Cultural responsiveness in substance-abuse treatment: a qualitative study using professionals’ and clients’ perspectives

As a result of the growing number of ethnic and cultural minority clients in substance-abuse treatment during the last decades, a culturally responsive approach has become more and more imperative. In this article the statements (n = 1330) of professionals (n = 11) and clients (n = 11) representing the substance-abuse treatment centres in the region of Ghent and its suburbs (Belgium) are analysed. In focus are the specific treatment needs of ethnically and culturally diverse substance-abusing clients and the difficulties consequent to treating this target group. Possible approaches to overcoming these difficulties are highlighted and elaborated by means of semi-structured interviews and focus groups. The participants in the study stress the importance of an integrated approach, with special attention given to the factors that can promote or jeopardise treatment.

Key words: cultural responsiveness, substance-abuse treatment, ethnic and cultural diversity, qualitative research

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Introduction

As outlined in the introductory article to this mini-symposium contribution, therapeutic communities have always considered cultural diversity as an essential concept within their treatment approach (De Leon, Melnick, Schoket & Jainchill, 1993). Currently, because of the increasing number of ethnic minority clients in substance-abuse treatment in general (Finn, 1994, 1996), the need for and implementation of a culturally responsive treatment has become more urgent and widespread (Argeriou & Daley, 1997; Ellis, 1999; Kline, 1996; Terrell, 1993; Westermeyer, 1996). In this context, it is worthwhile noting that the organisation of treatment centres is almost always modelled after the dominant (autochthon) culture (Lee, 1994). Research points out that ethnic minorities often fail to make use of the existing treatment facilities (Ashruf & van der Eijnden, 1996; Longshore, Grills, Anglin & Annon, 1997) and that there is a disproportionate ethnic distribution in some treatment centres, especially in those with a high threshold (e.g. therapeutic communities) (Braam, Verbraeck & van de Wijngaert, 1998; De Leon, Melnick, Schoket & Jainchill, 1993; Vandevelde, Vanderplasschen & Broekaert, 2000). Furthermore, minority clients are less likely to successfully complete treatment (Finn, 1994, 1996) and more likely to experience specific difficulties due to typical characteristics of the (traditional) treatment system, methods and techniques (Tucker, 1985).

To cope with these difficulties, recent research has revealed the importance of taking the specific needs of minority clients and other ethno-cultural factors into account when treating culturally diverse client groups (Jackson, Stephens & Smith, 1997; Rounds-Bryant, Kristiansen & Hubbard, 1999; Varma & Siris, 1996). Therapeutic communities and other treatment centres also share these concerns and insist on the necessity of specification. First of all, substance-abuse treatment centres are not equally distributed over different cities and regions in Belgium, regardless of need (Vanderplasschen, De Bourdeaudhuij & Van Oost, 2002); moreover, treatment is influenced by many cultural and traditional factors. Important differences can exist – such as country of origin, religion, values and beliefs – amongst persons with culturally diverse
backgrounds who seek help. American research focusing on alcohol abuse among people of Hispanic origin emphasised the real need for specification when identifying populations, since clients differ substantially when it comes to alcohol use and incidence, although the population itself can have much in common in other respects (Rodriguez-Andrew, 1998). It is also important to draw attention to differences between individuals because of the possible diversity within as well as between ethnic groups (Cheung, 1993; Longshore et al., 1999; Tucker, 1985).

Aims
This article investigates if and to what extent substance-abuse treatment centres are currently working in a culturally responsive way, which can be described as ‘the need for program staff to play an active role in integrating the client’s cultural background into the treatment process’ (Finn, 1996: 449). The article examines the views of clients and professionals who daily – from different perspectives – experience these problems in treatment facilities; how they perceive and cope with the problems and which improvements they suggest. The aim is to gain information on obstacles to cultural responsiveness in substance-abuse treatment (Kline, 1996; Tucker, 1985) and on methods to overcome these difficulties.

Ethnicity versus nationality
The terms ‘(ethnic and cultural) minority clients’, ‘clients with ethnically/culturally diverse backgrounds’, ‘ethnic cultural minorities’ are used in this article to stress ethnic origin and culture (or ethnicity) as against nationality. Currently, nationality is largely used as an exclusion-variable to differentiate between autochthons and ethnic cultural minorities, which leads to a serious underestimation of the complexity of dealing with a culturally diverse population (Provinciaal Integratiecentrum Oost-Vlaanderen (PICO), 1999).

According to Blommaert and Martiniello (1996), there are no official numbers of ethnic minorities in Belgium and the only criterion used in official statistics is nationality. Moreover, research reveals that in some cases data based on nationality cover only half of the real number of people with another ethnic cultural origin (PICO, 1999). Cheung (1993) critically evaluates some possible indicators of ethnicity – including race, country of origin, ethnic identification and ethnic culture – and concludes that it is preferable to use several of the above-mentioned indicators rather than rely on only one. Due to the lack of a widely used and qualitative indicator of ethnicity, it is nearly impossible to present exact data relating to substance abuse among ethnic minority groups (Khan, 1999).

Method
Sample
The research was carried out in all (specialised) substance-abuse treatment centres in Ghent and its suburbs (Belgium). The sample of participants was comprised of 11 professionals, who were delegated by the treatment centres themselves, and 11 clients. It is important to note that each facility was represented by a professional, whereas it was impossible to recruit a client in each of the treatment centres. Although the aim was to include in the sample of professionals as many persons as possible with another ethnic and cultural background, we found only one such person.

