Substance Abuse: Clinical Issues in Intensive Outpatient Treatment

A Treatment Improvement Protocol

TIP 47

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Treatment
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INTENSIVE OUTPATIENT TREATMENT

Substance Abuse: Clinical Issues in Intensive Outpatient Treatment

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9 Adapting Intensive Outpatient Treatment for Specific Populations

In This Chapter...

Many assumptions and approaches used in intensive outpatient treatment (IOT) programming were developed for and validated with middle-class, employed, adult men. This chapter presents information about how IOT can be adapted to meet the needs of specific populations: the justice system population, women, people with co-occurring mental disorders, and adolescents and young adults. Chapter 10 presents information on treatment approaches for other special groups, including minority populations.

Justice System Population

The number of people in the justice system with a history of substance use disorders has increased dramatically over the last 20 years because of increased drug-related crime, Federal and State legislation, and mandatory sentencing guidelines; many of these people are caught in a cycle of repeated incarcerations.

Between 1990 and 1999, the number of inmates sentenced to Federal prison for drug offenses rose more than 60 percent (Beck and Harrison 2001). About three-quarters of all prisoners reported some type of involvement with alcohol or drug abuse before their offenses, and an estimated 33 percent of State prisoners and 22 percent of Federal prisoners say that they had committed their current offenses while under the influence of drugs, with marijuana/hashish and cocaine/crack used most often (Mumola 1999).

Description of the Population

Justice system populations are younger than the general population, are overwhelmingly male, and are challenged with many psychosocial, medical, and financial problems (Brochu et al. 1999).

Psychosocial issues

People involved with the justice system typically have many problems related to employment and financial support, housing, education, transportation, and unresolved legal issues. Many inmates have not completed high school or earned a general equivalence diploma. Only about 55 percent were employed full time before their incarceration (Bureau of Justice Statistics 2000).

Medical and psychiatric problems

Offenders with a substance use disorder may have co-occurring psychiatric disorders. Approximately 16 percent of State inmates, 7 percent of Federal inmates, and 16 percent of jail inmates and probationers reported having mental illnesses, and nearly 60 percent of these offenders reported that they were under the influence of alcohol or drugs at the time of their offenses (Ditton 1999). People in prison have a high incidence of HIV/AIDS (Maruschak 2002), tuberculosis, sexually transmitted diseases, and hepatitis C (National Institute of Justice 1999).

A major challenge to IOT providers is to integrate substance abuse treatment with justice system processes.

Female offenders

Between 1990 and 2000, the number of women involved with the justice system (incarcerated, on probation, or paroled) increased by 81 percent (Bloom et al. 2003). Women accounted for 15 percent of the total correctional population in 1998; 90 percent were under community supervision (Glaze 2003; Harrison and Beck 2003). Seventy-two percent of the women in Federal prisons were convicted of drug offenses or committed their crimes while under the influence of drugs or alcohol (Greenfeld and Snell 1999). Female offenders with substance use disorders experienced more health, educational, and employment problems; had lower incomes; reported more depression, suicidal behavior, and sexual and physical abuse; and had more mental and physical health problems than did male offenders with substance use disorders (Langan and Pelissier 2001). More than half the female inmates in prisons had at least one child younger than 18 (Mumola 2000). The National Institute of Corrections' *Gender-Responsive Strategies: Research, Practice, and Guiding Principles for Women Offenders* (Bloom et al. 2003) provides more information about female offenders.

Double stigma

Offenders often are affected by the stigma associated with involvement in the justice system, as well as the stigma associated with substance abuse. These two factors can impede an offender's ability to obtain appropriate employment or housing.

Implications for IOT

In response to the increase in drug-related judicial cases, several approaches for treating offenders who have a substance use disorder have been developed. IOT providers become involved in treating offenders when the offender is (1) referred to treatment in lieu of incarceration, (2) incarcerated, or (3) released.

Coercion frequently is used to compel offenders to participate in treatment. Coercion may be a sentence mandating treatment or a prison policy mandating treatment for inmates discovered to have a substance use disorder while incarcerated for a non-drug-related crime. For nonincarcerated offenders, a sanction for refusing to participate in treatment often is incarceration. Research indicates that treatment adherence and outcomes of clients legally referred to

treatment were the same as or better than those of clients entering treatment of their own volition (Farabee et al. 1998; Marlowe et al. 1996, 2003).

Working With the Judicial System

IOT programs provide treatment for the following justice system clients:

- **Offenders referred to treatment in lieu of incarceration.** IOT providers have developed effective partnerships with drug courts and Treatment Accountability for Safer Communities (TASC) programs to provide treatment (Farabee et al. 1998). Drug courts, begun in 1989, divert nonviolent offenders with substance use disorders into treatment instead of incarceration. Drug courts oversee the offender's treatment, coordinate justice and treatment systems procedures, and monitor progress. TASC, formerly known as Treatment Alternatives to Street Crime, identifies and assesses offenders involved with drugs and refers them to community treatment services.
- **Offenders discharged from residential substance abuse treatment who need continuing community-based treatment.** IOT programs provide stepdown, but structured, services and transitional services and links to other services for offenders who are discharged from residential treatment.
- **Offenders who need treatment and are placed under community supervision (pretrial, probation, or parole).** Many justice programs have been developed to support this type of treatment for people who are under the supervision of the justice system but are allowed to remain in the community.
- **Offenders reentering the community after incarceration.** Reentry management programs funded by various Federal agencies facilitate the transition and reintegration of prisoners released into the community. IOT providers, working closely with justice staff before individuals are released, engage offenders in treatment and support their continuing recovery through flexible, individualized approaches. TIP 30, *Continuity of Offender Treatment for Substance Use Disorders From Institution to Community* (CSAT 1998*b*), provides more information on transition of prisoners to the community.
- **Offenders who participate in treatment while incarcerated.** IOT can be modified for use in prisons and jails, although this stretches the concept of outpatient treatment. Institutions that can segregate offenders in IOT from the rest of the incarcerated population provide a more effective and supportive structure (U.S. House Committee on the Judiciary 2000).

Forging a Working Partnership

A major challenge to IOT providers is to integrate substance abuse treatment with justice system processes. Partnerships are being forged effectively as justice agencies and treatment providers recognize that, although they have different perspectives, they can work together. Both parties need to be flexible and interact with clients on a case-by-case basis (Farabee et al. 1998). Justice officials and IOT providers need to agree on which clients are appropriate for treatment and establish clear screening and admission criteria.

Rules for Offenders in Treatment

Most justice system and IOT program partners agree that offenders in treatment must not commit another offense, must abstain from drug use, and must comply with treatment requirements. However, disagreements about additional rules may emerge. As a result, some policies and sanctions may work against the recovery they are designed to achieve. IOT program staff members can

help prevent or resolve such conflicts by discussing these matters with judges and other criminal justice officials. Staff members who are familiar with research on treatment outcomes are best suited to convey to others a realistic, convincing argument for treatment and to foster cooperation that leads to client recovery. Developing and agreeing on a process for resolving conflicts early in the collaboration may reconcile discordant opinions. For the collaboration to function smoothly, IOT program staff needs the discretion to make decisions about treatment, such as whether the offender needs a different level of care. The justice system staff needs to be confident that it will be informed of treatment progress or if sanctions are justified. The partners must agree on the following:

- **Consequences for lapses in abstinence and continued drug use.** When a client admits to a single episode of drug use in a treatment session, the counselor may view this as a positive development; this admission of use may indicate that the client has gone beyond denial and begun to work on treatment issues. Justice system staff, however, may disagree and consider any drug use grounds for incarceration. IOT staff members may agree to sanctions only when continued episodes of drug use indicate that the offender is not committed to treatment.
- **Consequences for use of alcohol.** The justice system considers alcohol a legal substance and is concerned only with illegal activity resulting from its use. Consequently, the justice agency may not apply sanctions for continued alcohol use. In contrast, treatment providers consider alcohol an addictive substance and usually enforce no-use-of-alcohol rules. The topic warrants extended conversation between partners to develop reasonable responses to alcohol use.
- **Discharge criteria.** Agreed-on discharge criteria that define treatment goals, conditions indicating therapeutic discharge, and behavior meriting immediate discharge are needed.
- **Uses of drug-testing results.** The justice system regards drug-screening test results as an objective measure of progress or nonadherence to treatment and can impose severe consequences for positive drug tests. Many IOT programs use drug test results therapeutically, to inform treatment plans and to deter clients from using substances. Both systems need to discuss how drug test results will be used.

Communication Between Systems

Clear communication between the two systems is essential. For all referrals from the justice system (pretrial services, probation, and parole), an IOT program should designate point-of-contact personnel. To ensure clients' privacy rights, programs need to have confidentiality release forms that specify the information to be shared and the length of time the forms are in effect; all clients must sign these forms. These forms permit the two agencies to communicate information about the offender for monitoring purposes.

IOT providers are advised to discuss and agree on the following communication issues with their justice system partners:

- The form and timing of updates on treatment progress from the treatment program to the justice agency
- Reportings of critical incidents, such as when an offender threatens to commit a crime or fails to appear for treatment
- Reportings from the criminal justice agency, such as when an offender is rearrested or incarcerated

Memorandum of Understanding

Once justice system and IOT program partners agree on rules, consequences, and elements of communication, the agreement

needs to be formalized in a written memorandum of understanding (MOU). The suggested elements of an MOU include

- Parameters of treatment, including the kinds of services
- Each partner's responsibilities (e.g., the criminal justice agency refers and monitors clients; the treatment program assesses and treats clients)
- The consequences for noncompliant behavior, recognizing that not every contingency can be foreseen
- Identification of which agency determines the consequences of noncompliant behavior
- The types, content, and timetable of communications and reportings required between the partners
- Definitions of critical incidents that require the treatment program to notify the justice agency

Clinical Issues and Services

Although working with clients involved with the criminal justice system is challenging, it can be rewarding. For example, approximately 60 percent of people involved with drug courts remained in treatment for at least a year, with a minimum 48-percent graduation rate (Belenko 1999). Clients involved with the justice system have unique stressors, including, but not limited to, their precarious legal situation. Clients may need help with transportation, educational services, family issues, financial issues such as obtaining welfare and Medicaid benefits and arranging restitution payments, housing such as arranging temporary shelter and permanent housing, and job skills and employment counseling. Case management can coordinate services for justice system clients.

