Section 3, Chapter 2:

Addressing Diverse Populations in Treatment

Treatment programs increasingly are called on to serve individuals with diverse backgrounds. Roughly one-third of the U.S. population belongs to an ethnic or racial minority group. More than 11 percent of Americans, the highest percentage in history, are now foreign born (Schmidley 2003).

Culture is important in substance abuse treatment because clients' experiences of culture precede and influence their clinical experience. Treatment setting, coping styles, social supports, stigma attached to substance use disorders, even whether an individual seeks help all are influenced by a client's culture. Culture needs to be understood as a broad concept that refers to a shared set of beliefs, norms, and values among any group of people, whether based on ethnicity or on a shared affiliation and identity.

In this broad sense, substance abuse treatment professionals can be said to have a shared culture, based on the Western worldview and on the scientific method, with common beliefs about the relationships among the body, mind, and environment (Jezewski and Sotnik 2001). Treating a client from outside the prevailing United States culture involves understanding the client's culture and can entail mediating among U.S. culture, treatment culture, and the client's culture.

This chapter contains

- An introduction to current research that supports the need for individualized treatment that is sensitive to the client's culture
- Principles in the delivery of culturally competent treatment services
- Topics of special concern, including foreign-born clients, women from other cultures, and religious considerations
- Clinical implications of culturally competent treatment

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- Sketches of diverse client populations, including
    - Hispanics/Latinos
    - African-Americans
    - Native Americans
    - Asian Americans and Pacific Islanders
    - Persons with HIV/AIDS
    - Lesbian, gay, and bisexual (LGB) populations
    - Persons with physical and cognitive disabilities
    - Rural populations
    - Homeless populations
    - Older adults
- Resources on culturally competent treatment for various populations

What It Means To Be a Culturally Competent Clinician

It is agreed widely in the health care field that an individual's culture is a critical factor to be considered in treatment. The Surgeon General's report, *Mental Health: Culture, Race, and Ethnicity,* states, “Substantive data from consumer and family self-reports, ethnic match, and ethnic-specific services outcome studies suggest that tailoring services to the specific needs of these [ethnic] groups will improve utilization and outcomes” (U.S. Department of Health and Human Services 2001, p. 36). The *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition (DSM-IV) (American Psychiatric Association 1994) calls on clinicians to understand how their relationship with the client is affected by cultural differences and sets up a framework for reviewing the effects of culture on each client.

Mental Health: Culture, Race, and Ethnicity is the first comprehensive report on the status of mental health treatment for minority groups in the United States. This report synthesizes research data from a variety of disciplines and concludes that

- Disparities in mental health services exist for racial and ethnic minorities. These groups face many barriers to availability, accessibility, and use of high-quality care.
- The gap between research and practice is worse for racial and ethnic minorities than for the general public, with problems evident in both research and practice settings. No ethnic-specific analyses have been done in any controlled clinical trials aimed at developing treatment guidelines.
- In clinical practice settings, racial and ethnic minorities are less likely than Whites to receive the best evidence-based treatment. (It is worth noting, however, that given the requirements established by funders and managed care, clients at publicly funded facilities are perhaps *more* likely than those at many private treatment facilities to receive evidence-based care.)

Because verbal communication and the therapeutic alliance are distinguishing features of treatment for both substance use and mental disorders, the issue of culture is significant for treatment in both fields. The therapeutic alliance should be informed by the clinician's understanding of the client's cultural identity, social supports, self-esteem, and reluctance about treatment resulting from social stigma. A common theme in culturally competent care is that the treatment provider — not the person seeking treatment — is responsible for ensuring that treatment is effective for diverse clients.

Meeting the needs of diverse clients involves two components: (1) understanding how to work with persons from different cultures and (2) understanding the specific culture of the person being served (Jezewski and Sotnik 2001). In this respect, being a culturally competent clinician differs little from being a responsible, caring clinician who looks past first impressions and stereotypes, treats clients with respect, expresses genuine interest in clients as individuals, keeps an open mind, asks questions of clients and other providers, and is willing to learn.

This chapter cannot provide a thorough discussion of attributes of people from various cultures and how to attune treatment to those attributes. The information in this chapter provides a starting point for exploring these important issues in depth. More detailed information on these groups, plus discussions of substance abuse treatment considerations, is found in the resources listed at the back of this chapter. The following resources may be especially helpful in understanding the broad concepts of cultural competence:

- *Mental Health: Culture, Race, and Ethnicity* (U.S. Department of Health and Human Services 2001) (www.mentalhealth.org/cre/default.asp). Chapter 2 discusses the ways in which culture influences mental disorders and mental health services. Subsequent chapters explain the historical and sociocultural context in which treatment occurs for four major groups — African-Americans, American Indians and Alaska Natives, Asian Americans and Pacific Islanders, and Hispanic/Latino Americans.

- The forthcoming TIP *Improving Cultural Competence in Substance Abuse Treatment* (CSAT forthcoming *a*) will include an inservice training guide.

Principles in Delivering Culturally Competent Services

The Commonwealth Fund Minority Health Survey found that 23 percent of African-Americans and 15 percent of Latinos felt that they would have received better treatment if they were of another race. Only 6 percent of Whites reported the same feelings (La Veist et al. 2000). Against this backdrop, it clearly is important for providers to have a genuine understanding of their clients from other cultures, as well as an awareness of how personal or professional biases may affect treatment.

Most counselors who provide treatment services are White and come from the dominant Western culture, but nearly half of clients seeking treatment are not White (Mulvey et al. 2003). This stark fact supports the argument that clinicians consider treatment in the context of culture. Counselors often feel that their own social values are the norm — that their values are typical of all cultures. In fact, U.S. culture differs from most other cultures in a number of ways. Clinicians and program staff members can benefit from learning about the major areas of difference and from understanding the common ways in which clients from other cultures may differ from the dominant U.S. culture.

Treatment Principles

Members of racial and ethnic groups are not uniform. Each group is highly heterogeneous and includes a diverse mix of immigrants, refugees, and multigenerational Americans who have vastly different histories, languages, spiritual practices, demographic patterns, and cultures (U.S. Department of Health and Human Services 2001).

For example, the cultural traits attributed to Hispanics/Latinos are at best generalizations that could lead to stereotyping and alienation of an individual client. Hispanics/Latinos are not a homogeneous group. For example, distinct Hispanic/Latino cultural groups — Cuban Americans, Puerto Rican Americans, Mexican Americans, and Central and South Americans — do not think and act alike on every issue. How recently immigration occurred, the country of origin, current place of residence, upbringing, education, religion, and income level shape the experiences and outlook of every individual who can be described as Hispanic/Latino.

Many people also have overlapping identities, with ties to multiple cultural and social groups in addition to their racial or ethnic group. For example, a Chinese American also may be Catholic, an older adult, and a Californian. This individual may identify more closely with other Catholics than with other Chinese Americans. Treatment providers need to be careful not to make facile assumptions about clients' culture and values based on race or ethnicity.

To avoid stereotyping, clinicians must remember that each client is an individual. Because culture is complex and not easily reduced to a simple description or formula, generalizing about a client's culture is a paradoxical practice. An observation that is accurate and helpful when applied to a large group of people may be misleading and harmful if applied to an individual. It is hoped that the utility of offering broad descriptions of cultural groups outweighs the potential misunderstandings. When using the information in this chapter, counselors need to find a balance between understanding clients in the context of their culture and seeing clients as merely an extension of their culture. Culture is only a starting point for exploring an individual's perceptions, values, and wishes. How strongly individuals share the dominant values of their culture varies and depends on numerous factors, including their education, socioeconomic status, and level of acculturation to U.S. society.

Differences in Worldview

A first step in mediating among various cultures in treatment is to understand the Anglo-American culture of the United States. When compared with much of the rest of the world, this culture is materialistic and competitive and places great value on individual achievement and on being oriented to the future. For many people in U.S. society, life is fast paced, compartmentalized, and organized around some combination of family and work, with spirituality and community assuming less importance.

