1986. Recent advances in American Indian mental health research: Implications for clinical research and training. In M. R. Miranda and H. H. L. Kitano (Eds.), *Mental Health Research and Practice in Minority Communities, Development of Culturally Sensitive Training Programs.* Rockville, MD: National Institute of Mental Health.

May, P.A. 1996. Overview of alcohol abuse epidemiology for American Indian populations. In G.D. Sandefur, R.R. Rundfass, and B. Cohen (Eds.), *Changing numbers, changing needs: American Indian demography and public health.* Washington, DC: National Academy Press.

Medicine, B. 1983. *An ethnography of drinking and sobriety among the Lakota Sioux.* Doctoral dissertation, University of Wisconsin at Madison.

Moran, J.R., and May, P.A. 1997. American Indians. In J. Philleo, F.L. Brisbane, and L.G. Epstein (Eds.), *Cultural competence in substance abuse prevention* (pp. 1-31). Washington D.C.: National Association of Social Workers Press

National Institute on Alcohol Abuse and Alcoholism (NIAAA). 1986. *A Guide to Planning Alcoholism Treatment Programs.* Washington, DC: US

Department of Health and Human Services. Public Health Service. Alcohol, Drug Abuse, and Mental Health Administration.

Nieto, S. 1992. *Affirming Diversity: The Sociopolitical Context of Multicultural Education.* New York: Longman.

Novins, D.K., Beals, J., Shore, J.H., Manson, S.M. 1996. Substance abuse treatment of American Indian adolescents: Comorbid symptomatology, gender differences and treatment pattern. *Journal of the American Academy of Child and Adolescent Psychiatry* 35(12):1593-1601.

Pedersen, P. B. 1988. *A Handbook for Developing Multicultural Awareness.* Alexandria, VA: American Association for Counseling and Development.

Ponterotto, J. 1988. Racial consciousness development among white counselor trainees: A stage model. *Journal of Multicultural Counseling and Development* 16.

Ponterotto, J., and Casas, J. M. 1991. *Handbook of Racial/Ethnic Minority Counseling Research.* Springfield, IL: Charles C. Thomas Publisher.

Poor Thunder, C. 1991. *People in Prison Entering Sobriety (P.I.P.E.S.) Program Manual.* Minneapolis, MN: Heart of the Earth Survival School.

Red Horse, J. 1982. Clinical strategies for American Indian families in crisis. *The Urban and Social Change Review* 15(2):17-19.

Rhoades, E. R., Mason, R. D., Eddy, P., Smith, E. M., and Burns, T. R. 1988. The Indian Health Service approach to alcoholism among American Indians and Alaska Natives. *Public Health Reports* 103(6): 621-627.

Robin, R.W., Chester, B., Rasmussen, J.K., and Jarason, J.M. 1997. Factors influencing utilization of mental health and substance abuse services by American Indian men and women. *Psychiatric Services* 48(6):826-832.

Sanderson, M. 1991. Counselor for the People in Prison Entering Sobriety Program (PIPES). Telephone interview, South Dakota Men's Prison, Sioux Falls, SD.

Stubben, J. 1992a. Unpublished data from interviews.

Stubben, J. 1992b. *Substance abuse treatment policy: A failure for American Indians.* Paper delivered at Midwest Political Science Association Meeting, Chicago, April 1992.

Topper, M. D. 1985. Navajo "alcoholism": Drinking, alcohol abuse, and treatment in a changing cultural environment. In L. A. Bennett and G. M. Ames (Eds.), *The American Experience With Alcohol.* New York: Plenum Press.

Trimble, J. E., Bryan, J., and Padilla, A. M. 1985. *Drug abuse prevention research priorities for ethnic-minority populations.* Paper prepared for the National Institute on Drug Abuse, Division of Clinical Research, Prevention Research Branch.

U.S. Bureau of the Census. 1998. *Resident population of the United States: Estimates by sex, race, and Hispanic origin, with median age.* Washington, D.C.: U.S. Bureau of the Census.

U.S. Department of Health and Human Services (DHHS). 1985. *Report of the Secretary's Task Force on Black and Minority Health.* Washington, DC: US Government Printing Office.

U.S. Department of Health and Human Services (DHHS). 1997. *Treatment Episode Data Set* (Advance Report no.12). Rockville, MD: Substance Abuse and Mental Health Administration.

U.S. Department of Health and Human Services (DHHS). 1998. *Prevalence of substance abuse among racial and ethnic subgroups in the United States, 1991-1993.* Rockville, MD: Substance Abuse and Mental Health Services Administration.

U.S. Government Office of Technology Assessment. 1994. *Technologies for understanding and preventing substance abuse and addiction.* Washington, D.C.: U.S. Printing Office.

U.S. House Committee on Appropriations. Washington, D.C.: General Printing Office, 1989.

Walker, R. D., and Kivlahan, D. R. 1984. Definitions, models, and methods in research on sociocultural factors in American Indian alcohol use. *Substance and Alcohol Actions/Misuse* 5:9-19.

Wiebe, J., and Huebert, K.M. 1996. Community mobile treatment: What it is and how it works. *Journal of Substance Abuse Treatment* 13:23-31.

Wilbur, S. 1994. Director of Maehnowesekiyah Treatment Center, Menominee Indian Tribe, Gresham, Wisconsin.

Wing, D.M., Crow, S.S., and Thompson, T. 1995. An ethnonursing study of Muscogee (Creek) Indians and effective health care practices for treating alcohol abuse. *Family and Community Health* 18:52-64.

Wingert, J.L. 1982. *Inhalant use among Native American adolescents: A comparison of users and nonusers at Intermountain Intertribal School.* Unpublished dissertation, Utah, State University.