TIP 44, *Substance Abuse Treatment for Adults in the Criminal Justice System* (CSAT 2005*d*), provides more information about treating this population.

Staff Training

Treatment is impeded when counselors have a negative attitude toward clients, believe that clients have a poor prognosis for recovery, or are reluctant to serve offenders in general. These issues should be included in staff training and cross-training.

To provide effective substance abuse treatment to criminal justice system clients, staffs in both systems need cross-training (Farabee et al. 1999). Topics include the philosophy, approach, goals, objectives, and boundaries of both systems. Treatment providers need information about the responsibilities, structure, operations, and goals of the justice system; public safety and security concerns; and how involvement with the justice system affects offenders. Criminal justice system personnel need information about the dynamics of substance use disorders, components of treatment, how treatment can reduce recidivism, confidentiality, and co-occurring psychiatric disorders.

> For all referrals from the justice system...an IOT program should designate point-of-contact personnel.

Women

In recent years, heightened awareness and new funding have encouraged the development of specialized programs to address the treatment needs of women. The number of treatment facilities offering programs for pregnant and postpartum women rose from 1,890 in 1995 to 2,761 in 2000, and more than 5,000 facilities offered special programs for women (Substance Abuse and Mental Health Services Administration 2002). The forthcoming TIP *Substance Abuse Treatment: Addressing the Specific Needs of Women* (CSAT forthcoming *b*), TIP 25, *Substance Abuse Treatment and Domestic Violence*

(CSAT 1997*b*), and TIP 36, *Substance Abuse Treatment for Persons With Child Abuse and Neglect Issues* (CSAT 2000*b*), provide more information.

Description of the Population

Even though women and men who have substance use disorders have many similarities, they differ in some important ways. Women typically begin using substances later and enter treatment earlier in the course of their illnesses than do men (Brady and Randall 1999). Other differences with therapeutic implications are briefly surveyed below. Discussions of strategies for addressing women-specific treatment issues follow.

Violence

Women with substance use disorders are more likely than men with substance use disorders to have been physically or sexually abused as children (Bartholomew et al. 2002; Simpson and Miller 2002). In addition, women who have a substance use disorder are more likely to be victims of domestic violence (Chermack et al. 2001), with reported rates of women in treatment who have been victims of physical and sexual violence ranging from 75 percent (Oumiette et al. 2000) to 88 percent (B.A. Miller 1998).

Mental disorders

Compared with men, women with substance use disorders have nearly double the occurrence (30.3 percent vs. 15.7 percent) of serious mental illness and past year substance use disorders (Epstein et al. 2004). These higher rates of psychiatric comorbidity are particularly evident in mood and anxiety disorders (Zilberman et al. 2003).

Parenting issues

Women in treatment often bear the sole caretaking responsibility for their children, and this role can be a substantial obstacle to seeking and remaining in treatment. Women may have difficulty finding reliable and affordable child care. They may fear losing custody of their children because of their substance use, and this fear may deter them from entering treatment. At the same time, women (and men) who abuse substances are more likely to abuse or neglect their children (National Clearinghouse on Child Abuse and Neglect Information 2003).

Welfare issues

Some States require that individuals receiving welfare benefits be screened and treated for substance use disorders; failure to enroll in or dropping out of treatment may jeopardize benefits (Legal Action Center 1999). Such requirements can help retain a client in an IOT program, and a case manager should coordinate treatment with welfare staff.

Pregnancy

Substance use during pregnancy can mean poor prenatal care, unregistered delivery, and low-weight and premature babies (Howell et al. 1999). Heavy or binge alcohol or drug use during pregnancy can result in negative consequences for the child such as neurological damage, including fetal alcohol syndrome (American Academy of Pediatrics 2000).

Relationships

A woman's substance use disorder is often influenced by her partner. Women with male partners who use substances are retained in treatment for a shorter time than women with substance-free partners (Tuten and Jones 2003). Conversely, a woman's partner can have a positive influence on treatment through support and participation in treatment.

Implications for IOT

Effective treatment for women cannot occur in isolation from the social, health, legal, and other challenges facing female clients. Some studies suggest that gender-specific treatment may be advantageous for female

clients (Grella et al. 1999), producing higher success rates in women-only groups or programs. However, research to date on the best treatment for women is inconclusive (Blume 1998).

Barriers to treatment entry and retention

Once a woman decides to seek help, she may face a long wait because of the lack of appropriate treatment. In addition, she faces gender-specific barriers and issues that may affect entry and retention in treatment such as

- Concerns about fulfilling her responsibilities as a mother, wife, or partner
- Fears of retribution from an abusive spouse or partner
- Gender and cultural insensitivity of some treatment programs
- Threat of legal sanction, such as loss of child custody
- Lack of affordable or reliable child care
- The disproportionate societal intolerance and stigma associated with substance abuse in women compared with men
- Ineligibility for treatment medications if she is pregnant or may become pregnant
- Having few other women in treatment with her

Entry and assessment

A woman entering treatment needs to feel that the environment is safe and supportive. IOT program staff members who are understanding, respectful, optimistic, and nurturing can build a positive, therapeutic relationship. It may help if the intake counselor is a woman. The client may be fearful, confused, in withdrawal, or in denial, and staff members need to be patient and supportive, understanding that it is empowering for the client to choose when to provide information and what information to provide. Additional ways to facilitate entry include providing help with child care and extending program hours for working women.

Using a comprehensive assessment, staff members can identify the client's strengths and weaknesses and work with her to develop specific treatment goals and a treatment plan. Because of the likelihood of victimization and presence of co-occurring psychiatric disorders, female clients need careful assessments for psychiatric disorders and history of childhood trauma and adult victimization. Chapter 5 discusses intake forms that can be used or modified to gather these data. Victimization experiences may be hidden beneath shame and guilt but, as trust develops, the client can discuss these events.

A woman entering treatment needs to feel that the environment is safe and supportive.

Clinical Issues and Strategies

Some women-specific programs are based on the philosophy that supporting and empowering women improve treatment success. Some programs advocate using predominantly female staff in professional and support positions. Providing enhanced services that respond to the social service needs of women is important for effective substance abuse treatment for women with children (Marsh et al. 2000; Volpicelli et al. 2000).

Treatment components specific to women

Exhibit 9-1 identifies core clinical needs and service elements that should be addressed in IOT for women (CSAT 1994*d*).

It is important to identify issues that the client is uncomfortable discussing in a group setting. As a woman feels more comfortable, she may be able to discuss them. Relapse prevention techniques may need to be modified for women. There is some evidence that

Exhibit 9-1

Core Treatment Needs and Service Elements for Women

Core Treatment Needs	Service Elements
Relationships with family and significant others	Provide family or couples counseling
Feelings of low self-esteem and self-efficacy	Address in group and individual counseling Identify and build on the client's strengths
History of physical, sexual, and emotional abuse	Avoid using harsh confrontational techniques that could retraumatize the client Hold individual and group therapy sessions or refer for treatment
Psychiatric disorders	Refer for or provide evaluation and treatment of psychiatric disorders, medication management, and therapy
Parenting, child care, and child custody	Hold parenting classes Develop substance abuse prevention services for children Provide or arrange for licensed child care, including a nursery for infants and young children and afterschool programs for older children Assist with Head Start enrollment
Medical problems	Refer for medical care, including reproductive health, pregnancy testing, and testing for or treating of infectious diseases
Gender discrimination and harassment	Ensure that the program has policies against harassment and that they are enforced

women's relapses are related to negative mood, more so than men's (Rubin et al. 1996). Also, women may do better in women-only counseling groups (Hodgins et al. 1997).

Therapeutic styles

Women who abuse substances may benefit more from supportive therapies than from other approaches and need a treatment environment that is safe and nurturing (Cohen 2000). Safety includes appropriate boundaries between counselor and client, physical and emotional safety, and a therapeutic relationship of respect, empathy, and compassion (Covington 2002).

For women with low self-esteem and a history of abuse, harsh confrontational approaches may further diminish their self-image and retraumatize them. Less aggressive approaches based on understanding and trust are more likely to effect change (Miller and Rollnick 2002). The confrontational approach of "breaking down" a person in treatment and rebuilding her as a recovering person may be overly harsh and not conducive to treating women (Covington 1999).

Woman clients can be referred to mutual-help groups such as Women for Sobriety and 12-Step groups that are sensitive to the needs of women. Some areas have women-only Alcoholics Anonymous (AA) and Narcotics Anonymous meetings, and some groups provide onsite child care. *A Woman's Way Through the Twelve Steps* (Covington 1994) and its companion workbook can help women adapt the 12 Steps for their use (Covington 2000).

Considerations for domestic violence survivors

IOT providers need to consider the safety of the client, develop and implement a personal safety plan for her, and notify the proper authorities if she is in danger. TIP 25, *Substance Abuse Treatment and Domestic Violence* (CSAT 1997*b*), provides additional information.

Treatment for pregnant women

Because of the possible harm to fetuses, it is important to provide comprehensive treatment services to pregnant women who abuse substances. IOT has produced positive results for pregnant women, and retention in treatment is facilitated by provision of support services such as child care, parenting classes, and vocational training (Howell et al. 1999). Elements of one model program for pregnant women include (CSAT 1993*a*; Howell et al. 1999)

- A family-centered approach with pregnancy and parenting education and mother–child play groups
- Interdisciplinary staff
- Counselor continuity
- Physical and mental health services
- Child care and transportation services
- Housing services that address homelessness or unstable and unsafe housing conditions

Other programs have found that being flexible and responsive to clients' needs and using nonconfrontational approaches improve the health of the women and newborns (Whiteside-Mansell et al. 1999).