Some examples of this worldview that differ from that of other cultures include

- **Holistic worldview.** Many cultures, such as Native-American and Asian cultures, view the world in a holistic sense; that is, they see all of nature, the animal world, the spiritual world, and the heavens as an intertwined whole. Becoming healthy involves more than just the individual and his or her family; it entails reconnecting with this larger universe.
- **Spirituality.** Spiritual beliefs and ceremonies often are central to clients from some cultural groups, including Hispanics/Latinos and American Indians. This spirituality should be recognized and considered during treatment. In programs for Native Americans, for example, integrating spiritual customs and rituals may enhance the relevance and acceptability of services.
- **Community orientation.** The Anglo-American culture assumes that treatment focuses on the individual and the individual's welfare. Many other cultures instead are oriented to the collective good of the group. For example, individual identity may be tied to one's forebears and descendants, with their welfare considered in making decisions. Asian-American and Native-American clients may care more about how the substance use disorder harms their family group than how they are affected as individuals.
- **Extended families.** The U.S. nuclear family consisting of parents and children is not what most other cultures mean by family. For many groups, family often means an extended family of relatives, including even close family friends. Programs need a flexible definition of family, accepting the family system as it is defined by the client.
- **Communication styles.** Cultural misunderstandings and communication problems between clients and clinicians may prevent clients from minority groups from using services and receiving appropriate care (U.S. Department of Health and Human Services 2001). Understanding manifest differences in culture, such as clothing, lifestyle, and food, is not crucial (with the exception of religious restrictions on dress and diet) to treating clients. It often is the invisible differences in expectations, values, goals, and communication styles that cause cultural differences to be misinterpreted as personal violations of trust or respect. However, one cannot know an individual's communication style or values based on that person's group affiliation.

- **Multidimensional learning styles.** The Anglo-American culture emphasizes learning through reading and teaching. This method sometimes is described as linear learning that focuses on reasoned facts. Other cultures, especially those with an oral tradition, do not believe that written information is more reliable, valid, and substantial than oral information. Instead, learning often comes through parables and stories that interweave emotion and narrative to communicate on several levels at once. The authority of the speaker may be more important than that of the message. Expressive, creative, and nonverbal interventions that are characteristic of a specific cultural group can be helpful in treatment. Cultures with this kind of rich oral tradition and learning pattern include Hispanics/Latinos, African-Americans, American Indians, and Pacific Islanders.

Common issues affecting the counselor-client relationship include the following:

- **Boundaries and authority issues.** Clients from other cultures often perceive the counselor as a person of authority. This may lead to the client's and counselor's having different ideas about how close the counselor-client relationship should be.

- **Respect and dignity.** For most cultures, particularly those that have been oppressed, being treated with respect and dignity is supremely important. The Anglo-American culture tends to be informal in how people are addressed; treating others in a friendly, informal way is considered respectful. Anglo Americans generally prefer casual, informal interactions even when newly acquainted. However, some other cultures view this informality as rudeness and disrespect. For example, some people feel disrespected at being addressed by their first names.

- **Attitudes toward help from counselors.** There are wide differences across cultures concerning whether people feel comfortable accepting help from professionals. Many cultures prefer to handle problems within the extended family. The clinician and client also may harbor different assumptions about what a clinician is supposed to do, how a client should act, and what causes illness (U.S. Department of Health and Human Services 2001).

Clinical Implications of Culturally Competent Treatment

Programs should take the following steps to ensure culturally competent treatment for their clients:

- Assess the program for policies and practices that might pose barriers to culturally competent treatment for diverse populations. Removing these barriers could entail something as simple as rearranging furniture to accommodate clients in wheelchairs or as involved as hiring a counselor who is from the same cultural group as the population the program serves. Section 2 provides more information about assessing program needs.
- Ensure that all program staff receives training about the meaning and benefits of cultural competence in general and about the specific cultural beliefs and practices of client populations that the program serves.
- Incorporate family and friends into treatment to support the client. Although family involvement is often a good idea in any program, it may be particularly effective given the importance of family in many cultures. Some clients left families and friends behind when they came to the United States. Helping these clients build support systems is critical.
- Provide program materials on audiotapes, in Braille, or in clients' first languages. All materials should be sympathetic to the culture of clients being served.
- Ensure that client materials are written at an appropriate reading level. People who are homeless and those for whom English is a second language may need materials written at an elementary school reading level.
- Include a strong outreach component. People who are unfamiliar with U.S. culture may be unaware that substance abuse treatment is available or how to access it.
- Hire counselors and administrators and appoint board members from the diverse populations that the program serves. Section 2 provides more information about recruiting and hiring diverse staff members.
- Incorporate elements from the culture of the populations being served by the program (e.g., Native-American healing rituals or Talking Circles).

- Partner with agencies and groups that deliver community services to provide enhanced services, such as child care, transportation, medical screening and services, parenting classes, English-as-a-second-language classes, substance-free housing, and vocational assistance. These services may be necessary for some clients to be able to stay in treatment.
- Provide meals at the program facility. This may bring some clients (e.g., those who are elderly or homeless) into treatment and induce them to stay.
- Make case management services available for clients who need them.
- Emphasize structured programming, as opposed to open-ended discussion, in group therapy settings.
- Base treatment on clients' strengths. Experienced providers report that this approach works well with clients from many cultures and is the preferred approach for clients struggling with self-esteem or empowerment.
- Use a motivational framework for treatment, which seems to work well with clients from many cultures. Basic principles of respect and collaboration are the basis of a motivational approach, and these qualities are valued by most cultures.
- Encourage clients to participate in mutual-help programs to support their recovery. Although the mutual-help movement's roots are in White, Protestant, middle-class American culture, data show that members of minorities benefit from mutual-help programs to the same extent as do Whites (Tonigan 2003).

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Sketches of Diverse Client Populations

The following demographic sketches focus on diverse clients who may be part of any treatment caseload. These descriptions characterize entire groups (e.g., number of people, geographic distribution, rates of substance use) and include generalized cultural characteristics of interest to the clinician. This type of cultural overview is only a starting point for understanding an individual. To serve adequately clients from the diverse groups described here, providers need to get to know their clients and educate themselves. Appendix A contains an annotated list of resources on cultural competence in general, as well as resources listed by population group. These resources include free publications available from government agencies — in particular the Center for Substance Abuse Treatment and the Center for Substance Abuse Prevention — and describe population-specific treatment guidelines and strategies.

Hispanics/Latinos

Hispanics/Latinos include individuals from North, Central, and South America, as well as the Caribbean. Hispanic people can be of any race, with forebears who may include American Indians, Spanish-speaking Caucasians, and people from Africa. Great disparities exist among these subgroups in education, economic status, and labor force participation. In 2002, the Hispanic/Latino population totaled 37.4 million, more than 13 percent of the total U.S. population, and it is now the largest ethnic group in the Nation. Mexican Americans are the largest subgroup, representing more than two-thirds of all Hispanics/Latinos in the United States (Ramirez and de la Cruz 2003).

Two-thirds of the Hispanic/Latino people in the United States were born here. As a group, they are the most urbanized ethnic population in the country. Although poverty rates for Hispanics/Latinos are high compared with those of Whites, by the third generation virtually no difference in income exists between Hispanic/Latino and non-Hispanic/Latino workers who have the same level of education (Bean et al. 2001).