RECOMMENDATIONS FOR INCORPORATING CULTURAL ISSUES IN SUBSTANCE ABUSE TREATMENT

In Jean-Jacques Rousseau's view, the process of discovering the essential characteristics of mankind entails a search for differences. Paradoxically, it is in the search of these differences that common threads running across different groups are uncovered. It is in this spirit that this chapter summarizes important issues to take into account when reaching the ultimate goal in the treatment of ethnic/racial minority substance abusers in the United States: the provision of culturally competent services. Provided here is a summary of the most salient points under the various topics discussed for each group as they are relevant to the implementation of culturally competent treatment interventions for racial/ethnic groups.

POPULATION COMPOSITION AND SOCIODEMOGRAPHIC PROFILE

- Both the willingness and the ability to adapt are essential for all programs which must constantly meet the demand of different patient populations. Changing demographics, among and within many racial and ethnic minority populations suggest that programs in specific geographic locations may be treating different populations or sub-populations over a period of several years. Practitioners bear a large share of the responsibility for knowing the realities and experiences of the communities in which their programs operate.

- Those who work in multicultural treatment programs must educate themselves about the particulars of the community and patient populations with which they will be working – how patients and potential patients regard family life, work, communication, and the need for treatment of substance abuse problems. Local participation in the planning of treatment programs can facilitate staff training as well as increase the community's commitment to the treatment program.

MIGRATION EXPERIENCE

- In order to effectively serve substance abusers who have migrated to the United States, it is important to be aware of the role migration has played in the settlement experiences of these individuals and their families. For some, the experience has been one of uprootedness, while for others, it has led to better opportunities.

- The migration experience, along with the circumstances surrounding their departure from their country of origin, can be traumatic for some migrants, particularly those arriving from war-torn countries. High consumption of alcohol and other substances among these migrants has been viewed as a coping strategy to deal with the aftermath of trauma.

- Generational status is an important factor to consider when delivering treatment services to minority populations. Providers of services should raise several questions. How different are the experiences of recent migrants compared to those who have been living in the United States for a long period of time? How different are migrants' offspring from their parents? How do those differences lead to intergenerational conflicts that might result in substance abuse problems among the younger generation? Answers to these questions may provide crucial information to understand the nature of the substance abuse problem and to inform the development of appropriate interventions.

CULTURE, HELP-SEEKING BEHAVIOR AND ACCESS TO CARE ISSUES

- Facilities do not always have professionally trained personnel who can speak the language spoken by non-English monolingual patients. This affects the quality of the treatment these individuals receive. Although most Asian Americans/Pacific Islanders and first-generation Hispanics are learning English at a faster rate than did previous generations, millions are still not fluent in English and are unable to communicate. It is important to realize that the level of English proficiency needed to fully avail oneself of treatment services far surpasses a passing acquaintance or minimal knowledge of the English language. The same is true for those attempting to provide services and treatment in languages other than English. Well-developed verbal skills are required for the speakers at both ends.

ENGAGEMENT AND RETENTION ISSUES

- Onsite provision of substance abuse treatment by culturally competent staff improves the likelihood of retaining individuals in treatment. Staff training and continuing education are central issues in the development of culturally competent treatment programs. In some communities, as many as half of the patients admitted to treatment never return after the first visit, largely due to a lack of responsiveness to the clients' needs (Sue, 1977).

- Substance abuse services have the task of attracting, retaining, and maintaining individuals in need of treatment. Building a strong foundation of cultural competence requires that all program staff and the community it serves be committed to and engaged in the planning process. Working closely with established community-based organizations on a continuous basis is often necessary in order to develop the funding, staffing, and experience needed to establish a program's leadership in substance abuse treatment.

PRACTICES USED TO MEET TREATMENT NEEDS

- Effective treatment requires multifaceted approaches and culturally appropriate intervention strategies. The comprehensiveness of a treatment system may be key to sustaining its effectiveness. A host of physiological, psychological, social, political, and environmental factors contributes to the onset and maintenance of substance abuse problems. It is well documented that addiction is correlated with crime, child abuse, homelessness, and poverty. Therefore, an individual's addiction cannot be treated in isolation from his or her primary health, mental health, or socioeconomic deficits and disorders.

- The most basic ingredient in the implementation of cultural competent treatment is for clinicians to perform good counseling practices that have always worked in the treatment of any client (Finn, 1994). This includes avoiding to jump to precipitous conclusions in interpreting what the client is expressing but rather focusing on what it means to the client.

- General counseling techniques that can be integrated in a culturally competent treatment model are: (1) individualization of the counseling approach; (2) avoidance of assumptions; (3) building of trust; and (4) identification of issues that affect client recovery (Finn, 1994).

- Evaluation and measurement practices are areas that need to be further developed to achieve culturally competent substance abuse treatment. Very few measurement or assessment instruments have been based on culturally congruent conceptual frameworks. The lack of studies that have tested the reliability and validity of assessment instruments for racial and ethnic minority populations poses important difficulties for outcome evaluations of specific treatment modalities.

- Significant progress has been made in the process of incorporating cultural competency into substance abuse treatment. However, the field still awaits systematic research studies that document the effectiveness of specific culturally derived treatment interventions. It is hoped that current emerging studies in this area develop into large and encompassing research efforts that will make this goal an attainable one.

REFERENCES

Finn, P. 1994. Addressing the needs of cultural minorities in drug treatment. *Journal of Substance Abuse Treatment* 11:325-337.

Sue, S. 1977. Community mental health services to minority groups. *American Psychologist* 32:616-624.

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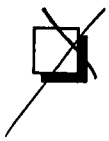

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