Staffing and Training

Making a treatment program gender sensitive requires changes in staffing, training, and treatment approaches. Female program staff and advisory board members may be more sensitive to the needs of female clients. However, male clinicians can work effectively with female clients.

Training on issues and resources specific for women is necessary. Both female and male staff members should be trained about the ramifications for treatment of sexual, physical, and emotional abuse and partner violence. Training should overcome the tendency to blame the victim. Other training needs may include assessment techniques for violence or abuse, appropriate referrals

to mental health professionals, coordinating services with other agencies, and food programs that serve women and children. To prevent sexual harassment of female clients, program rules should be explicit and strictly enforced. Providers need to become familiar with the duty-to-warn requirement as it pertains to reporting child abuse and neglect and partner violence.

Populations With Co-Occurring Psychiatric Disorders

In the field of substance abuse treatment, people with both psychiatric and substance use disorders are said to have co-occurring mental disorders.

Description of the Population

Many clients with co-occurring disorders are in IOT. The Drug Abuse Treatment Outcome Study found that 39 percent of admissions to substance abuse treatment met *Diagnostic and Statistical Manual of Mental Disorders*, Third Edition, Revised (DSM-III-R) (American Psychiatric Association 1987) diagnostic criteria for an antisocial personality disorder, 11.7 percent met criteria for a major depressive episode, and 3.7 percent met criteria for a general anxiety disorder (Flynn et al. 1996). Other studies support these findings (Compton et al. 2000; Merikangas et al. 1998).

Most people with co-occurring mental and substance use disorders are not receiving appropriate care.

According to the Treatment Episode Data Set, people admitted to treatment who had a co-occurring psychiatric disorder were less likely than people admitted with only substance use disorders to be in the labor force. They were more likely to be women, abuse alcohol, and be referred through alcohol or drug abuse treatment providers and other health care providers than people admitted for substance abuse only (who were more likely to be have been referred by the criminal justice system) (Office of Applied Studies 2003*a*).

Group characteristics

When a client has co-occurring disorders, both the client and IOT counselor are presented with many challenges, such as

- Interacting symptoms that complicate treatment
- Increased biopsychosocial disruptions such as increased family problems, violent victimization, financial instability, homelessness, incarceration, suicidal ideation or attempts, and medical problems

Barriers to accessing treatment

Most people with co-occurring mental and substance use disorders are not receiving appropriate care (Watkins et al. 2001). Two of the numerous barriers to treatment are limited access to treatment and poor coordination between treatment systems.

In addition, historically, substance abuse and psychiatric treatments were provided in separate settings, and it was believed that one disorder must be stabilized before the other disorder could be treated, resulting in fragmented services. Clients were caught between two systems (Drake et al. 2001). The different treatment approaches led to misunderstandings between mental health and substance abuse treatment providers. Mental health providers may use more motivational and supportive techniques and professionally trained staff, whereas substance abuse treatment programs use more confrontational approaches, which may be distressing

for clients with co-occurring disorders, and often combine peer support with professionally trained counselors (Minkoff 1994). Some substance abuse treatment providers and recovering peers still may harbor antimedication attitudes and not understand the benefit of psychotropic medications.

Implications for IOT

Although clients with co-occurring psychiatric disorders may be challenging, they benefit from treatment (Dixon et al. 1998). Treatment has produced marked reductions in suicide attempts, mental health visits, and reports of depression (Karageorge 2002). Clients with less serious mental disorders appear to do well in traditional substance abuse treatment settings (Sloan and Rowe 1998), and outpatient treatment can be an effective setting for treating substance use disorder in clients with less serious mental disorders (Flynn et al. 1996). Long-term approaches seem more effective than short-term acute care (Bixler and Emery 2000). Clients with psychotic conditions, however, might pose insurmountable challenges for most IOT programs.

Theoretical Background

Integrated treatment

For the past two decades, integrated treatment has been proposed as an effective treatment approach. Minkoff (1994) presents a theoretical framework that considers both disorders chronic, primary, biologically based mental illnesses that are likely to be lifelong, but he suggests that conjoint treatment could reduce symptoms of both disorders effectively and promote recovery. His general treatment principles follow:

- Recognize that the basic elements and processes of addiction treatment are the same for clients who have a psychiatric disorder as for those without one.
- Include education, empathic confrontation of denial, relapse prevention, and involvement with both professional- and peer-led groups.
- Modify standard substance abuse treatment by simplifying interventions, accommodating cognitive limitations if necessary, adapting step or group work, and using mutual-help groups for people with co-occurring psychiatric disorders.
- Develop interventions specific to each phase of treatment.
- Provide comprehensive services that cover treatment of both disorders.

In a review of the literature on treating substance use disorders and co-occurring schizophrenia, Drake and colleagues (1998*b*) found that integrated treatment, especially when delivered for 18 months or longer, resulted in significant reduction in substance abuse and, in some cases, in substantial rates of remission, reductions in hospitalizations, and improvements in other outcomes. Many IOT programs do not treat clients with serious mental disorders such as schizophrenia on a regular basis and do not have the advantages of the programs cited in Drake and colleagues' review (e.g., intensive case management, 18-month treatment window). Charney and colleagues had similar success treating clients with co-occurring depression over a 6-month period (2001). Treatment retention and outcome improved when psychiatric services were provided at the substance abuse treatment facility.

Integrated treatment coordinates substance use and mental disorder interventions to treat the whole client and

- Recognizes the importance of ensuring that entry into *one* system provides access to *all* needed systems
- Emphasizes the association between the treatment models for mental disorders and addiction
- Advocates the concomitant treatment of both disorders
- Follows a staged approach

- Uses treatment strategies from both the mental health and substance abuse treatment fields

Conceptual framework

The National Association of State Mental Health Program Directors and the National Association of State Alcohol and Drug Abuse Directors, with support from the Substance Abuse and Mental Health Services Administration (SAMHSA), developed a conceptual framework of four quadrants to classify service coordination and help providers categorize treatment according to the severity of symptoms of both disorders (see exhibit 9-2) (Substance Abuse and Mental Health Services Administration 2002).

Clients in category I often are identified in primary care, educational, or community settings and may need consultation services for prevention and early intervention services. Clients in categories II and III generally present or are referred for treatment for their more severe disorder—either mental or substance use disorder—often leaving them with little or no care for the other disorder. These clients may be referred to IOT programs, and care requires collaboration between mental health and IOT providers. Clients in category IV generally need comprehensive, integrated treatment (Substance Abuse and Mental Health Services Administration 2002).

Clinical Issues and Strategies

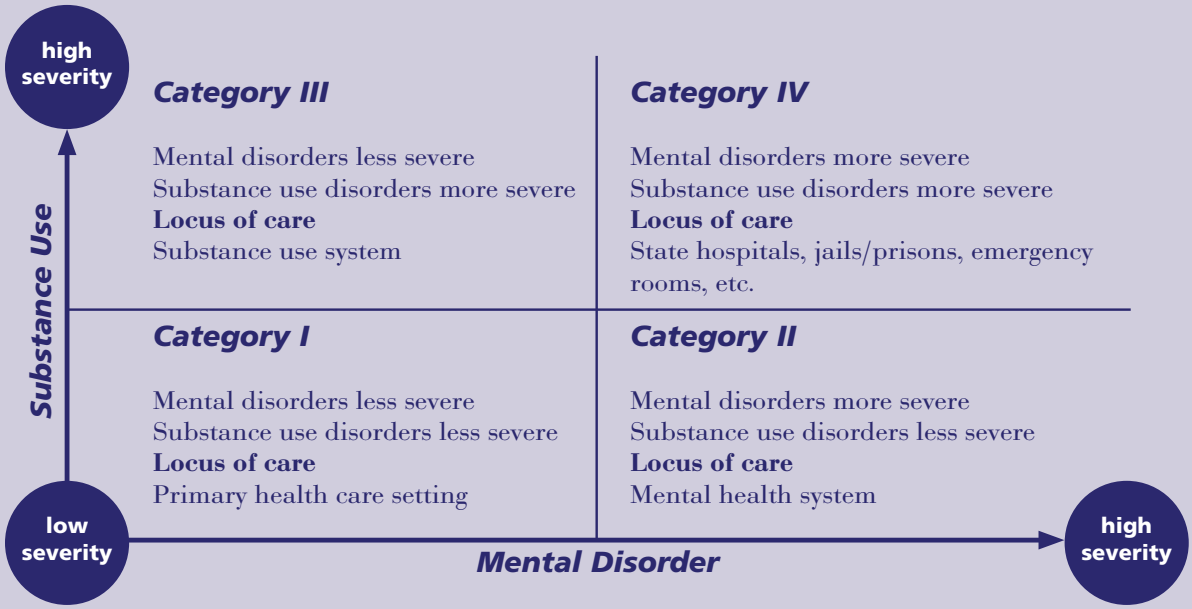
Modifications to clinical approaches and service elements to assist clients with mental disorders are essential. When financial or other limitations require the provision of care in separate settings, treatment services need to be coordinated assertively and efficiently.

Core treatment needs and service elements

Screening. All clients need to be screened for co-occurring psychiatric disorders to

Exhibit 9-2

SAMHSA's Service Coordination Framework for Co-Occurring Disorders



determine whether they have signs and symptoms warranting a comprehensive psychological assessment. These signs and symptoms may be subtle, and clients may minimize or deny symptoms because of fear of stigma.

Assessment. A thorough assessment should be performed either by a clinician trained in both areas or by clinicians from each field. On occasion, symptoms of acute or chronic alcohol and drug toxicity or withdrawal can mimic those of psychiatric disorders. The client should be observed closely for worsening conditions that warrant transfer to a more appropriate facility or to determine whether treatment for withdrawal symptoms is needed. Conversely, substance abuse can mask psychiatric symptoms, which may appear during the initial stages of abstinence. Programs should be organized around the premise that co-occurring disorders are common; assessment should proceed as soon as it is possible to distinguish the substance-induced symptoms from other independent conditions. Particular attention should be paid to the following:

- Psychiatric history of the client and family including diagnoses, previous treatment, and hospitalizations
- Current symptoms and mental status
- Medications and medication adherence
- Safety issues such as thoughts of suicide, self-harm, or harming others
- Severe psychiatric symptoms that result in the inability to function, communicate effectively, or care for oneself

This information can be augmented by objective measurement with assessment tools such as those described in the TIP 42, *Substance Abuse Treatment for Persons With Co-Occurring Disorders* (CSAT 2005*e*).