Celebrations and religious ceremonies are an important part of the culture, and use of alcohol is expected and accepted in these celebrations and ceremonies. In the interest of family cohesion and harmony, traditional Hispanic/Latino families tend not to discuss or confront the alcohol problems of family members. Among Hispanics/Latinos with a perceived need for treatment of substance use disorders, 23 percent reported the need was unmet — nearly twice the number of Whites who reported unmet need (Wells et al. 2001). Studies show that Hispanics/Latinos with substance use disorders receive less care and often must delay treatment, relative to White Americans (Wells et al. 2001). De La Rosa and White's (2001) review of the role social support systems play in substance use found that family pride and parental involvement are more

influential among Hispanic/Latino youth than among White or African-American youth. The 2000 Substance Abuse and Mental Health Services Administration's (SAMHSA's) National Household Survey on Drug Abuse (NHSDA) found that nearly 40 percent of Hispanics/Latinos reported alcohol use. Five percent of Hispanics reported use of illicit substances, with the highest rate occurring among Puerto Ricans and the lowest rate among Cubans (Office of Applied Studies 2001). Hispanics/Latinos accounted for 9 percent of admissions to substance abuse treatment in 2000 (Office of Applied Studies 2002).

Spanish-language treatment groups are helpful for recently arrived Hispanic/Latino immigrants. Programs in areas with a large population of foreign-born Hispanics/Latinos should consider setting up such groups, using Spanish-speaking counselors. AA has Spanish-language meetings in many parts of the country, especially in urban areas.

African-Americans

African-Americans make up 13 percent of the U.S. population and include 36 million residents who identify themselves as Black, more than half of whom live in a metropolitan area (McKinnon 2003). The African-American population is extremely diverse, coming from many different cultures in Africa, Bermuda, Canada, the Caribbean, and South America. Most African-Americans share the experience of the U.S. history of slavery, institutionalized racism, and segregation (Brisbane 1998).

Foreign-born Africans living in America have had distinctly different experiences from U.S.-born African-Americans. As one demographer points out, “Foreign-born African-Americans and native-born African-Americans are becoming as different from each other as foreign-born and native-born Whites in terms of culture, social status, aspirations and how they think of themselves” (Fears 2002, p. A8). Nearly 8 percent of African-Americans are foreign born; many have grown up in countries with majority Black populations ruled by governments consisting of mostly Black Africans.

The 2000 NHSDA found that 34 percent of African-Americans reported alcohol use, compared with 51 percent of Whites and 40 percent of Hispanics/Latinos. Only 9 percent of African-American youth reported alcohol use, compared with at least 16 percent of White, Hispanic/Latino, and Native-American youth (Office of Applied Studies 2001). Six percent of African-Americans reported use of illicit substances, compared with 6 percent of Whites and 5 percent of Hispanics/Latinos (Office of Applied Studies 2001). African-Americans accounted for 24 percent of admissions to substance abuse treatment in 2000 (Office of Applied Studies 2002). Among African-Americans with a perceived need for substance abuse treatment, 25 percent reported the need was unmet — more than twice the number of Whites who reported unmet need (Wells et al. 2001).

Native Americans

The Bureau of Indian Affairs recognizes 562 different Native-American tribal entities. (The term "Native American" as it is used here encompasses American Indians and Alaska Natives.) Each tribe has unique customs, rituals, languages, beliefs about creation, and ceremonial practices. On the 2000 census, about 2.5 million Americans listed themselves as Native Americans and 1.6 million Americans listed themselves as at least partly Native American, accounting for 4.1 million people or 1.5 percent of the U.S. population (Ogunwole 2002).

Currently only 20 percent of American Indians and Alaska Natives live on reservations or trust lands, where they have access to treatment from the Indian Health Service. More than half live in urban areas (Center for Substance Abuse Prevention 2001). The 2000 NHSDA found that 35 percent of Native Americans reported alcohol use. Thirteen percent of Native Americans reported use of illicit substances (Office of Applied Studies 2001). Among all youth ages 12 to 17, the use of illicit substances was most prevalent among Native Americans — 22 percent (Office of Applied Studies 2001). Native Americans begin using substances at higher rates and at a younger age than any other group (U.S. Government Office of Technology Assessment 1994). Native Americans accounted for 3 percent of admissions to substance abuse treatment in 2000 (Office of Applied Studies 2002). More than three-quarters of all Native-American admissions for substance use are due to alcohol. Alcoholism, often intergenerational, is a serious problem among Native Americans (CSAT 1999*b*). One study found that rates for alcohol dependence among Native Americans were higher than the U.S. average (Spicer et al. 2003) but not as high as often had been reported. Thirty percent of men in culturally distinct tribes from the Northern Plains and the Southwest were alcohol dependent, compared with the national average of 20 percent of men. Among the Northern Plains community, 20 percent of women were alcohol dependent, compared with the national average of 8.5 percent. Only 8.7 percent of all women in the Southwest were found to be alcohol dependent.

Among Native Americans, there is a movement toward using Native healing traditions and healers for the treatment of substance use disorders. Spiritually based healing is unique to each tribe or cultural group and is based on that culture's traditional ceremonies and practices.

Asian Americans and Pacific Islanders

Asian Americans and Pacific Islanders are the fastest growing minority group in the United States, making up more than 4 percent of the U.S. population and totaling more than 12 million. They account for more than one-quarter of the U.S. foreign-born population. The vast majority live in metropolitan areas (Reeves and Bennett 2003); more than half live in three States: California,

New York, and Hawaii (Mok et al. 2003). Nearly 9 out of 10 Asian Americans either are foreign born or have at least one foreign-born parent (U.S. Census Bureau 2003). Asian Americans represent many distinct groups and have extremely diverse cultures, histories, and religions.

Pacific Islanders are peoples indigenous to thousands of islands in the Pacific Ocean. Pacific Islanders number about 874,000 or 0.3 percent of the population. Fifty-eight percent of these individuals reside in Hawaii and California (Grieco 2001).

Grouping Asian Americans and Pacific Islanders together can mask the social, cultural, linguistic, and psychological variations that exist among the many ethnic subgroups this category represents. Very little is known about interethnic differences in mental disorders, seeking help, and use of treatment services (U.S. Department of Health and Human Services 2001).

The 2000 NHSDA found that 28 percent of Asian Americans and Pacific Islanders reported alcohol use. Only 7 percent of adolescent Asian Americans and Pacific Islanders reported alcohol use, compared with at least 16 percent of White, Hispanic/Latino, and Native-American youth (Office of Applied Studies 2001). Three percent of Asian Americans and Pacific Islanders reported use of illicit substances (Office of Applied Studies 2001). As a group Asian Americans and Pacific Islanders have the lowest rate of illicit substance use, but significant intragroup differences exist. Koreans (7 percent) and Japanese (5 percent) use illicit substances at much greater rates than Chinese (1 percent) and Asian Indians (2 percent) (Office of Applied Studies 2001). Asian Americans and Pacific Islanders accounted for less than 1 percent of admissions to substance abuse treatment in 2000 (Office of Applied Studies 2002).

Persons With HIV/AIDS

In the United States, more than 918,000 people are reported as having AIDS (Centers for Disease Control and Prevention 2004). HIV is still largely a disease of men who have sex with men and people who inject drugs; these groups together account for nearly four-fifths of all cases of HIV/AIDS (Centers for Disease Control and Prevention 2004). Minorities have a much higher incidence of infection than does the general population. Although African-Americans make up only 13 percent of the U.S. population, they accounted for 50 percent of new HIV infections in 2004 (Centers for Disease Control and Prevention 2004). HIV is spreading most rapidly among women and adolescents. In 2000, females accounted for nearly half of new HIV cases reported among 13- to 24-year-olds. Among 13- to 19-year-olds, females accounted for more than 60 percent of new cases (Centers for Disease Control and Prevention 2002). HIV/AIDS is increasing rapidly among African-American

and Hispanic/Latino women. Although they represent less than a quarter of U.S. women, these groups account for more than four-fifths of the AIDS cases reported among women; African-American women account for 64 percent of this total (Centers for Disease Control and Prevention 2004). Gay people who abuse substances also are at high risk because they are more likely to engage in risky sex after alcohol or drug use (Greenwood et al. 2001).

The development of new medications — and combinations of medications — has had a significant effect on the length and quality of life for many people who live with HIV/AIDS. However, these new treatment protocols require clients to take multiple medications on a complicated regimen. Clients with HIV often present with a cluster of problems, including poverty, indigence, homelessness, mental disorders, and other medical problems.

