A TreATmenT ImprovemenT proTocol

Improving Cultural Competence

TIP 59

Substance Abuse and Mental Health Services Administration
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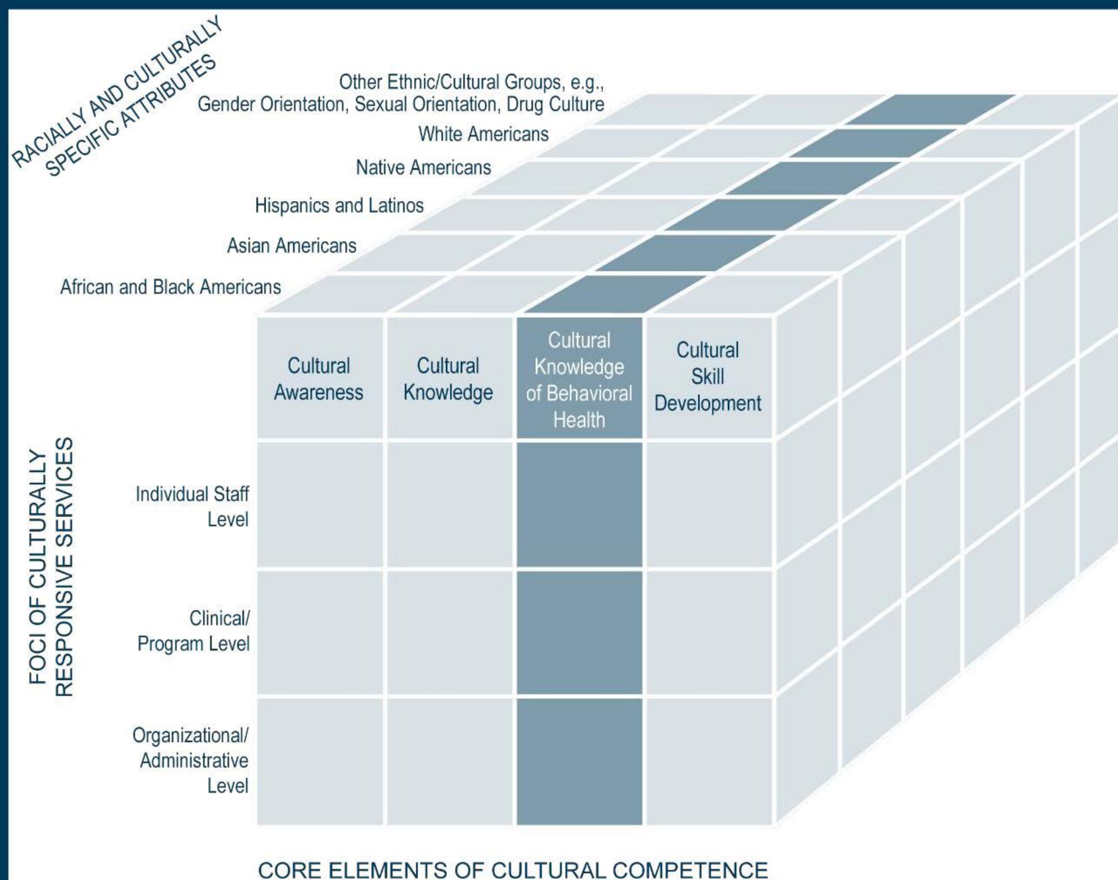
Introduction

Culture is a primary force in the creation of a person's identity. Counselors who are culturally competent are better able to understand and respect their clients' identities and related cultural ways of life. This chapter proposes strategies to engage clients of diverse racial and ethnic groups (who can have very differ-ent life experiences, values, and traditions) in treatment. The major racial and ethnic groups in the United States covered in this chapter are African Americans, Asian Americans (including Native Hawaiians and other Pacific Islanders), Latinos, Native Americans (i.e., Alaska Natives and American Indians), and White Americans. In addition to providing epidemiological data on each group, the chap-ter discusses salient aspects of treatment for these racial/ethnic groups, drawing on clinical and research literature. This information is only a starting point in gaining cultural knowledge as it relates to behavioral health. Understanding the diversity within a specific culture, race, or ethnicity is essential; not all information presented in this chapter will apply to all individuals. The material in this chapter has a scientific basis, yet cultural beliefs,

Multidimensional Model for Developing Cultural Competence: Cultural Knowledge of Behavioral Health



traditions, and practices change with time and are not static factors to consider in providing services for clients, families, or communities. Although these broad racial/ethnic categories are often used to describe diverse cultural groups, the differences between two members of the same racial/ethnic group can be greater than the differences between two people from different racial/ethnic groups (Lamont and Small 2008; Zuckerman 1998). It is not possible to capture every aspect of diversity within each cultural group. Behavioral health workers should acknowledge that there will be many individual variations in how people interact with their environments, as well as in how environmental context affects behavioral health. However, to provide a framework for understanding many diverse cultural groups, some generalizations are necessary; thus, broad categories are used to organize information in this chapter. Counselors are encouraged to learn as much as possible about the specific populations they serve. Sources listed in Appendix F provide additional information.