Many programs have rigid guidelines for the initial mental health assessment and evaluation, including the initial psychopharmacology evaluation, such as requiring a certain length of abstinence. Programs should be flexible about assessment, removing these barriers when possible. Similarly, denial of access to evaluation or treatment for a substance use disorder because an individual is taking a prescribed psychotropic medication is inappropriate. Clients should continue taking medication for a serious mental disorder while being treated for their substance use disorders (Minkoff 2002).

Treatment engagement. Some clients with co-occurring psychiatric disorders, especially severe disorders, may have difficulty committing to and staying in treatment. Providing continuous support and outreach, assisting with immediate problems (such as housing), monitoring individual needs, and helping clients access services help develop a therapeutic treatment relationship. In the absence of such support, clients with co-occurring psychiatric disorders may be at high risk for dropping out (Drake and Mueser 2000).

Treatment planning. Factors to consider when developing a treatment plan for these clients include the client's psychiatric status, housing, social support, income, medication adherence, and symptom management. By understanding the client's strengths and goals, IOT program staff can develop a treatment plan that is consistent with the client's needs. Regular reassessments monitor the client's progress in both conditions and are the basis for adjustments to the treatment plan. Increased individual sessions and smaller group sizes also are indicated.

Referral. Clients with psychiatric disturbances that require secure inpatient treatment setting, 24-hour medical monitoring, or detoxification (such as clients who are actively suicidal or hallucinating) should be referred to a facility equipped to provide appropriate care. The American Society of Addiction Medicine provides placement criteria for clients with co-occurring psychiatric disorders (Mee-Lee et al. 2001).

Mental health care

Any IOT program that serves a significant number of clients with co-occurring psychiatric

disorders should include mental health specialists and psychiatric consultants on the treatment team.

Prescribing psychiatrist. It is ideal to have a psychiatrist with substance abuse treatment expertise on site to provide assessment and treatment services, on a full-time, part-time, or consultant basis (Charney et al. 2001). This approach overcomes problems with offsite referral such as the client's lack of transportation and the difficulty of working with another agency. However, when funding or other constraints prohibit providing mental health care services on site, other options are (1) employing a master's-level clinical specialist who can treat clients, consult with other staff members on mental disorders, and function as the liaison with psychiatric consultants or (2) establishing a working relationship with a mental health care agency to provide onsite care.

Medication provision and monitoring. Appropriate psychotropic medications are essential. Pharmacological advances over the past decade have resulted in medications with improved effectiveness and fewer side effects. Psychotropic medications stabilize clients, control their symptoms, and improve their functioning. The IOT program counselor can

- Refer the client to a psychiatrist or other mental health care provider for treatment evaluation.
- Help arrange appointments with the mental health care provider and encourage the client to keep them.
- Become familiar with common psychotropic medications, their indications, and their side effects.
- Instruct the client on the importance of complying with the medication regimen.
- Report symptoms and behavior to the prescribing psychiatrist and other staff members to assist in the determination of medication needs.
- Use peers or peer groups to monitor medication and to support the client's proper use of medication.
- Monitor side effects.

A helpful resource is *Psychotherapeutic Medications 2003: What Every Counselor Should Know* (Mid-America Addiction Technology Transfer Center 2000).

Collaboration with mental health care agencies

If circumstances prevent the provision of mental health care services in the IOT program, a collaborative relationship with a mental health agency can be established. One way to form this relationship is through an MOU that ensures that psychiatric services are adequate and comprehensive. The MOU specifies referral procedures, responsibilities of both parties, communication channels, payment requirements, emergency contacts, and other necessary procedures. TIP 46, *Substance Abuse: Administrative Issues in Outpatient Treatment* (CSAT 2006*f*), provides more information about setting up formal mechanisms for working with other agencies.

Case management services provide assistance with service coordination when clients with co-occurring disorders require treatment in two or more systems of care. TIP 27, *Comprehensive Case Management for Substance Abuse Treatment* (CSAT 1998*a*), provides extensive details about case management.

Modified program structure

Treating clients with co-occurring psychiatric disorders in an IOT program often necessitates modifying the program structure or approach.

Separate treatment tracks in IOT. Separate tracks for clients with both disorders allow clients to be grouped together to address issues pertinent to them in group sessions. This arrangement particularly helps clients

with severe co-occurring psychiatric disorders. Establishing a separate track may entail organizational change as the agency modifies its scheduling, staffing, and training needs.

Staged approaches. Staged approaches provide successive interventions geared to the client's current stage of motivation and recovery and address varying levels of severity and disability of the co-occurring disorders (Drake et al. 1998*a*; Minkoff 1989). The model developed by Osher and Kofoed (1989) includes four overlapping stages—engagement, persuasion, active treatment, and relapse prevention—that integrate treatment principles from both fields. The model advocates treatment components consisting of low-intensity, highly structured programs; case management services; provision of appropriate detoxification; toxicology screening; family involvement; and participation in mutual-help groups. Other staged approaches are described in Minkoff (1989) and Prochaska and DiClemente (1992).

Working with clients with co-occurring psychiatric disorders

When mental and substance use disorders co-occur, both disorders require specific and appropriately intensive primary treatment and need to be individualized for each client according to diagnosis, phase of treatment, level of functioning, and assessment of level of care based on acuteness, severity, medical safety, motivation, and availability of recovery support (Minkoff 2002).

The treatment of clients with substance use and high-severity psychiatric disorders (schizophrenia or schizoaffective disorder) differs from the treatment of clients who have anxiety or mood disorders and a substance use disorder. Clients with severe disorders often are the most difficult to treat. Examples of approaches that attempt to integrate and modify psychiatric and substance abuse treatments to meet the needs of the client are (1) a skills-based approach, (2) dual-recovery therapy, (3) assertive community treatment, and (4) money-management therapy (Ziedonis and D'Avanzo 1998).

The treatment of clients with substance use and mood or anxiety disorders incorporates approaches such as cognitive–behavioral therapy, which addresses both disorders. Several other components, such as relaxation training, stress management, and skills training, are emphasized in the treatment of both types of disorders (Petrakis et al. 2002).

Some clients may have cognitive deficits that make it difficult for them to comprehend written material or to comply with program assignments. Materials can be adapted to express ideas and concepts simply and concretely, incorporating stepped assignments and using visual aids to reinforce information. TIP 29, *Substance Use Disorder Treatment for People With Physical and Cognitive Disabilities* (CSAT 1998*e*), provides more information on accommodating clients with disabilities.

Pharmacological advances... have resulted in medications with improved effectiveness and fewer side effects.

The therapeutic relationship

Establishing a trusting, therapeutic relationship is essential during the engagement process and throughout treatment. TIP 42, *Substance Abuse Treatment for Persons With Co-Occurring Disorders* (CSAT 2005*e*), suggests the following guidelines for developing a therapeutic relationship with clients with both disorders:

- Maintain a belief that recovery is possible.
- Manage countertransference.

- Monitor psychiatric symptoms.
- Provide additional structure and support.
- Use supportive and empathic counseling.
- Use culturally appropriate methods.

The clinician's ease in establishing and maintaining a therapeutic alliance is affected by comfort with the client. IOT program clinicians may find working with some clients with psychiatric illnesses unsettling or feel threatened by them and may have difficulty forming a therapeutic alliance with them. Consultation with a supervisor is important, and with experience, training, supervision, and mentoring, the problem can be overcome.

Confrontational approaches may be ineffective for clients with co-occurring psychiatric disorders because they may be unable to tolerate stressful interpersonal challenges. When counseling clients with co-occurring psychiatric disorders, it is helpful if the counselor is empathic and firm at the same time. By setting limits on negative behaviors, counselors provide structure for clients. Another assertive intervention involves counselors' supplying feedback that consists of a straightforward and factual presentation of the client's conflicting thoughts or problem behavior. Provided in a caring manner, such feedback can be both "confrontive" and caring. The ability to do this well is often critical in maintaining the therapeutic alliance with a client who has co-occurring psychiatric disorders (see chapter 5 in TIP 42 [CSAT 2005*e*]). TIP 35, *Enhancing Motivation for Change in Substance Abuse Treatment* (CSAT 1999*c*, p. 41), provides more information.

Group treatment... is used widely and effectively with clients with co-occurring disorders.

Clients with co-occurring psychiatric disorders may become demoralized and despairing because of the complexity of having two disorders and the slow pace of improvement in symptoms and functioning. Inspiring hope is a necessary task of the IOT program clinician. Some suggestions include

- Demonstrating an understanding and acceptance of the client
- Helping the client clarify the nature of his or her difficulties
- Communicating to the client that the clinician will help the client help himself or herself
- Expressing empathy and a willingness to listen to the client
- Assisting the client in solving external problems immediately
- Fostering hope for positive change

Group treatment

Group treatment, a mainstay of IOT, is used widely and effectively with clients with co-occurring disorders (Weiss et al. 2000), including clients with schizophrenia (Addington and el-Guebaly 1998). Several approaches can be used: 12-Step based, educational, supportive, and social skills improvement. These group interventions have demonstrated success in increasing treatment engagement and abstinence rates and decreasing the need for hospitalization (Drake et al. 1998*a*). Some examples of groups follow:

- **Psychoeducational groups** increase clients' awareness of both problems in a safe and positive environment.
- **Psychiatric disorders groups** present topics such as signs and symptoms of mental disorders, use of medications, and the effects of mental disorders on substance use problems.
- **Medication management groups** provide a forum for clients to learn about medication and its side effects and help the counselor develop solutions to compliance problems.
- **Social skills training groups** provide opportunities to learn how to handle

common social situations by teaching clients to solicit support, develop drug and alcohol refusal skills, and develop effective strategies to cope with pressures to discontinue their prescribed psychiatric medication. Group participants role play situations and practice appropriate responses. Reinforcing the difference between substances of abuse and treatment medications is another simple but important activity of these groups.
- **Onsite support groups** are led by an IOT staff facilitator and provide an arena for discussing problems and practicing new coping skills.