Lesbian, Gay, and Bisexual Clients

LGB individuals come from all cultural backgrounds, ethnicities, racial groups, and regions of the country. Cultural groups differ in how they view their LGB members. In Hispanic culture, matters of sexual orientation tend not to be discussed openly. LGB members of minority groups often find themselves targets of discrimination within their minority culture and of racism in the general culture.

Because of inconsistent research methods and instruments that do not ask about sexual orientation, no reliable information is available on the number of people who use substances among LGB individuals (CSAT 2001). Studies indicate, however, that LGB individuals are more likely to use alcohol and drugs, more likely to continue heavy drinking into later life, and less likely to abstain from using drugs than is the general population. They also are more likely to have used many drugs, including such drugs as Ecstasy, ketamine (“Special K”), amyl nitrite (“poppers”), and gamma hydroxybutyrate during raves and parties. These drugs affect judgment, which can increase risky sexual behavior and may lead to HIV/AIDS or hepatitis (Centers for Disease Control and Prevention 1995; Greenwood et al. 2001; Woody et al. 1999).

Persons With Physical and Cognitive Disabilities

Nearly one-sixth of all Americans (53 million) have a disability that limits their functioning. More than 30 percent of those with disabilities live below the poverty line and generally spend a large proportion of their incomes to meet their disability-related needs (LaPlante et al. 1996). Most people with disabilities can and want to work. But those with skills tend to be underemployed or unemployed. The combination of depression, pain, vocational difficulties, and functional limitations places people with physical disabilities at increased risk of substance use disorders (Hubbard et al. 1996).

Those with cognitive or physical disabilities are more likely than the general population to have a substance use disorder but less likely to receive effective treatment (Moore and Li 1998). Many community-based treatment programs do not currently meet the Federal requirements of the Americans with Disabilities Act. Any treatment program is likely to have clients who present with a variety of disabilities. Experienced clinicians report that an appreciable number of individuals with substance use disorders have unrecognized learning disabilities that can impede successful treatment. People who have the same disability may have differing functional capacities and limitations.

Treating substance use disorders in persons with disabilities is an emerging field of study. Culture brokering is a treatment approach that was developed to mediate between the culture of a foreign-born person and the health care culture of the United States. This model helps rehabilitation providers understand the role that culture plays in shaping the perception of disabilities and treatment (Jezewski and Sotnik 2001). Culture brokering is an extension of techniques that providers already practice, including assessment and problem solving.

Rural Populations

In 2000, nearly 20 percent of the U.S. population (55.4 million people) lived in nonmetropolitan areas; the nonmetropolitan population increased 10.2 percent from 1990 to 2000 (Perry and Mackun 2001). The economic base and ethnic diversity of these populations, not just their isolation, are critical factors. This population includes people of Anglo-European heritage in Appalachia and in farming and ranching communities of the Midwest and West, Hispanic/Latino migrant farm workers across the South, and Native Americans on reservations.

Despite this diversity, rural communities from different parts of the country have commonalities: low population density, limited access to goods and services, and considerable familiarity with other community members. People living in rural situations also share broad characteristics that affect treatment. These characteristics are

- Overall higher resistance to seeking help because of pride in self-sufficiency
- Concerns about confidentiality and resistance to participating in group work because in small communities “everyone knows everyone else”
- A sense of strong individuality and privacy, sometimes coupled with difficulty in expressing emotions
- A culturally embedded suspicion of treatment for substance use and mental disorders, although this varies widely by area

Among adults older than age 25, the rate of alcohol use is lower in rural areas than in metropolitan areas. But rates of heavy alcohol use among youth ages 12 to 17 in rural areas are almost double those seen in metropolitan areas (Office of Applied Studies 2001). Women in rural areas have higher rates of alcohol use and alcoholism than women in metropolitan areas (American Psychological Association 1999). However, in one study, urban residents received substance abuse treatment at more than double the rate of their rural counterparts (Metsch and McCoy 1999). Researchers attribute this disparity to the relative unavailability and unacceptability of substance abuse treatment in rural areas of the United States (Metsch and McCoy 1999).

Homeless Populations

Approximately 600,000 Americans are homeless on any given night. One census count of people who are homeless found about 41 percent were White, 40 percent were African- American, 11 percent were Hispanic, and 8 percent were Native American. Compared with all U.S. adults, people who are homeless are disproportionately African-American and Native American (Urban Institute et al. 1999). Homeless populations include groups of people who are

- **Transient.** These individuals may stay temporarily with others or have a living pattern that involves rotating among a group of friends, relatives, and acquaintances. These individuals are at high risk of suddenly finding themselves on the street. For some, continued living in other people's residences may be contingent on providing sex or drugs.
- **Recently displaced.** Some people may be employed but have been evicted from their homes. Their housing instability may be related to financial problems resulting from substance use.
- **Chronically homeless.** These individuals may have severe substance use and mental disorders and are difficult to attract into traditional treatment settings. Reaching these individuals requires the program to bring its services to the homeless through a variety of creative outreach and programming initiatives.

Approximately two-thirds of people who are homeless report having had an alcohol, drug, or mental disorder in the previous month (Urban Institute et al. 1999). Three-quarters of people who are homeless and need substance abuse treatment do not receive it (Magura et al. 2000). For 50 percent of people who are homeless and admitted to treatment, alcohol is the primary substance of abuse, followed by opioids (18 percent) and crack cocaine (17 percent) (Office of Applied Studies 2003*b*). Twenty-three percent of people who are homeless

and in treatment have co-occurring disorders, compared with 20 percent who are not homeless (Office of Applied Studies 2003*b*). People who are homeless are more than three times as likely to receive detoxification services as people who are not homeless (45 percent vs. 14 percent) (Office of Applied Studies 2003*b*).

In addition to the resources found in Appendix A, the following clinical guidelines will assist providers in treating people who are homeless:

- Clients who are homeless often drop out of treatment early. Meeting survival needs of clients who are homeless is integral to successful outcomes. A treatment program needs to provide safe shelter, warmth, and food, in addition to the components of effective treatment provided to other clients who use substances, including extensive continuing care (Milby et al. 1996).

- Individuals who are homeless benefit from intensive contact early in treatment. Clients who attend treatment an average of 4.1 days per week are more successful than those attending fewer days (Schumacher et al. 1995).

- The Alcohol Dependence Scale, the Alcohol Severity Index, and the personal history form have been found to be reliable and valid screening tools for this population (Joyner et al. 1996). Reliability is higher when items are factual and based on a recent time interval and when individuals are interviewed in a protected setting.

- Case management must be available to ease access to and coordinate the variety of services needed by clients who are homeless and abuse substances. Case management should arrange for stable, safe, and drug-free housing. The availability of housing is a powerful influence on recovery. Making such housing contingent on abstinence has been shown to be a useful strategy (Milby et al. 1996). Case management also should coordinate medical care, including psychiatric care, with vocational training and education to help individuals sustain a self-sufficient life.

- Providers should work with homeless shelters to provide treatment services. Strategies include (1) working with staff members at shelters and with public housing authorities to find and arrange for housing, (2) locating the program within a homeless shelter or at least providing core elements of treatment at the shelter, and (3) placing a substance abuse treatment specialist at the shelter as a liaison with the program.

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Older Adults

The number of older adults needing treatment for substance use disorders is expected to increase from 1.7 million in 2001 to 4.4 million by 2020. This increase is the result of a projected 50-percent increase in the number of older adults as well as a 70-percent increase in the rate of treatment need among older adults (Gfroerer et al. 2003). America's aging cohort of baby boomers (people born between 1946 and 1964) is expected to place increasing demands on the substance abuse treatment system in the coming years, requiring a shift in focus to address their special needs. This older generation will be more ethnically and racially diverse and have higher substance use and dependence rates than current older adults (Korper and Council 2002).