Counseling for African and Black Americans

According to the 2010 U.S. Census definition, African Americans or Blacks are people whose

origins are "in any of the black racial groups of Africa" (Humes et al. 2011, p. 3). The term includes descendants of African slaves brought to this country against their will and more recent immigrants from Africa, the Caribbean, and South or Central America (many individ-uals from these latter regions, if they come from Spanish-speaking cultural groups, iden-tify or are identified primarily as Latino). The term "Black" is often used interchangeably with African American, although sometimes the term "African American" is used specifi - cally to describe people whose families have been in this country since at least the 19th century and thus have developed distinct African American cultural groups. "Black" can be a more inclusive term describing African Americans as well as more recent immigrants with distinct cultural backgrounds.

Beliefs About and Traditions Involving Substance Use

In most African American communities, significant alcohol or drug use may be socially unacceptable or seen as a sign of weakness (Wright 2001), even in communities with limited resources, where the sale of such sub-stances may be more acceptable. Overall, African Americans are more likely to believe that drinking and drug use are activities for which one is personally responsible; thus, they may have difficulty accepting alcohol abuse/dependence as a disease (Durant 2005).

Substance Use and Substance Use Disorders

To date, there has not been much research analyzing differences in patterns of substance use and abuse among different groups of Blacks, but there are indications that some gender differences exist. For example, alcohol consumption among African American wom-en increases as they grow older, but Caribbean Black women report consistently low alcohol consumption as they grow older (Center for Substance Abuse Treatment [CSAT] 1999*a* ; Galvan and Caetano 2003). Rates of overall substance use among African Americans vary significantly by age. Several researchers have observed that despite Black youth being less likely than White American youth to use substances, as African Americans get older, they tend to use at rates comparable with those of White Americans (Watt 2008). This increase in substance use with age among Blacks is often referred to as a crossover effect.

However, Watt (2008), in her analysis of 4 years of National Survey on Drug Use and Health (NSDUH) data (1999–2002), found that when controlling for factors such as drug exposure, marriage, employment, education, income, and family/social support, the cross-over effect disappeared for Blacks ages 35 and older; patterns for drug and heavy alcohol use among Black and White American adults remained the same as for Black and White American adolescents (i.e., White Americans were significantly more likely to use substanc-es). Watt concludes that systemic issues, such as lower incomes and education levels, and other factors, such as lower marriage rates, contribute to substance use among Black adults. Additional research also suggests that exposure to discrimination increases willing - ness to use substances in African American youth and their parents (Gibbons et al. 2010). When comparing African Americans with other racial and ethnic groups, NSDUH data from 2012 suggest that they are somewhat more likely than White Americans to use illicit drugs and less likely than White Americans to use alcohol. They also appear to have an inci-dence of alcohol and drug use disorders simi-lar to that seen in White Americans (Substance Abuse and Mental Health Services Administration [SAMHSA] 2013*d*). Crack cocaine use is more prevalent among Blacks

than White Americans or Latinos, whereas rates of abuse of methamphetamine, inhalants, most hallucinogens, and prescription drugs are lower (SAMHSA 2011*a*). Phencyclidine use also appears to be a more serious problem, albeit affecting a relatively small group, among African Americans than among members of other racial/ethnic groups.

There appear to be some other differences in how African Americans use substances compared with members of other racial/ethnic groups. For example, Bourgois and Schonberg (2007) observed that among people who injected heroin in San Francisco, White Americans tended to administer the drug quickly whether or not they could find a vein, which led them to inject into fat or muscle tissue and resulted in a higher rate of abscesses. However, African Americans who injected heroin were more methodical and took the time to find a vein, even if it took multiple attempts. This, in turn, often resulted in using syringes that were already bloodied and increased their chances of contracting HIV/AIDS and other blood-borne diseases. African Americans who inject-ed heroin were significantly more likely to also use crack cocaine than were White Americans who injected heroin (Bourgois et al. 2006).

African American patterns of substance use have changed over time and will likely continue to do so. Based on treatment admission data, admissions of African Americans who injected heroin declined by 44 percent during a 12-year period, whereas admissions declined by only 14 percent among White Americans (Broz and Ouellet 2008). Additionally, during this period, the peak age for African Americans who injected heroin increased by 10 years, yet it decreased by 10 years for White Americans. This suggests that the decrease in injectable heroin use among African Americans was largely due to decreased use among younger individuals.