Group treatment may need to be modified and augmented with individual counseling sessions for clients with both disorders. The clients' ability to participate in counseling depends on their level of functioning, stability of symptoms, response to medication, and mental status. Some clients cannot tolerate the emotional intensity of interpersonal interactions in group sessions or may have difficulty focusing or participating. Many clients with a serious mental illness (schizophrenia, schizoid and paranoid personality) have difficulty participating in groups but can be incorporated gradually into a group setting at their own pace. Clients with less severe psychiatric disorders may have little problem participating in group sessions. Some suggestions for working with groups of clients with co-occurring disorders include

- Orally communicate in a brief, simple, concrete, and repetitive manner.
- Affirm accomplishments instead of using disapproval or sanctions.
- Address negative behavior rapidly in a positive manner.
- Be sensitive and responsive to needs of the client.
- Shorten sessions.
- Organize smaller groups.
- Use more focused, but gentle directional techniques.

Mutual-help groups in the community

The consensus panel encourages the use of "double trouble" mutual-help recovery groups for people with co-occurring psychiatric disorders. Because all attendees have a co-occurring psychiatric disorder, they are less likely to be subject to the misunderstanding and conflicting messages about their psychiatric symptoms or use of psychotropic medications that sometimes occur in traditional 12-Step-oriented groups (Magura et al. 2003). These groups do not provide clinical or counseling interventions; members help one another achieve and maintain recovery and be responsible for their personal recovery.

Various dual recovery organizations have been established by people in recovery and usually are based on the AA model but adapted for people with both disorders, including

- Double Trouble in Recovery (www.doubletroubleinrecovery.org)
- Dual Disorders Anonymous
- Dual Recovery Anonymous (www.draonline.org)
- Dual Diagnosis Anonymous

The research on traditional 12-Step groups is not definitive, but attendance at such groups may be beneficial for some clients with co-occurring psychiatric disorders (Kelly et al. 2003). However, clients with severe mental disorders may have difficulty attending these groups (Jordan et al. 2002). Some people with co-occurring disorders attend both dual disorder and traditional mutual-help groups (Laudet et al. 2000*b*). In one study, most AA respondents had positive attitudes toward people with co-occurring disorders and 93 percent indicated that such individuals should continue taking their psychotropic medications (Meissen et al. 1999). AA has published *The A.A. Member—Medications and Other Drugs* (Alcoholics Anonymous World Services 1991), a helpful booklet that discusses AA members' use of

medications when prescribed by a physician knowledgeable about alcoholism (visit www.alcoholics-anonymous.org to order).

Relapse prevention

In addition to learning techniques to prevent relapse to substance abuse, clients with co-occurring psychiatric disorders may benefit from learning to recognize worsening psychiatric symptoms, manage symptoms, or seek support from a "buddy" or a mutual-help group. Some providers suggest that clients keep "mood logs" to increase their awareness of how they feel and the situational factors that trigger negative feelings or symptoms. Other techniques include affect or emotion management, including how to identify, contain, and express feelings appropriately. Several relapse prevention interventions for clients with both disorders have been developed (Evans and Sullivan 2000; Weiss et al. 2000).

Other issues

Family education and support. Clients with co-occurring disorders frequently have unsatisfactory relationships with their families. Some clients with psychiatric disorders remain dependent on their families for an extended period, creating complicated family dynamics. Other clients may be estranged from or have strained relationships with family members, partners, or children. Groups for family members can be a venue for education and support. Psychoeducation combines fundamental information, guidance, and support and allows for low-key engagement and continued assessment opportunities. Family members and significant others need to understand the implications of both disorders and the ways that one disorder, if not properly monitored and treated, can worsen the symptoms of the other.

At times more intensive family intervention may require removing clients from stressful family relationships and helping them toward independence. Some families may be in need of intensive family therapy and should be referred for appropriate care.

Peer networks. Developing supportive peer networks to replace friends who use substances is an important component of recovery and needs to be addressed in treatment. When a client's family is not supportive, other, more supportive networks can be sought.

Discharge planning and continuing care

Because people with co-occurring psychiatric disorders have two chronic conditions, they often require long-term care that supports their progress and can respond quickly to a relapse of either disorder. Some clients may need to continue intensive mental health care but can manage their substance use disorder by participation in support groups. Other clients may need minimal mental health care but require some form of continued formal substance abuse treatment. Participation in continuing care tends to improve treatment outcomes (Moggi et al. 1999).

Cross-Training

Ideally, an interdisciplinary staff that provides both substance abuse treatment and psychiatric services works as an integrated unit, and providers have training and expertise in both fields. Cross-training about the differing views of treatment and challenges helps staff members from both fields reach a common perspective and approach for treating clients with co-occurring psychiatric disorders.

A helpful training resource is the Mid-America Addiction Technology Transfer Center's *A Collaborative Response: Addressing the Needs of Consumers With Co-Occurring Substance Use and Mental Health Disorders*, an eight-session curriculum designed to promote a cross-disciplinary understanding between mental and substance use disorder clinicians (available at

www.mattc.org). SAMHSA's *Strategies for Developing Treatment Programs for People With Co-Occurring Substance Abuse and Mental Disorders* (Substance Abuse and Mental Health Services Administration 2003) provides information on starting a program for treating people with both disorders.

Adolescents

It is important to recognize that youth are not little adults, and IOT for adolescents should differ from that provided for adult populations (Deas et al. 2000). Adolescents experience many developmental changes, may require habilitation rather than rehabilitation, may be considered dependents legally, and may require parental consent for treatment.

Treatment for adolescents requires a comprehensive approach that addresses their social, medical, and psychological needs. The best candidates for adolescent IOT are youth who are experiencing problems as a result of recent, moderate-to-heavy use of legal or illegal substances, who have functional but ineffective coping skills, and who need a marginally structured setting, not complete removal from their living situation (CSAT 1999*f*).

TIP 31, *Screening and Assessing Adolescents for Substance Use Disorders* (CSAT 1999*d*), and TIP 32, *Treatment of Adolescents With Substance Use Disorders* (CSAT 1999*f*), provide additional information about screening and treating adolescents for substance abuse.

Description of the Population

Developmental changes

Adolescence is a period characterized by physical, emotional, and cognitive changes. Developmental tasks include the many transformations that move adolescents from childhood to adulthood. Physical changes include rapid growth, development of secondary sex characteristics, and fluctuations in hormonal levels. Cognitively, adolescents often have shorter attention spans than adults, have limited perspectives on the future, may be inconsistent in applying abstract thinking skills, and may be impulsive. During adolescence, morals, values, and ideals continue to develop, and intellectual interests expand. During late adolescence, youth become more introspective and sensitive to the consequences of their actions (CSAT 1999*f*) and improve their capacity for setting goals.

IOT for adolescents should differ from that provided for adult populations.

Development of substance abuse in adolescents

Many factors are associated with the onset of substance use problems in adolescents including genetic background, parental substance use and troubled family relations, individual characteristics such as cognitive dysfunction, and to some extent peer influence (Weinberg et al. 1998). Risk factors for developing a substance use disorder include a history of personality problems such as aggression or an affective disorder, school failure, distant or hostile relations with parents or guardians, family disruption, or a history of victimization (Weinberg et al. 1998).

Implications for IOT

Adolescents reach IOT by a number of paths, including parental request, school referral, and juvenile justice system mandate. The IOT provider must be prepared to meet developmental, family, psychiatric, behavioral, and other treatment challenges that may resemble those of adult clients only superficially.

Adolescents need thorough biopsychosocial, medical, and psychological assessments and may need educational, medical, mental health, and social services. Unlike adult clients, adolescents are likely to be entering treatment for the first time, may have little knowledge of the treatment process, and need more orientation than adults.

The assessment process involves a comprehensive evaluation of the adolescent's risks, needs, strengths, and motivation. Psychosocial assessment instruments appropriate for adolescents should be used. Information to gather includes school records, class schedule, and school involvement; relationships with peers; sexual activity and pressures; relationship with family members; mental and physical health status; history of abuse and trauma; and involvement with the juvenile justice system.

Family assessment

The adolescent's family consists of the main caregivers (usually parents) and anyone the client considers family. Family issues to assess include family structure and functioning, financial and housing statuses, substance use history and treatment episodes, mental and physical health, the family's feelings about the adolescent, and family members' problems with violence and involvement in the legal system. The strengths and resources available to the family need to be identified as well. IOT program staff members may want to interview the adolescent in private initially and then meet with family members.

Psychiatric assessment

Every client can benefit from a thorough psychiatric assessment by a mental health professional trained in adolescent care. As many as 60 percent of adolescents with a substance use disorder also have co-occurring psychiatric disorders (Armstrong and Costello 2002), such as anxiety, mood disorders (Kandel et al. 1999), or attention deficit/hyperactivity disorder (Weinberg et al. 1998). Adolescents should be assessed for suicide risk as well.

Diagnosis

Although some adolescents may meet the diagnostic criteria for substance dependence, many are in the early stage of involvement with alcohol or drugs. The *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition, Text Revision (American Psychiatric Association 2000) does not contain diagnostic criteria specific to adolescent substance dependence, and some adult diagnostic criteria, such as withdrawal symptoms and alcohol-related medical problems, present differently in adolescents. For these reasons, the DSM criteria have limitations when applied to adolescents (Martin and Winters 1998).

Clinical Issues and Strategies

Family involvement

Because outpatient family therapy may offer benefits superior to other outpatient treatments (Williams et al. 2000), IOT providers are encouraged to work with the family as much as possible. Chapter 6 on family therapy in this TIP and TIP 39, *Substance Abuse Treatment and Family Therapy* (CSAT 2004*c*), provide more information.