As a group, older people tend to feel shame about substance use and are reluctant to seek out treatment. Many relatives of older individuals with substance use disorders also are ashamed of the problem and rationalize the substance use or choose not to address it. Diagnosing and treating substance use disorders are more complex in older adults than in other populations because older people have more — and more interconnected — physical and mental health problems. Barriers to effective treatment include lack of transportation, shrinking social support networks, and financial constraints.

Oslin and colleagues (2002) find that older adults had greater attendance and lower incidence of relapse than younger adults in treatment and conclude that older adults can be treated successfully in mixed-age groups, provided that they receive age-appropriate individual treatment. When treating older clients, programs need to be involved actively with the local network of aging services, including home- and community-based long-term care providers. Older individuals who do not see themselves as abusers — particularly those who misuse over-the-counter or prescription drugs or do not understand the problems caused by alcohol and drug interactions — need to be reached through wellness, health promotion, social service, and other settings that serve older adults. In addition, programs can broaden the multicultural resources available to them by working through the aging service network to link up with diverse language, cultural, and ethnic resources in the community.

Programs that develop geriatric expertise can provide an essential service by making consultation available to staff members at programs that face similar challenges, along with inservice training, coordination of interventions, and care conferences designed to solve problems and develop care plans for individuals. There also may be opportunities to make this expertise available to caregivers and participants in settings where older adults receive interdisciplinary care (e.g., a support group for family caregivers or a discussion group for participants at a social daycare or adult day health center).

Exhibit 1. Glossary of Cultural Competence Terms

Cultural diversity. Differences in race, ethnicity, nationality, religion, gender, sexual identity, socioeconomic status, physical ability, language, beliefs, behavior patterns, or customs among various groups within a community, organization, or nation.

Culture. Social norms and responses that condition the behavior of a group of people, that answer life's basic questions about the origin and nature of things, and that solve life's basic problems of human survival and development.

Discrimination. The act of treating a person, issue, or behavior unjustly or inequitably as a result of prejudices; a showing of partiality or prejudice in treatment; specific actions or policies directed against the welfare of minority groups.

Ethnicity. The beliefs, values, customs, or practices of a specific group (e.g., its characteristics, language, common history, and national origin). Every race has a variety of ethnic groups.

Ethnocentrism. The attitude that the beliefs, customs, or practices of one's own ethnic group, nation, or culture are superior; an excessive or inappropriate concern for racial matters.

Multiculturalism. Being comfortable with many standards and customs; the ability to adapt behavior and judgments to a variety of interpersonal settings.

Prejudice. Preconceived judgments, opinions, or assumptions formed without knowledge or examination of facts about individuals, groups of people, behaviors, or issues. These judgments or opinions usually are unfavorable and are marked by suspicion, fear, or hatred.

Race. The categorizing of major groups of people based solely on physical features that distinguish certain groups from others.

Adapted from Administration for Children and Families 1994, pp. 108–109.

Exhibit 2. Stages of Cultural Competence for Organizations

Stage 1. Cultural Destructiveness

- Makes people fit the same cultural pattern; excludes those who do not fit (forced assimilation).
- Uses differences as barriers.

Stage 2. Cultural Incapacity

- Supports segregation as a desirable policy, enforces racial policies, and maintains stereotypes.
- Maintains a paternalistic posture toward “lesser races” (e.g., discriminatory hiring practices, lower expectations of minority clients, and subtle messages that they are not valued).
- Discriminates based on whether members of diverse groups “know their place.”
- Lacks the capacity or will to help minority clients in the community.
- Applies resources unfairly.

Stage 3. Cultural Blindness

- Believes that color or culture makes no difference and that all people are the same.
- Ignores cultural strengths.
- Encourages assimilation; isolates those who do not assimilate.
- Blames victims for their problems.
- Views ethnic minorities as culturally deprived.

Stage 4. Cultural Precompetence

- Desires to deliver quality services; has commitment to civil rights.
- Realizes its weaknesses; attempts to improve some aspect of services.
- Explores how to serve minority communities better.
- Often lacks only information on possibilities and how to proceed.
- May believe that accomplishment of one goal or activity fulfills obligations to minority communities; may engage in token hiring practices.

Stage 5. Cultural Competence

- Shows acceptance of and respect for differences.
- Expands cultural knowledge and resources.
- Provides continuous self-assessment.
- Pays attention to the dynamics of difference to meet client needs better.
- Adapts service models to needs.
- Seeks advice and consultation from minority communities.
- Is committed to policies that enhance services to diverse clientele.

Stage 6. Cultural Proficiency

- Holds all cultures in high esteem.
- Seeks to add to knowledge base.
- Advocates continuously for cultural competence.

Source: Cross et al. 1989, pp. 13–18.

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Cultural Competence Resources

Many resources listed below are volumes in the TIP and Technical Assistance Publication (TAP) Series published by CSAT. TIPs and TAPs are free and can be ordered from SAMHSA's National Clearinghouse for Alcohol and Drug Information (NCADI) at www.ncadi.samhsa.gov or (800) 729–6686 (TDD, [800] 487–4889). The full text of each TIP can be searched and downloaded from www.samhsa.gov/centers/csat2002/publications.html.

The Health Resources and Services Administration lists cultural competence assessment tools, resources, curricula, and Web-based trainings at www.hrsa.gov/culturalcompetence.

General

Cultural Issues in Substance Abuse Treatment (CSAT 1999*b*) — This booklet contains population-specific discussions of treatment for Hispanic Americans, African-Americans, Asian Americans and Pacific Islanders, and American Indians and Alaska Natives, along with general guidelines on cultural competence. Order from SAMHSA's NCADI.

Chapter 4, "Preparing a Program To Treat Diverse Clients," in TIP 46, *Substance Abuse: Administrative Issues in Outpatient Treatment* (CSAT 2006*f*) — This chapter includes an introduction to cultural competence and why it matters to treatment programs, as well as information on assessing a diverse population's treatment needs and conducting outreach to attract clients and involve the community. This chapter also includes a list of resources for assessment and training, in addition to culture-specific resources.

"Alcohol Use Among Special Populations" (National Institute on Alcohol Abuse and Alcoholism 1998) — This special issue of the journal *Alcohol Health & Research World* (now called *Alcohol Research & Health*) includes articles on alcohol use in Asian Americans and Pacific Islanders, African-Americans, Alaska Natives, Native Americans, and Hispanics/Latinos. Authors also address such topics as alcohol availability and advertising in minority communities, special populations in AA, and alcohol consumption in India, Mexico, and Nigeria. Visit pubs.niaaa.nih.gov/publications/arh22-4/toc22-4.htm to download the articles.

Mental Health: Culture, Race, and Ethnicity (U.S. Department of Health and Human Services 2001) — This publication describes the disparities in mental health services that affect minorities, presents evidence of the need to address those disparities, and documents promising strategies to eliminate them. Visit www.mentalhealth.samhsa.gov/cre/default.asp to download a copy of this publication.

Counseling the Culturally Different: Theory and Practice, Third Edition (Sue and Sue 1999) — This book offers a conceptual framework for counseling across cultural lines and includes treatment recommendations for specific cultural groups, with individual chapters on counseling Hispanics/Latinos, African-Americans, Asian Americans, and Native Americans and special sections on women, gay and lesbian people, and persons who are elderly and disabled.

The Cultural Context of Health, Illness, and Medicine (Loustaunau and Sobo 1997) — This book, written by a sociologist and an anthropologist, examines the ways in which cultural and social factors shape understandings of health and medicine. Although its discussions are not specific to substance abuse, they address the effect of social structures on health, differing conceptions of wellness, and cross-cultural communication.

Pocket Guide to Cultural Health Assessment, Third Edition (D'Avanzo and Geissler 2003) — This quick reference guide has individual sections on 186 countries, each of which lists demographic information (e.g., population, ethnic and religious descriptions, languages spoken), political and social information, and health care beliefs.