Some preliminary evidence suggests that African Americans are less likely to develop drug use disorders following initiation of use (Falck et al. 2008), yet more research is needed to identify variables that influence the devel - opment of drug use disorders. Even though African Americans seem less likely than White Americans to develop alcohol use disorders, a number of older studies have found that they more frequently experience liver cirrhosis and other alcohol-related health problems (Caetano 2003; Polednak 2008). In tracking 25 years of data, Polednak (2008) found that the magnitude of difference has decreased over time; nonetheless, health dispar-ities continue to exist for African Americans in terms of access to and quality of care, which can affect a number of health problems (Agency for Healthcare Research and Quality 2009; Smedley et al. 2003).

Mental and Co-Occurring Disorders

A number of studies have found biases that result in African Americans being overdiagnosed for some disorders and underdiagnosed for others. African Americans are less likely than White Americans to receive treatment for anxiety and mood disorders, but they are more likely to receive treatment for drug use disorders (Hatzenbuehler et al. 2008). In one study evaluating posttraumatic stress disorder (PTSD) among African Americans in an outpatient mental health clinic, only 11 percent of clients had documentation referring to PTSD, even though 43 percent of the clients showed symptoms of PTSD (Schwartz et al. 2005). Black immigrants are less likely to be diagnosed with mental disorders than are Blacks born in the United States (Burgess et al. 2008; Miranda et al. 2005*b*).

African Americans are more likely to be diagnosed with schizophrenia and less likely to be diagnosed with affective disorders than

White Americans, even though multiple studies have found that rates of both disorders among these populations are comparable (Baker and Bell 1999; Bresnahan et al. 2000; Griffith and Baker 1993; Stockdale et al. 2008; Strakowski et al. 2003). African Americans are about twice as likely to be diagnosed with a psychotic disorder as White Americans and more than three times as likely to be hospital-ized for such disorders. These differences in diagnosis are likely the result of clinician bias in evaluating symptoms (Bao et al. 2008; Trierweiler et al. 2000; Trierweiler et al. 2006). Clinicians should be aware of bias in assessment with African Americans and with other racial/ethnic groups and should consid-er ways to increase diagnostic accuracy by reducing biases. For an overview of mental health across populations, refer to *Mental Health United States, 2010* (SAMHSA 2012*a*).

In some African American communities, incidence and prevalence of trauma exposure and PTSD are high, and substance use appears to increase trauma exposure even further (Alim et al. 2006; Breslau et al. 1995; Curtis-Boles and Jenkins-Monroe 2000; Rich and Grey 2005). Black women who abuse substances report high rates of sexual abuse (Ross-Durow and Boyd 2000). Trauma histories can also have a greater effect on relapse for African American clients than for clients from other ethnic/racial groups (Farley et al. 2004). There are few integrated approaches to trau-ma and substance abuse that have been evalu-ated with African American clients, and although some have been found effective at reducing trauma symptoms and substance use, the extent of that effectiveness is not necessarily as great as it is for White Americans (Amaro et al. 2007; Hien et al. 2004; SAMHSA 2006).

African Americans are less likely than White Americans to report lifetime CODs (Mericle et al. 2012). However, limited research indi-cates that, as with other racial groups, there are differences across African American groups in the screening and symptomatology of CODs. Seventy- four percent of African Americans who had a past-year major depressive episode were identified as also having both alcohol and marijuana use disorders (Pacek et al. 2012). Miranda et al. (2005*b*) found that American-born Black women were more than twice as likely to be screened as possibly having depression than African- or Caribbean-born Black women, but this could reflect, in part, differences in acculturation (see Chapter 1). However, research findings strongly suggest that cultural responses to some disorders, and possibly the rates of those disorders, do vary among different groups of Blacks. Differences do not appear to be simply reflections of differences in acculturation (Joe et al. 2006). For a review of African American health, see Hampton et al. (2010).

Treatment Patterns

African Americans may be less likely to receive mental health services than White Americans. In the Baltimore Epidemiologic Catchment Services Area study conducted during the 1980s, African Americans were less likely than White Americans to receive mental health services. However, at follow-up in the early 1990s, African American respondents were as likely as White Americans to receive such services, but they were much more likely to receive those services from general practitioners than from mental health specialists (Cooper-Patrick et al. 1999). Stockdale et al. (2008) analyzed 10 years of data from the National Ambulatory Medical Care Survey; they found significant improvements in diag-nosis and care for mental disorders among African Americans in psychiatric settings

between 1995 and 2005, but they also found that disparities persisted in the diagnosis and treatment of mental disorders in primary care settings. Fortuna et al. (2010) suggest that persistent problems exist in the delivery of behavioral health services, as evidenced by lower retention rates for treating depression.
Even among people who enter substance abuse treatment, African Americans are less likely to receive services for CODs. A study of administrative records from substance abuse and mental health treatment providers in New Jersey found that African Americans were significantly more likely than White Americans to have an undetected co-occurring mental disorder, and, if detected, they were signifi-cantly less likely than White Americans or Latinos to receive treatment for that disorder (Hu et al. 2006). Among persons with sub-stance use disorders and co-occurring mood or anxiety disorders, African Americans are significantly less likely than White Americans to receive services (Hatzenbuehler et al. 2008). African Americans who do receive services for CODs are more likely to obtain them through substance abuse treatment programs than mental health programs (Alvidrez and Havassy 2005).