Engaging the family. The IOT counselor can engage family members by

- Emphasizing how critical family members are to the adolescent's recovery
- Requiring (whenever possible) that a family member accompany the adolescent to the initial intake interview and including time for the family assessment during that meeting
- Encouraging family attendance at the program's family education and therapy sessions

- Helping family members participate in developing and reinforcing the behavioral contract (see below)
- Supporting family members in encouraging the adolescent to attend treatment

Treatment of the family. Family-oriented interventions have long been used to treat adolescents who abuse substances. Szapocznik and colleagues (1983, 1986) helped establish the effectiveness of family therapy in treating adolescents. The premise of family therapy is that the family plays a role in creating conditions leading to adolescent drug use and that family elements help adolescents recover (Liddle et al. 2001). Evidence shows that youth who receive family therapy have less drug use at treatment completion than those who receive peer group therapy or whose families participate in parent education or a multifamily intervention (Liddle et al. 2001).

Some family-based approaches are as follows:

- Multidimensional family therapy and multisystemic therapy expand classic family therapy models to focus on promoting change in four areas: (1) the adolescent, (2) family members, (3) family interaction patterns, and (4) influences from outside the family (Liddle 1999, 2002).
- Family cognitive–behavioral therapy integrates traditional family systems theory with techniques of cognitive–behavioral therapy. This approach considers adolescent substance abuse as a conditioned behavior that is reinforced by cues and contingencies within the family (Latimer et al. 2003).
- The adolescent community reinforcement approach focuses on teaching adolescents coping skills and changing environmental influences related to continued substance use (Godley et al. 2001).
- The family support network intervention increases parental support of an adolescent's recovery through developing a support group for parents, provides home therapy sessions combined with group sessions, and can be used with any standard adolescent treatment approach (Hamilton et al. 2001).
- The family intervention program (see exhibit 9-3) addresses many problems experienced by families with an adolescent who uses substances. It includes the family and systems that affect the family, such as schools and the community.

As many as 60 percent of adolescents with a substance use disorder also have co-occurring psychiatric disorders...

The behavioral contract

Adolescents who abuse substances may behave in disruptive, destructive, or sometimes criminal ways, such as skipping school, having poor school performance, violating curfew, being argumentative with or withdrawing from family members, joining gangs, or committing crimes.

To address these behaviors, a behavioral contract can be a valuable therapeutic tool. The clinician works with the adolescent (and his or her family) to develop a contract that specifies treatment goals, acceptable and unacceptable behaviors, and the rewards or consequences associated with each.

The conditions defined in the contract help the youth and the family understand the treatment process and what is expected of them. Once the contract is completed, the client and each family member indicate their agreement by signing the contract. IOT program staff uses the contract to guide discussions during family group sessions, to monitor progress, and to minimize the undermining of treatment by family members.

Exhibit 9-3

The Family Intervention Program

This approach partners a family therapist with a community resource specialist. The specialist helps the family establish healthy community networks. Working as a team, the therapist and specialist conduct five family therapy sessions and perform the following:

1. Assess the family system; explore the family's resources, concerns, and goals; and create a treatment plan.
2. Explore relationships among family members, identify areas of difficulty and stress, and determine the effect on the family system.
3. Determine the effect of other systems, such as schools, on the family.
4. Focus on the family's concerns and goals and include others who can help resolve problems.
5. Work on how the family can resolve issues without staff help and develop a followup plan.

Source: Fishman and Andes 2001.

Case management services for adolescents

The IOT provider may need to provide extensive case management services. The case manager works with schools to monitor a youth's compliance with the behavioral contract; coordinates medical, mental health, and social services; and works with the juvenile justice system, if needed. Caseloads are best kept to about 8 to 10 adolescents per staff member.

Group work strategies for adolescents

Treating adolescents involves bringing together youth from different areas, backgrounds, and developmental levels. Many practitioners recommend, if possible, that the groups consist of adolescents of the same gender, with similar levels of motivation for change, and of similar age. Clients in middle-to-late adolescence (ages 16 to 18) usually have different life experiences, developmental levels, and concerns than do younger adolescents. There is limited evidence of the effectiveness of treating adolescents in groups, perhaps because of the complexities just mentioned. The consensus panel reports that, with this population, approaches emphasizing structured discussions around a topic introduced by the counselor are more successful than open-ended sessions. Same-gender groups can provide a safe environment in which to explore such issues as sexuality, intimacy, self-esteem, and relationships. If programs do not have enough adolescent clients to have a treatment group, a gender-specific group session can be held weekly to discuss sensitive issues.

To foster productive group work, it is helpful to enforce clear, specific, concrete rules. IOT program staff can post the rules in the session room and ask each participant to sign a copy. Rules should prohibit bullying and teasing. Groups also commonly prohibit nostalgic stories of substance use.

Group members frequently are asked to sign a confidentiality statement promising that information shared in the group will not be repeated outside group. Other suggestions for treating adolescents in groups are

- Including activities and keeping discussions short
- Varying session content, activity level, and purpose
- Including frequent breaks

CSAT's Cannabis Youth Treatment Series offers many specific ideas for use with adolescents (Godley et al. 2001; Hamilton et al. 2001; Liddle 2002; Sampl and Kadden 2001; Webb et al. 2002).

A co-counselor is helpful in running groups for adolescents because of the complexity of adolescent issues and behavior management challenges.

Clinical considerations

Providing incentives acknowledges the efforts of youth and encourages them to persevere. Incentives should be meaningful to the youth, such as gift certificates from a music store, movie theater, or clothing store.

Other key points about treating adolescents include the following:

- A cognitive–behavioral model and motivational enhancement techniques are useful.
- Not all adolescents who use substances are dependent, and prematurely diagnosing or labeling adolescents or pressuring them to accept that they have an addictive disease may not work.
- Many adolescents respond better to motivational interviewing than to confrontation.

Exhibit 9-4 lists characteristics and behaviors of adolescents in treatment and practical treatment suggestions.

Staff Training

IOT program staff members need to understand adolescent development and treatment needs. Clinicians working with youth should

- Be flexible and able to interact warmly with adolescents.
- Observe clear and appropriate personal boundaries.
- Be able to set firm behavioral limits in a nonjudgmental or nonpunitive manner.
- Know about the substances and combinations that adolescents use, the slang in use, and the physical and behavioral effects of any new drugs.
- Have substantial knowledge of the school system.
- Understand family dynamics.

Core program staff members should include a clinical coordinator who is trained in adolescent treatment. Skills development training for staff should occur regularly on topics appropriate for adolescent treatment.

Young Adults

Some caregivers may find it difficult to recognize or accept that young adults (ages 18 to 24) are no longer legal dependents. Even though a youth still may live at home or be in school, parental responsibility changes and the young adult can make his or her own choices. Counselors may find that they need to help both the young adult client and parents realize that the client can make choices and is responsible for actions. Some young adult clients may be totally on their own, with little family contact.

The use of alcohol or drugs at an early age may have delayed normal development. Although these young clients are legally adults, they may not have grown into young adult social roles.

The young adult may be ready clinically for placement in an adult treatment group or may be placed more appropriately in an adolescent program. A thorough assessment is needed to determine appropriate placement.

IOT Programming for Young Adults

To engage and retain these clients, IOT programming can incorporate techniques used in adolescent programs. To involve young adult clients in treatment, it is important to

Exhibit 9-4

Characteristics and Behaviors of Adolescents and Treatment Suggestions

Characteristics and Behaviors of Adolescents in Treatment	Suggestions for Improving the Treatment Experience for Adolescents
Inconsistent ability for abstract thinking	Limit abstract, future-oriented activities Use mentors Avoid scare tactics and labels
Impulsive, often with short attention spans	Design activities to teach self-control skills; allow practice time
Need to belong and identify with others; vulnerability to peer influence	Create opportunities for group members to bond Help clients establish positive peer groups and develop skills in resisting negative peer pressure Promote positive peer feedback in group
Frequent emotional fluctuations	Validate feelings Acknowledge the pressures and stresses of adolescence Help youth improve stress management skills
Lack of involvement in healthy recreational activities	Help clients develop daily schedules Help youth find new recreational activities not involving substance use such as games, sports, hobbies, and religious or spiritual groups
Tendency toward pessimistic or fatalistic attitudes	Recognize fatalist attitudes such as "I'm going to die soon, anyway," and "Drugs are the only way out for me" Validate clients' anger, hopelessness, or perceived obstacles to success, but challenge youth to think positively

reach out to them through family, colleges, employers, and the court system. Treatment should be relevant to young adult concerns, interests, and social activities and be flexible enough to adapt to the client's developmental deficits. The following issues are relevant:

- **Education and employment.** Educational and job skill levels need to be assessed and addressed. Some clients who have grown up in poverty have witnessed the futility of working at a low-paying job versus the financial benefits of selling illicit drugs. These clients need special attention.
- **Family roles.** Some clients may have children and family responsibilities and need assistance in obtaining child care and developing parenting skills.
- **Separating from parents.** Young adults in treatment often have parents who are unwilling to set limits, which fosters dependence and intense attachment on the part of the clients. Parents need to understand that their enabling behavior is a barrier to their young adult's recovery. Young adult clients often require life skills development. Treatment should focus on habilitation, rather than rehabilitation.
- **Peer relationships.** Some clients may need assistance in developing and maintaining healthy peer networks and family relationships.
- **Mentoring.** A positive adult role model provides a meaningful example.
- **Community service.** Young adults in treatment can contribute to society and should be encouraged to participate in and volunteer for community or faith-based events.

10 Addressing Diverse Populations in Intensive Outpatient Treatment

In This Chapter...

Intensive outpatient treatment (IOT) 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
- 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 in appendix 10-A (page 197). 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.
- Chapter 4 of TIP 46, *Substance Abuse: Administrative Issues in Outpatient Treatment* (CSAT 2006*f*). This chapter describes steps that an IOT administrator can take to prepare an IOT organization to treat diverse clients more competently and sensitively. Chapter 4 also lists resources not found in the appendix at the end of this chapter.
- The forthcoming TIP *Improving Cultural Competence in Substance Abuse Treatment* (CSAT forthcoming *a*) includes an in-service training guide.