American Cultural Patterns: A Cross-Cultural Perspective, Second Edition (Stewart and Bennett 1991) — This book focuses on aspects of American culture that are central to understanding how American society functions. The authors examine perceptions, thought processes, language, and nonverbal behaviors and their effect on cross-cultural communication.

Hispanics/Latinos

CSAP Substance Abuse Resource Guide: Hispanic/Latino Americans (Center for Substance Abuse Prevention 1996*b* ; www.ncadi.samhsa.gov/govpubs/MS441/) — This resource guide provides information and referrals to help prevention specialists, educators, and community leaders better meet the needs of the Hispanic/Latino community. Order from SAMHSA's NCADI.

“Counseling Latino Alcohol and Other Substance Users/Abusers: Cultural Considerations for Counselors” (Gloria and Peregoy 1996) — This article discusses Hispanic/Latino cultural values as they relate to substance use and presents a substance abuse counseling model for use with Hispanic/Latino clients.

“Drugs and Substances: Views From a Latino Community” (Hadjicostandi and Cheurprakobkit 2002) — The researchers explore perceptions and use of licit and illicit substances in a Hispanic/Latino community. The primary concerns of the community are the increasing availability and use of substances among Hispanic/Latino youth.

“Acculturation and Latino Adolescents' Substance Use: A Research Agenda for the Future” (De La Rosa 2002) — This article reviews literature on the effects of acculturation to Western values on Hispanic/Latino adolescents' mental health and substance use, discusses the role that acculturation-related stress plays in substance use, and suggests directions for treatment and further research.

“Cultural Adaptations of Alcoholics Anonymous To Serve Hispanic Populations” (Hoffman 1994) — This article evaluates two specific adaptations to 12-Step fellowship: one adapts conceptions of machismo and the other is less confrontational.

African-Americans

Chemical Dependency and the African American: Counseling and Prevention Strategies, Second Edition (Bell 2002) — This book from the co-founder of the Institute on Black Chemical Abuse explores the dynamics of race, culture, and class in treatment and examines substance abuse and recovery in the context of racial identity.

Cultural Competence for Health Care Professionals Working With African-American Communities: Theory and Practice (Center for Substance Abuse Prevention 1998*a*) — This book provides tips for health care workers. Order from SAMHSA's NCADI or download at www.hawaii.edu/hivandaids/links.htm.

Relapse Prevention Counseling for African Americans: A Culturally Specific Model (Williams and Gorski 1997) — This book examines the way that cultural factors interact with relapse prevention efforts in African-Americans.

Native Americans

Health Promotion and Substance Abuse Prevention Among American Indian and Alaska Native Communities: Issues in Cultural Competence (Center for Substance Abuse Prevention 2001) — This volume frames the development of substance abuse prevention and treatment efforts in the context of health disparities that have affected Native-American and Alaskan-Native communities in rural and urban settings, as well as on reservations. Grounded in traditional healing practices, the volume examines innovative approaches to substance abuse prevention. Order from SAMHSA's NCADI.

Substance Abuse Resource Guide: American Indians and Native Alaskans (Center for Substance Abuse Prevention 1998*b*) — A substance abuse resource guide for American Indians and Alaska Natives, including books, articles, classroom materials, posters, and Web sites. Order from SAMHSA's NCADI.

Promising Practices and Strategies To Reduce Alcohol and Substance Abuse Among American Indians and Alaska Natives (American Indian Development Associates 2000) — This report collects descriptions of successful substance abuse prevention efforts by Native-American groups. It also includes a literature review and list of Federal resources. Visit www.ojp.usdoj.gov/americannative/promise.pdf to download the report.

"Morning Star Rising: Healing in Native American Communities" (Nebelkopf et al. 2003) — This special issue of the *Journal of Psychoactive Drugs* is devoted to healing in Native-American communities, with 13 articles on various aspects of prevention and treatment. Contact Haight-Ashbury Publications at (415) 565–1904.

Walking the Same Land — This videotape presents young Indians who are returning to traditional cultural ways to strengthen their recovery from substance abuse. It includes aboriginal men from Australia and Mohawk men from New York. Order from SAMHSA's NCADI.

Asian Americans and Pacific Islanders

Asian and Pacific Islander American Health Forum (www.apiahf.org/resources/index.htm) — This site provides links to information and resources.

Asian Community Mental Health Services (www.acmhs.org) — This site provides links to information and describes a substance abuse treatment program in Oakland, California.

Substance Abuse Resource Guide: Asian and Pacific Islander Americans (Center for Substance Abuse Prevention 1996*a*; www.ncadi.samhsa.gov/govpubs/MS408) — This guide contains resources appropriate for use in Asian and Pacific Islander communities. It also contains facts and figures about substance use and prevention within this diverse group.

Responding to Pacific Islanders: Culturally Competent Perspectives for Substance Abuse Prevention (Center for Substance Abuse Prevention 1999) — This book examines the culture-specific factors that affect substance abuse prevention in Pacific Islander communities. Order from SAMHSA's NCADI.

"Communicating Appropriately With Asian and Pacific Islander Audiences" (Center for Substance Abuse Prevention 1997) — This *Technical Assistance Bulletin* discusses population characteristics, lists cultural factors related to substance use in nine distinct ethnic groups, and presents guidelines on developing effective prevention materials for these populations. Visit www.ncadi.samhsa.gov/govpubs/MS701 to download the bulletin.

Opening Doors: Techniques for Talking With Southeast Asian Clients About Alcohol and Other Drug Issues — This program is available on videocassette in Vietnamese and Khmer with English subtitles. Order from SAMHSA's NCADI, and visit http://ncadistore.samhsa.gov/catalog/productDetails.aspx?ProductID=15136 to view it on the Web.

Persons With HIV/AIDS

TIP 37, *Substance Abuse Treatment for Persons With HIV/AIDS* (CSAT 2000*c*) — This TIP discusses the medical aspects of HIV/AIDS (epidemiological data, assessment, treatment, and prevention), the legal and ethical implications of treatment, the counseling of patients with HIV/AIDS, the integration of treatment and enhanced services, and funding sources for programs.

The Hawaii AIDS Education and Training Center has numerous resources available for download at www.hawaii.edu/hivandaids/links.htm.

LGB Populations

The Web site of the National Association of Lesbian and Gay Addiction Professionals is a clearinghouse for information and resources, including treatment programs and mutual-help groups, organized by State. Visit www.nalgap.org.

Substance Abuse Resource Guide: Lesbian, Gay, Bisexual, and Transgender Populations (Center for Substance Abuse Prevention 2000) — This publication lists books, fact sheets, magazines, newsletters, videos, posters, reports, Web sites, and organizations that increase understanding of issues important to lesbian, gay, bisexual, and transgender clients. Download the resource guide from www.ncadi.samhsa.gov/referrals/resguides.aspx?InvNum=MS489.

Addictions in the Gay and Lesbian Community (Guss 2000) — This volume includes personal experiences of substance use and recovery and research into the sources of and treatment for substance use disorders in gay and lesbian clients. The book also includes techniques for assessing and treating LGB clients, including adolescents.

Persons With Physical and Cognitive Disabilities

Programs should link with local groups that offer specialized housing, vocational training, and other supports for people who are disabled. The Centers for Independent Living (CILs) are organizations run by and for persons with disabilities to provide mutual-help and advocacy. CILs and Client Assistance Programs were developed to provide a third party to broker the interaction between clients and the service system. The Special Olympics may be able to help locate recreational activities appropriate for individual clients.

Coping With Substance Abuse After TBI — This report answers basic questions about substance use and traumatic brain injury (TBI) and includes recommendations from clients with TBI who are now abstinent. Download the publication at www.mssm.edu/tbicentral/resources/publications/tbi_consumer_reports.shtml.

TIP 29, *Substance Use Disorder Treatment for People With Physical and Cognitive Disabilities* (CSAT 1998*e*) — This volume discusses screening, treatment planning, and counseling for clients with disabilities. The book includes a compliance guide for the Americans with Disabilities Act, a list of appropriate terms to use when referring to people with disabilities, and screening instruments for use with this population, including an Education and Health Survey and an Impairment and Functional Limitation Screen.