According to the Treatment Episode Data Sets (TEDS) from 2001 to 2011, African American clients entering substance abuse treatment most often reported alcohol as their primary substance of abuse, followed by mari-juana. However, gender differences are evident, indicating that women report a broader range of substances as their primary substance of abuse than men do (SAMHSA, Center for Behavioral Health Statistics and Quality [CBHSQ], 2013). Most recent research sug-gests that African Americans are about as likely to seek and eventually receive substance abuse treatment as are White Americans (Hatzenbuehler et al. 2008; Perron et al. 2009; SAMHSA, CBHSQ 2011; Schmidt et al. 2006). Data analyzed by Perron et al. (2009) indicate that among African Americans with lifetime diagnoses of drug use disorders, 20.8 percent had received some type of treatment, as defined broadly to include resources such as pastoral counseling and mutual-help group attendance. This made them more likely to have received treatment than White Ameri-cans (15.5 percent of whom received treat-ment) or Latinos (17.3 percent of whom received treatment). Although data indicate that African Americans were less likely to receive services from private providers, they also indicate that African Americans were more likely to use more informal services (e.g., pastoral counseling, mutual help).
Although most major studies have found that race is not a significant factor in receiving treatment, African Americans report lengthier waiting periods, less initiation of treatment, more barriers to treatment participation (e.g., lack of childcare, lack of insurance, lack of knowledge about available services), and shorter lengths of stay in treatment than do White Americans (Acevedo et al. 2012; Brower and Carey 2003; Feidler et al. 2001; Grant 1997; Hatzenbuehler et al. 2008; Marsh et al. 2009; SAMHSA 2011*c*; Schmidt et al. 2006). In SAMHSA's 2010 NSDUH, 33.5 percent of African Americans who had a need for substance abuse treatment but did not receive it in the prior year reported that they lacked money or the insurance coverage to pay for it (SAMHSA, CBHSQ 2011). Economic disadvantage does leave many Africans Amer-icans uninsured; approximately 16.1 percent of non-Latino Blacks had no coverage in 2004 (Schiller et al. 2005).
Likewise, some researchers have found that African Americans are less likely than White Americans to receive needed services or an appropriate level of service (Alegria et al.

2011; Bluthenthal et al. 2007; Marsh et al. 2009). For example, African Americans and Latinos are less likely than White Americans to receive residential treatment and are more likely to receive outpatient treatment, even when they present with more serious substance use problems (Bluthenthal et al. 2007). Other studies have found that African Americans with severe substance use or CODs were less likely to enter or receive treatment than White Americans with equally severe disorders (Schmidt et al. 2006, 2007). African Americans are overrepresented among people who are incarcerated in prisons and jails (for review, see Fellner 2009), and a sub-stantial number of those who are incarcerated (64.1 percent of jail inmates in 2002) have substance use disorders (Karberg and James 2005) and mental health problems (SAMHSA 2012*a*). However, according to Karberg and (James 2005), African Americans with sub-stance dependence disorders who were in jail in 2002 were less likely than White Americans or Latinos to participate in substance abuse treatment while under correctional supervision (32 percent of African Americans participated compared with 37 percent of Latinos and 45 percent of White Americans). In the 2010 TEDS survey, African Americans entering treatment were also less likely than Asian Americans, White Americans, Latinos, Native Hawaiians/Pacific Islanders, or American Indians in the same situation to be referred to treatment through the criminal justice system (SAMHSA, CBHSQ 2012). Notwithstand-ing, African Americans are more likely to be referred to treatment from criminal justice settings rather than self-referred or referred by other sources (Delphin-Rittmon et al. 2012)

Beyond issues related to diagnosis and care that can prevent African Americans from accessing mental health services, research suggests that a lack of familiarity with the value and use of specialized behavioral health services among some African Americans may limit service use. Hines-Martin et al. (2004) found a positive relationship between famili-arity and use of mental health services among African Americans. Additionally, factors such as social and familial prejudices (Ayalon and Alvidrez 2007; Mishra et al. 2009; Nadeem et al. 2007) and fears relating to past abuses of African Americans within the mental health system (Jackson 2003) can contribute to the lack of acceptance and subsequent use of these services. An essential step in decreasing dis-parity in behavioral health services among African Americans involves conducting cul-turally appropriate mental health screenings and using culturally sensitive instruments and evaluation tools (Baker and Bell 1999).