Principles in Delivering Culturally Competent IOT 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 IOT counselors 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. IOT 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.

> ...an individual's culture is a critical factor to be considered in treatment.

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.

Culture is only a starting point for exploring an individual's perceptions, values, and wishes.

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. IOT 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 (see appendix 10-A for more information and resources on cross-cultural communication).
- **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).

Issues of Special Concern

The IOT consensus panel recommends that IOT programs look at the following areas of special concern:

- Whether the program is prepared to adequately serve foreign-born clients living within their catchment area

- Whether the special needs of their minority or foreign-born women clients are being addressed adequately
- Whether the program needs to make any content adjustments out of respect for the religious orientation of current or potential clients

Foreign-Born Clients

In 2002, according to the U.S. Census Bureau, about 32.5 million U.S. residents were foreign born, of whom 52 percent came from Latin America and 26 percent from Asia (Schmidley 2003). Eleven percent were born in another country and may be speaking or learning English as a second language. Migration is a stressful life event, and immigrants are at risk for substance abuse because of stress, isolation, and the lack of social support they experience in adjusting to their new country.

The reason for a person's immigration is considered an important factor in the level of stress that immigrants experience as they settle into a new life. Refugees typically have been forced to abandon their countries and former lives, leaving their belongings behind, to relocate to a different and sometimes unwelcoming new world in which language, social structures, and community resources may be totally unfamiliar (Jezewski and Sotnik 2001). This displacement can be particularly difficult for older refugees.

Clinical considerations

Having a personal history of abuse and trauma is recognized as a major factor in substance use disorders and in the inability to maintain recovery. A large percentage of Asian-American and Hispanic-American immigrants show clinical evidence of posttraumatic stress disorder (PTSD) as a result of exposure to severe trauma, such as genocide, war, torture, or extreme threat of death or serious injury (U.S. Department of Health and Human Services 2001). In some samples, up to 70 percent of refugees from Vietnam, Cambodia, and Laos met diagnostic criteria for PTSD, compared with about 4 percent with a prevalence for PTSD in the U.S. population as a whole (U.S. Department of Health and Human Services 1999). For this reason, treatment for foreign-born clients often needs to address both substance use and the client's background of abuse and violence.

Other clinical issues include the following:

- **Mistrust of authority.** Immigrants and refugees from many regions of the world feel extreme mistrust of government based on the atrocities committed in their countries of origin or fear of deportation by U.S. authorities. This mistrust can be a barrier to entering treatment and to obtaining services.
- **Extreme sense of stigma.** Clients from other cultures view mental disorders, including substance abuse, much more negatively than does the general U.S. population (U.S. Department of Health and Human Services 1999). In some Asian cultures, this stigma is so strong that a person's substance dependence is thought to reflect poorly on the family lineage, diminishing the marriage and economic prospects for the client and for other family members.
- **Level of acculturation.** Providers should take into account a client's level of acculturation in assessment and treatment. Generally speaking, foreign-born persons have rates of substance use lower than U.S.-born counterparts; the more acculturated the person is to the United States, the more that person's use approaches U.S. substance-using norms. Among Hispanics/Latinos, substance use disorders are less frequent in those who were born outside the United States (Turner and Gil 2002). For example, foreign-born Cuban Americans have lower lifetime use of alcohol and start drinking later in life than do U.S.-born Cuban Americans (Vega et al. 1993). However, being born in the United States does not mean necessarily that a

person is acculturated. In a later study, Vega and colleagues (1998) found that the highest rates of substance abuse among Hispanic/Latino adolescents were seen in those who were born in the United States but had low acculturation levels. The researchers attributed these results to the fact that these adolescents faced the language problems of foreign-born Hispanics/Latinos and the acculturation conflicts of U.S.-born Hispanics/Latinos.

Implications for IOT providers

IOT providers who want to reach out to foreign-born clients in their community and serve them better should become more knowledgeable about the history and experiences of the newcomers. One way to start is by researching and reading about these cultural groups. Providers also should get to know newcomer populations by visiting community refugee and immigrant organizations, such as their Mutual Assistance Associations. Representatives of these associations can identify the need for substance abuse treatment among their constituents, as well as provide advice and suggestions about designing culturally specific services.

Providers can consider setting up an IOT group in the immigrants' native language. For example, it has been found that linguistic Spanish-only groups are helpful for recently arrived Hispanic/Latino immigrants. One note on language: In addition to native-language treatment groups, programs should provide services in English for those clients who want them. Many immigrants understand that not knowing English can be a barrier, and they are motivated to improve their English-language skills.

Some suggestions for programs that establish language-specific groups include the following:

- A program catering to a language-specific population needs to facilitate communication in that language. All documents in the program should be adapted. The program also can have a phone message in the clients' native language, with calls returned by a counselor who speaks the language.
- The important issues that immigrants face need to be addressed as part of the treatment program. These issues include cultural differences between the dominant culture and their native culture, sense of displacement, lack of community, language problems, accessing social services, and finding employment.
- The clients' cultural attitudes and values about substance use should shape program content. Clients need to acquire an understanding of how their native cultural attitudes differ from the values of U.S. society, which involves understanding U.S. laws, social expectations, and way of life.
- Using the terminology of the treatment field becomes a challenge because many words are difficult to translate and the meanings can vary according to the culture. Often, the counselor needs to translate both a word *and* its meaning in the English language and U.S. culture. For example, in Russian the concept of denial is positive. This concept generally translates into Russian as "It is good to deny that you have a problem." Likewise, "defenses" also translates as a positive concept. The word "defense" in Russian refers to a tool for addressing rude or disrespectful behavior from another person. In translation, these words carry the connotation of "To be defended and in denial are good tools to handle one's problems."

> ...mistrust can be a barrier to entering treatment and to obtaining services.

- Immigrant clients may need many social and educational support services that may be difficult for the clients to access because of language and cultural barriers. Often clients are not familiar with the existence, range, and purpose of these needed

Cultural Issues in a Russian-Language IOT Program

The ChangePoint IOT Program for Russian immigrants in Portland, Oregon, usually has about 15 clients in treatment at a time. Clients are immigrants from all over Russia, and most are religious refugees. The newcomers generally stay in family groups that immigrate together, so these clients have close family connections.

Clients learn about the social and legal expectations regarding substance use in the United States. The group work focuses on the cultural attitudes that these Russian clients bring to their substance use and treatment. Examples of differing U.S.–Russian cultural values that the program helps clients understand include

- **Acceptable levels of alcohol use.** Alcohol use among Russian clients is higher than average for the United States. In Russia, drinking enormous quantities of alcohol is tolerated provided the person behaves appropriately.
- **Legal expectations.** Russians tend to view the law in a "black or white" context. In Russia, there is zero tolerance for any blood alcohol level (BAL) when driving. When clients hear that a BAL below 0.08 is legal in the United States, they think, "I can drink and drive as long as I'm under 0.08 or as long as I'm careful."
- **Attitudes about money and treatment.** Russian clients may assume that the program will understand if they cannot pay their bills on time. Russian people expect that they will be paid regularly, often lend money to family and friends, and feel a high level of trust that they will be paid back. This translates into an expectation that the program also will trust them to pay their bills at some time in the future.

supports, and some fear or are confused by the complexities of government procedures; their access to these services may be impeded by the documentation processes that bureaucracies often require. IOT case management can broker needed support services. One model for doing this, called culture brokering, consists of conflict resolution and problemsolving strategies designed to help two cultures communicate and cooperate. In the context of cultural competence, the two cultures are represented by clients who are foreign born or disabled and treatment providers. (See cirrie.buffalo.edu/cbrokering.html for more information.)

Women From Other Cultures

Immigrant women face the same barriers to treatment that confront many Anglo-American women—restricted availability of child care, low income, unsupportive spouses, lack of health insurance benefits, and lack of education and job skills—but have the added barrier of being outsiders to the culture.

- **View the woman's behavior and treatment goals in the context of her culture.** Treatment needs to be sensitive to the cultural mores and female roles in that woman's culture and to the client's level of acculturation. Some societies can be paternalistic and dominated by men, with women expected to play traditional roles as wives and mothers. A woman client may have values and attitudes that reflect that culture. Her substance use disorder, her attitudes about her addiction, and her perception of her recovery options occur within that cultural framework. It is therefore important to understand the client's level of comfort with what is expected in treatment. Treatment goals should depend on the woman's hopes and should conform to the cultural role she wants for herself.
- **Expect to work within complex, conflicting value systems.** Women from male-dominated cultures often are raised to be

gentle, passive, and selfless in serving their husbands and families. Some counselors may want to push such women toward independence and self-assertion but should be aware that these attributes may not be personally or culturally desirable for foreign-born female clients.

Often, treatment must be more intensive for poor immigrant women than for immigrant women with more economic resources. Treatment programs that enhance women's economic autonomy through social and employment support are effective in reducing substance use (Gregoire and Snively 2001). As with many women in treatment, foreign-born women may need transportation to their medical and legal appointments, as well as to substance abuse treatment sessions. Other services should include

- **Domestic violence intervention.** Staff members need to understand the factors in clients' home life that interfere with recovery, such as domestic violence or having a significant other who also uses substances.
- **Multidisciplinary meetings with other caregivers.** The IOT staff can organize multidisciplinary meetings for the client that involve all referring agencies. Staff from the referring agencies should be encouraged to attend and develop a plan to address any issues that may be interfering with the client's treatment.
- **Parenting classes.** Parenting classes help women meet some of the stipulations required by State departments of child and family services. In addition, some child-rearing practices in other cultures may not be acceptable in American culture, and classes offer the chance for women to learn more acceptable practices.