Substance Abuse Resources and Disability Issues Program at Wright State School of Medicine (www.med.wright.edu/citar/sardi) — This Web site offers products for professionals and persons with disabilities, including a training manual with an introduction on substance abuse and the deaf culture, as well as a Web course on substance abuse and disability.

National Center for the Dissemination of Disability Research's Guide to Substance Abuse and Disability Resources (www.ncddr.org/du/products/saguide) — This Web site provides links to books, journal articles, newsletters, training manuals, audiotapes, and videotapes on substance abuse and individuals who are disabled.

Minnesota Chemical Dependency Program for Deaf and Hard of Hearing Individuals (www.mncddeaf.org) — This Web site includes links to articles on substance abuse treatment of individuals who are deaf and to manuals and videotapes for use in treatment.

Ohio Valley Center for Brain Injury Prevention and Rehabilitation (www.ohiovalley.org/abuse) — This Web site includes guidelines for treating people with substance use disorders and traumatic brain injury and links to other resources.

Center for International Rehabilitation Research and Information Exchange (www.cirrie.buffalo.edu/mseries.html) — This Web site includes downloadable versions of cultural guides that describe the demographics and attitudes toward disability of 11 countries, including countries in Asia, Central America, and the Caribbean. The site also includes a booklet that describes culture brokering, a practice in which counselors mediate between cultures to improve service delivery.

Rural Populations

TAP 17, *Treating Alcohol and Other Drug Abusers in Rural and Frontier Areas* (CSAT 1995*b*) — The papers in this volume describe providers' experiences across a variety of treatment issues relevant to rural substance abuse treatment, including domestic violence, enhanced service delivery, building coalitions and networks, and practical measures to improve treatment.

TAP 20, *Bringing Excellence to Substance Abuse Services in Rural and Frontier America* (CSAT 1996) — The papers in this volume examine innovative strategies and policies for treating substance use disorders in rural and frontier America. Topics include rural gangs and crime, needs assessment approaches, coalitions and partnerships, and minorities and women in treatment.

Rural Substance Abuse: State of Knowledge and Issues (Robertson et al. 1997) — This NIDA Research Monograph examines rural substance abuse from many perspectives, looking at substance use among youth and at the health, economic, and social consequences of substance use. The final section of the book addresses ethnic and migrant populations, including rural Native Americans, African-Americans, and Mexican Americans. Visit www.nida.nih.gov/PDF/Monographs/Monograph168/Download168.html to download the monograph.

Homeless Populations

National Resource Center on Homelessness and Mental Illness (www.nrchmi.samhsa.gov/pdfs/bibliographies/Cultural_Competence.pdf) — This Web site has an annotated, online bibliography of journal articles, resource guides, reports, and books that address cultural competence. Many resources discuss substance use disorders.

"The Effectiveness of Social Interventions for Homeless Substance Abusers" (American Society of Addiction Medicine 1995) — This special issue of the *Journal of Addictive Diseases* includes 11 articles that examine important aspects of treating people who are homeless, including retaining clients, residential versus nonresidential treatment, enhanced services, treating mothers who are homeless, and clients with co-occurring disorders.

The U.S. Department of Housing and Urban Development has compiled a list of local agencies by State and other resources to assist people who are homeless. Visit www.hud.gov/homeless/index.cfm.

The U.S. Department of Health and Human Services offers assistance and resources for people who are homeless. For example, the Health Care for the Homeless Program provides grants to community-based organizations in urban and rural areas for projects aimed at improving access for the homeless to primary health care, mental health care, and substance abuse treatment. Visit www.aspe.hhs.gov/homeless/index.shtml.

Substance Abuse Treatment: What Works for Homeless People? A Review of the Literature (Zerger 2002) — This report links research on homelessness and substance abuse with clinical practice and examines various treatment modalities, types of interventions, and methods for engaging and retaining people who are homeless. Download the report from National Health Care for the Homeless Council's Web site at www.nhchc.org/Publications/SubstanceAbuseTreatmentLitReview.pdf.

National Resource Center on Homelessness and Mental Illness (www.nrchmi.samhsa.gov) — This Web site lists trainings and workshops (such as the National Training Conference on Homelessness for People With Mental Illness and/or Substance Use Disorders), technical assistance, and fact sheets and other publications on homelessness.

Older Adults

TIP 26, *Substance Abuse Among Older Adults* (CSAT 1998*d*) — This volume discusses the relationship between aging and substance abuse and offers guidance for screening, assessing, and treating substance use disorders in older adults.

Substance Abuse Relapse Prevention for Older Adults: A Group Treatment Approach (CSAT 2005*c*) — This manual presents a relapse prevention intervention that uses a cognitive-behavioral and self-management approach in a counselor-led group setting to help older adults overcome substance use disorders. Order from SAMHSA's NCADI.

Substance Abuse by Older Adults: Estimates of the Future Impact on the Treatment System (Korper and Council 2002) — This report examines substance abuse treatment services for older adults in the context of increased demand in the future and calls for better documentation of substance abuse among older adults and prevention and treatment strategies that are tailored to subgroups of older adults, such as immigrants and racial and ethnic minorities. Download the report at www.drugabusestatistics.samhsa.gov/aging/toc.htm.

Alcohol and Aging (Beresford and Gomberg 1995) — This book for clinicians covers topics such as diagnosis and treatment, mental disorders, interactions of alcohol and prescription medications, and the biochemistry of intoxication for older adults.

Alcoholism and Aging: An Annotated Bibliography and Review (Osgood et al. 1995) — This volume surveys 30 years of research on older adults who use alcohol, providing abstracts of articles, books and book chapters, and research studies on the prevalence, effects, diagnosis, and treatment of alcohol use in older adults.

Administration on Aging (www.aoa.gov/prof/adddiv/adddiv.asp) — This Web site offers information on cultural competence, including resources on aging and ethnic minorities and the booklet, *Achieving Cultural Competence: A Guidebook for Providers of Services to Older Americans and Their Families,* which can be downloaded at www.aoa.gov/prof/adddiv/cultural/addiv_cult.asp.

References - Section 3

Section 3, Chapter 2

American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders,* Fourth Edition (DSM-IV). Washington, DC: American Psychiatric Association, 1994.

Bean, F.D.; Trejo, S.J.; Crapps, R.; and Tyler, M. *The Latino Middle Class: Myth, Reality, and Potential.* Los Angeles, CA: Tomás Rivera Policy Institute, 2001.

Brisbane, F.L. Introduction: Diversity among African Americans. In: Center for Substance Abuse Prevention (CSAP). *Cultural Competence for Health Care Professionals Working With African-American Communities: Theory and Practice.* CSAP Cultural Competence Series 7. DHHS Publication No. (SMA) 98–3238. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1998, pp. 1–8.

Center for Substance Abuse Prevention. *Substance Abuse Resource Guide: Asian and Pacific Islander Americans.* Rockville, MD: Substance Abuse and Mental Health Services Administration, 1996*a*. ncadi.samhsa/gov/govpubs/MS408 [accessed March 4, 2004].

Center for Substance Abuse Prevention. *Substance Abuse Resource Guide: Hispanic/Latino Americans*. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1996*b*. www.ncadi.samhsa.gov/govpubs/MS441 [accessed March 4, 2004].

Centers for Disease Control and Prevention*HIV/AIDS Surveillance Report* 16:1–46, 2004.

Cross, TL.; Bazron, B.J.; Dennis, K.R.; and Isaacs, M.R. *Towards a Culturally Competent System of Care,* Vol. 1. Washington, DC: Georgetown University Child Development Center, National Technical Assistance Center for Children's Mental Health, 1989.

CSAT (Center for Substance Abuse Treatment). *A Provider's Introduction to Substance Abuse Treatment for Lesbian, Gay, Bisexual, and Transgender Individuals.* DHHS Publication No. (SMA) 01–3498. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2001.

Fears, D. A Diverse — and Divided — Black Community. *Washington Post,* February 24, 2002, pp. A1, A8.

Gfroerer J, Penne M, Pemberton M, Folsom R. Substance abuse treatment need among older adults in 2020: The impact of the aging baby-boom cohort. *Drug and Alcohol Dependence.* 69((2)):127-135; 2003. (PubMed)

Greenwood G.L, White E.W, Page-Shafer K, Bein E, Osmond D.H, Paul J, Stall R.D. Correlates of heavy substance use among young gay and bisexual men: The San Francisco Young Men's Health Study. *Drug and Alcohol Dependence*. 61((2)):105-112; 2001. (PubMed)

Hubbard J.R, Everett A.S, Khan M.A. Alcohol and drug abuse in patients with physical disabilities. *American Journal of Drug Abuse*. 22((2)):215-231; 1996.

Jezewski, M.A., and Sotnik, P. *Culture Brokering: Providing Culturally Competent Rehabilitation Services to Foreign-Born Persons.* Buffalo, NY: Center for International Rehabilitation Research Information and Exchange, 2001.www.cirrie.buffalo.edu/cbrokering.html [accessed February 11, 2004].

Joyner L.M, Wright J.D, Devine J.A. Reliabilit and validity of the Addiction Severity Index among homeless substance misusers. *Substance Use & Misuse*. 31((6)):729-751; 1996. (PubMed)

Korper, S.P., and Council, C.L., eds. *Substance Use by Older Adults: Estimates of Future Impact on the Treatment System.* Analytic Series A-21. DHHS Publication No. (SMA) 03–3763. Rockville, MD: Office of Applied Studies, Substance Abuse and Mental Health Services Administration, 2002.

LaPlante, M.P.; Kennedy, J.; Kaye, H.S.; and Wenger, B.L. Disability and employment. *Disability Statistics Abstract*. Number 11. San Francisco: Disability Statistics Center, 1996.www.dsc.ucsf.edu/pdf/abstract11.pdf [accessed February 11, 2004].

La Veist, T.A.; Diala, C.; and Jarrett, N.C. Social status and perceived discrimination: Who experiences discrimination in the health care system, how, and why? In: Hogue, C.J.R.; Hargraves, M.A.; and Collins, K.S., eds. *Minority Health in America.* Baltimore: Johns Hopkins University Press, 2000, pp. 194–208.

Magura S, Nwakeze P.C, Rosenblum A, Joseph H. Substance misuse and related infectious diseases in a soup kitchen population. *Substance Use & Misuse.* 35((4)):551-583; 2000. (PubMed)

McKinnon, J. The Black population in the United States: March 2002. *Current Population Reports.* P20–541. Washington, DC: U.S. Census Bureau, 2003.

Metsch L.R, McCoy C.B. Drug treatment experiences: Rural and urban comparisons. *Substance Use & Misuse.* 34((4&5)):763-784; 1999. (PubMed)

Milby J.B, Schumacher J.E, Raczynski J.M, Caldwell E, Engle M, Michael M, Carr J. Sufficient conditions for effective treatment of substance abusing homeless persons. *Drug and Alcohol Dependence.* 43:39-47; 1996. (PubMed)

Moore D, Li L. Prevalence and risk factors of illicit drug use by people with disabilities. *American Journal on Addictions.* 7((2)):93-102; 1998. (PubMed)

Mulvey KP, Hubbard S, Hayashi S. A National Study of the Substance Abuse Treatment Workforce. *Journal of Substance Abuse Treatment.* 24:51-57; 2003. (PubMed)

Office of Applied Studies. *Summary of Findings From the 2000 National Household Survey on Drug Abuse.* NHSDA Series H–13. DHHS Publication No. (SMA) 01–3549. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2001.http://oas.samhsa.gov/NHSDA/2kNHSDA/2kNHSDA.htm [accessed February 11, 2004].

Office of Applied Studies. *Treatment Episode Data Set (TEDS): 1992–2000, National Admissions to Substance Abuse Treatment Services.* DASIS Series: S-17, DHHS Publication No. (SMA) 02–3727. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2002.wwwdasis.samhsa.gov/teds00/TEDS_2k_index.htm [accessed February 11, 2004].

Office of Applied Studies, Substance Abuse and Mental Health Services Administration (SAMHSA). *Treatment Episode Data Set (TEDS): 1992–2001. National Admissions to Substance Abuse Treatment Services.* DASIS Series S-12. DHHS Publication No. (SMA) 02-3778. Rockville, MD: SAMHSA, 2003*b*. wwwdasis.samhsa.gov/teds01/TEDS2K1Index.htm [accessed March 19, 2004].

Office of Applied Studies. *The DASIS Report: Characteristics of Homeless Admissions to Substance Abuse Treatment, 2000.* Rockville, MD: Substance Abuse and Mental Health Services Administration, August 8, 2003*b*.http://www.oas.samhsa.gov/2k3/homelessTX/homelessTX.htm [accessed February 11, 2004].

Ogunwole, S.U. The American Indian and Alaska Native population: 2000. *Census 2000 Brief.* C2KBR/01–15. Washington, DC: U.S. Census Bureau, 2002.

Oslin D.W, Pettinati H, Volpicelli J.R. Older age predicts better adherence and drinking outcomes. *American Journal of Geriatric Psychiatry.* 10:740-747; 2002. (PubMed)

Perry, M.J., and Mackun, P.J. Population change and distribution: 1990 to 2000. Census 2000 Brief. C2KBR/01-2. Washington, DC: U.S. Census Bureau, 2001.

Ramirez, R.R., and de la Cruz, G.P. The Hispanic population in the United States: March 2002. *Current Population Reports,* P20–545. Washington, DC: U.S. Census Bureau, 2003.

Schmidley, D. The foreign-born population in the United States: March 2002. *Current Population Reports,* P20–539. Washington, DC: U.S. Census Bureau, 2003.

Schumacher J.E, Milby J.B, Caldwell E, Raczynski J, Engle M, Michael M, Carr J. Treatment outcome as a function of treatment attendance with homeless persons abusing cocaine. *Journal of Addictive Diseases.* 14((4)):73-85; 1995. (PubMed)

Spicer P, Beals J, Croy C.D, Mitchell C.M, Novins D.K, Moore L, Manson S.M, the American Indian Service Utilization, Psychiatric Epidemiology, Risk and Protective Factors Project Team.. The prevalence of DSM-III-R alcohol dependence in two American Indian populations. *Alcoholism, Clinical and Experimental Research.* 27((11)):1785-1797; 2003.

Tonigan J.S. Project MATCH treatment participation and outcome by self-reported ethnicity. *Alcoholism, Clinical and Experimental Research.* 27((8)):1340-1344; 2003.

Urban Institute; Burt, M.R.; Aron, L.Y.; Douglas, T.; Valente, J.; Lee, E.; and Iwen, B. Homelessness: Programs and the People They Serve — Findings of the National Survey of Homeless Assistance Providers and Clients, Technical Report. Washington, DC: Interagency Council on the Homeless, 1999. www.huduser.org/publications/homeless/homeless_tech.html [accessed February 11, 2004].

U.S. Department of Health and Human Services. *Mental Health: Culture, Race, and Ethnicity — A Supplement to Mental Health: A Report of the Surgeon General.* Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2001.www.mentalhealth.org/cre/default.asp [accessed February 11, 2004].

Wells K, Klap R, Koike A, Sherbourne C. Ethnic disparities in unmet need for alcoholism drug abuse and mental health care. *American Journal of Psychiatry*. 158:2027-2032; 2001. (PubMed)

Woody G.E, Donnell D, Seage G.R, Metzger D, Marmor M, Koblin B.A, Buchbinder S, Gross M, Stone B, Judson F.N. Non-injection substance use correlates with risky sex among men having sex with men: Data from HIVNET. *Drug and Alcohol Dependence.* 53((3)):197-205; 1999. (PubMed)