Religious Orientation

IOT providers need to ensure that their program is welcoming to people from all religious faiths and that no treatment practices are a barrier to those from non-Christian religions. Programs should address specifically the following issues:

- **Religious acceptance and tolerance within the program.** Local religious leaders can educate substance abuse treatment providers about traditions and practices. Providers, in turn, can educate religious leaders about services that are available. In the years immediately following the attacks of September 11, 2001, American Muslims experienced increased incidents of bias, discrimination, overt hostility, abuse, and violence. Collaborating with local imams can help treatment providers and the religious community reach out and aid people more effectively (Goodman 2002). Intolerance by other clients in treatment should not be condoned and needs to be addressed. (For a brief introduction on responding to the mental health needs of Arab Americans and American Muslims in the wake of terrorism, see Goodman [2002].)
- **Knowledge of religious customs.** Providers need to understand and accommodate the religious customs of individual clients. A culturally sensitive IOT program should ask about clients' dietary preferences, special holidays, and religious customs (e.g., daily prayers).
- **Preparing clients for mutual-help programs.** Non-Christian clients who are referred to mutual-help programs for continuing care should be informed that meetings often incorporate elements of Christianity. As an example, the Lord's Prayer, which comes from the Christian Bible, frequently is selected for closing Alcoholics Anonymous (AA) meetings. Because this is a Christian prayer, it potentially is offensive to the religious point of view of such groups as Jews, Muslims, Hindus, and Buddhists. Jewish mutual-help meetings exist in many communities. The Web site of Jewish Alcoholics, Chemically Dependent Persons and Significant Others at www.jacsweb.org provides additional information. Many areas of the country have secular mutual-help

meetings. Providers should become familiar with these meetings, so they can direct their non-Christian clients to them.
- **Support from religious leaders.** Clients whose religious faith is central to their lives should be encouraged to seek help from their religious leaders and from fellow believers.

Clinical Implications of Culturally Competent Treatment

IOT 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. Chapter 4 of TIP 46, *Substance Abuse: Administrative Issues in Outpatient Treatment* (CSAT 2006*f*), provides more information about assessing program needs.
- Ensure that all program staff receive 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 an IOT 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. Chapter 4 of TIP 46, *Substance Abuse: Administrative Issues in Outpatient Treatment* (CSAT 2006*f*), 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 IOT 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).

Sketches of Diverse IOT Client Populations

The following demographic sketches focus on diverse clients who may be part of an IOT 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, IOT providers need to get to know their clients and educate themselves. Appendix 10-A (page 197) 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).

> All [program] materials should be sympathetic to the culture of clients being served.

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).

...only 20 percent of American Indians and Alaska Natives live on reservations or trust lands...

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. An IOT 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 IOT providers already practice, including assessment and problemsolving.

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.

Treating substance use disorders in persons with disabilities is an emerging field of study.

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 IOT 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 10-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. An IOT 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 IOT program within a homeless shelter or at least providing core elements of IOT at the shelter, and (3) placing a substance abuse treatment specialist at the shelter as a liaison with the IOT program.

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, IOT 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, IOT 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.

> ...older adults ha[ve] greater attendance and lower incidence of relapse than younger adults...

IOT programs that develop geriatric expertise can provide an essential service by making consultation available to staff members at IOT 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).

Appendix 10-A. 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

The Journal of Ethnicity in Substance Abuse—This quarterly journal (formerly *Drugs and Society*) explores culturally competent strategies in individual, group, and family treatment of substance abuse. The journal also investigates the beliefs, attitudes, and values of people who abuse substances to understand the origins of substance abuse for different populations. Visit www.haworthpress.com/web/JESA to find out more.

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.

The forthcoming TIP *Improving Cultural Competence in Substance Abuse Treatment* (CSAT forthcoming *a*)—This volume addresses screening, assessment, and treatment planning; case management; counseling for specific cultural groups; and engaging and retaining diverse clients in the context of cultural competence.

"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.

Cultural Competence Works: Using Cultural Competence To Improve the Quality of Health Care for Diverse Populations and Add Value to Managed Care Arrangements (Health Resources and Services Administration 2001)—This booklet bases its recommendations for implementing cultural competence

on practices already in place in health care programs across the country. Along with its general discussions of culturally competent care, the publication includes descriptions of the programs from which the recommendations are drawn and a list of resources. Visit minority-health.pitt.edu/archive/00000278 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.

Bridges to Recovery: Addiction, Family Therapy, and Multicultural Treatment (Krestan 2000)—This volume of essays discusses substance abuse treatment for Native-American, African-American, West Indian, Asian-American, Mexican-American, and Puerto Rican families.

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.

Promoting Cultural Diversity: Strategies for Health Care Professionals (Kavanagh and Kennedy 1992)—This text discusses strategies for learning about diversity and techniques for communicating effectively with culturally diverse populations. Case studies are used to illustrate the practical applications of cross-cultural communication.

Hispanics/Latinos

Materials for clients

NCADI has publications and videotapes for clients, parents, and employers available in Spanish. Visit www.ncadi.samhsa.gov.

The National Institute on Drug Abuse (NIDA) offers a number of publications in Spanish. Visit www.nida.nih.gov.

Relapse prevention workbooks in Spanish can be purchased at www.tgorski.com.

The Hazelden Foundation offers a collection of Spanish fellowship books and videotapes approved by AA and Narcotics Anonymous. Visit www.hazelden.org.

Materials for counselors

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.

Quality Health Services for Hispanics: The Cultural Competency Component (National

Alliance for Hispanic Health 2000)—This book includes sections on the culture, language, and history of Hispanics/Latinos in the United States, Hispanic/Latino health status, guidelines for education and outreach, recommendations for working cross-culturally, and case studies. Visit www.ask.hrsa.gov/detail.cfm?id=PC00029 to order this volume.

"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.

Relapse Prevention Workbook for African Americans: Hope and Healing for the Black Substance Abuser (Williams and Gorski 1999)—This workbook leads readers through clinical exercises designed to help them avoid relapse due to race-related issues.

"Drug Treatment Effectiveness: African-American Culture in Recovery" (Bowser and Bilal 2001)—This article endeavors to explain African-Americans' high rates of substance abuse and low rates of recovery. Culture is seen as both a problem and a solution; some African-American coping strategies act as barriers, but successful treatment programs incorporate African-American cultural elements.

Native Americans

Materials for clients

GONA (Gathering of Native Americans) is a community development and empowerment training process that uses Native-American trainers. A GONA curriculum provides structure for Native-American community gatherings and is available from SAMHSA. Visit p2001.health.org/CTI05/Cti05ttl.htm.

A significant recovery movement for Native-American people is the Red Road to Recovery developed by Gene Thin Elk, a Lakota elder. Many individuals, especially in urban areas, have achieved and maintained sobriety by following the Red Road. The Red Road to Recovery addresses the cognitive, affective, and experiential needs of Native Americans who are rebuilding their lives from substance use and mental disorders and presents a system of cultural values that promote an abstinent and balanced lifestyle. The following Web sites offer information on GONA, the Red Road to Recovery, and other Native-American recovery resources:

- www.naigso-aa.org. This Web site of the Native-American Indian General Service Office of Alcoholics Anonymous includes a link to information on Talking Circles. Talking Circles are common practice in Native-American treatment settings.
- www.whitebison.org. This Web site offers information about the Wellbriety Movement (a Native-American recovery movement that emphasizes health and abstinence), which includes information about Wellbriety for youth, children of people who abuse alcohol, and people in prison. The site also includes a Talking Circle chat room, training information and materials, and books, videotapes, and audiotapes on recovery.

Materials for counselors

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.

"Addiction and Recovery in Native America: Lost History, Enduring Lessons" (Coyhis and White 2002)—This journal article provides recommendations for treatment based on the history of addiction in Native-American communities.

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" (Nebelkof 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*; 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.

Asian American Mental Health: Assessment Theories and Methods (Kurasaki et al. 2002)—This compendium of essays highlights conceptual, theoretical, methodological, and practice issues related to Asian-American mental health assessment. This text focuses on important questions about the cultural nature of diagnostic and assessment processes.

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 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 store.health.org/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 ncadi.samhsa.gov/referrals/resguides.aspx?InvNum=MS489.

A Provider's Introduction to Substance Abuse Treatment for Lesbian, Gay, Bisexual, and Transgender Individuals (CSAT 2001)—This book addresses issues of interest to clinicians and administrators. It discusses treatment approaches for this population, ways to improve services to LGB clients, steps for starting LGB-sensitive programs, organizational missions, and strategies for building alliances to provide services. Order from SAMHSA's NCADI.

Counseling Lesbian, Gay, Bisexual, and Transgender Substance Abusers: Dual Identities, Second Edition (Finnegan and McNally 2002)—This guide examines different counseling approaches and provides practical treatment suggestions for LGB populations. The book includes an organization audit of attitudes and practices, plus a list of resources and other suggested readings.

*Addiction and Recovery in Gay and Lesbian Person*s (Kus 1995)—This book examines the incidence of substance use among gay and lesbian people and special concerns when treating this population, including HIV/AIDS, homophobia, gay and lesbian mutual-help groups, and special needs of rural gay and lesbian clients.

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

IOT 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.

Materials for clients

For a catalog of AA literature available on audiocassettes, in Braille, and in large print, as well as a list of closed-caption videotapes, AA books in American Sign Language on videotape, and easy-to-read literature, contact Alcoholics Anonymous General Service Office, P.O. Box 459, Grand Central Station, New York, NY 10163 or orders@aa.org.

Materials for counselors

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.

TIP 27, *Comprehensive Case Management for Substance Abuse Treatment* (CSAT 1998*a*)—This TIP discusses various models of case management and provides information on linking with service providers and evaluation. Chapter 5 explores the use of case management services with special needs populations.

TIP 38, *Integrating Substance Abuse Treatment and Vocational Services* (CSAT 2000*a*)—This volume examines the role that employment plays in recovery from substance use disorders, with special attention to referral relationships and their capacity to expand the services available to clients and enhance the resources available to programs.

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.

Co-Occurring and Other Functional Disorders Cluster Cultural Diversity Training Guide (www.med.wright.edu/citar/sardi/publications.html)—This guide recommends topics and methods for initial staff training in cultural diversity for programs serving clients who are disabled and includes a list of references on multicultural counseling.

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 (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 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.