The study focused on a population that has a Turkish, Moroccan, Tunisian or Algerian ethnic background, which reflected the distribution of these subgroups in the general population. Ghent is a relatively densely populated city with 225,000 inhabitants, of which approximately 17,000 (7.6%) do not have Belgian nationality. More than 10,000 (62.3%) of them are Turkish, Moroccan, Tunisian or Algerian (situation in January 1997 – National Institute for Statistics).

Furthermore, this study was limited to the specialised treatment facilities; that is, substance-abuse treatment centres and some social welfare and health-care centres that offer specialised care and treatment for substance-abusing clients (Vanderplasschen et al., 2002). It should be noted that the geographical limitation to Ghent is based on the diversity and comprehensiveness of the substance-abuse treatment system in this specific region. It is important to emphasise that, although the number of interviews with professionals (n = 11), interviews with clients (n = 11) and the focus groups (n = 3) may seem small, all the treatment centres in the region were represented.

Procedure and instruments
Semi-structured interviews were conducted with the professionals and clients. The interview with professionals consisted of 11 open-ended questions based on literature concerning culturally responsive treatment (Braam et al., 1998; Finn, 1994, 1996) and was administered by the first author of this article. The client interviews were based on the same questions (cf. Figure 1), but were slightly adapted when appropriate (Aga, 2001), and were administered by Masters-level students in Educational Sciences.

The interviewed professionals later participated in one of three parallel focus groups (moderated by the first author of this article), during which possible methods for achieving more effective treatment for ethnic-minority clients were discussed in depth. A focus group with clients was also planned, but was not
actually executed as not enough clients were willing to participate in a group discussion. The use of these different sources of data collection had given breadth and diversity to the research material. Because of the article’s explorative nature, the aim has been to grasp the totality of the data; in further research on the material, it might be necessary to make a distinction between the data collected through interviews and data collected through the focus groups.

Data analysis

The interviews and focus groups were audio-taped and then transcribed. General themes were recognised in the material and ordered in a tree structure. The texts were analysed using the qualitative computer program WinMAX98. ‘The methodological aim is to identify patterns in social regularities and to understand them in the sense of controlled Fremdverstehen (understanding the other)’ (Kuckartz, 1998: 13). From this point of view it becomes possible to classify and quantify the material and identify typologies (Broekaert, Soyez, Vanderplasschen, Vandevelde, Bradt, Morival & Kaplan, 2001).

Grounded in the codification of the written material, a scheme was constructed based on relevant literature (Braam et al., 1998; Finn, 1994, 1996). What are the most prevalent pitfalls in the treatment of minority clients, as seen from three separate perspectives: difficulties regarding ‘perception’; difficulties encountered in ‘current treatment’; and difficulties inherent in the ‘policy’ of the institution and the government (cf. Table 1)? Introducing several subcategories and focusing in greater detail on the problematic aspects of treatment completed the scheme.

Table 1. Global structure of coded segments and corresponding numbers/percentages of expressions (n = 1,330).

<table>
<thead>
<tr>
<th>Perspective</th>
<th>Difficulties</th>
<th>Pathways</th>
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<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
</tr>
<tr>
<td>Professionals</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Perception / knowledge</td>
<td>11</td>
<td>0.8</td>
</tr>
<tr>
<td>Treatment</td>
<td>329</td>
<td>24.7</td>
</tr>
<tr>
<td>Policy</td>
<td>30</td>
<td>2.2</td>
</tr>
<tr>
<td>Total number of expressions</td>
<td>370</td>
<td>27.8</td>
</tr>
<tr>
<td>Clients</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Perception / knowledge</td>
<td>7</td>
<td>0.5</td>
</tr>
<tr>
<td>Treatment</td>
<td>206</td>
<td>15.4</td>
</tr>
<tr>
<td>Policy</td>
<td>38</td>
<td>2.8</td>
</tr>
<tr>
<td>Total number of expressions</td>
<td>251</td>
<td>18.8</td>
</tr>
</tbody>
</table>

Possible pathways suggested by the professionals and clients were structured on a similar basis. The interviews were systematically reviewed and statements (‘hermeneutic units’) concerning one of the above-mentioned categories were added to the scheme, after which these statements were counted and compared (n = 1,330).

Results

General results

Seven of the eleven professionals pointed out the lack of an appropriate and commonly used term to describe the population of minority clients, whilst the remaining four did not expand on this topic. Nevertheless, the professionals seemed to agree that using ethnicity rather than nationality was a more suitable criterion for defining the group of ethnically and culturally diverse
minority clients. The professionals also stated that they had never implemented a specific method for working with clients with ethnically/culturally diverse backgrounds. Nevertheless, the statements indicate that most centres concur with the view that it is desirable to take the special needs of minority clients into account. However, this attitude was expressed informally and without benefit of a specific treatment protocol.

Many of the statements we obtained from the professionals focused on difficulties encountered in current methods of treatment (329/1,330 – 24.7%) and proposed improvements (273/1,330 – 20.5%), clarifying the professionals’ point of view that the therapeutic relationship between caregiver and client is more important than the professionals’ perception of difficulties (11/1,330 – 0.8%) or pathways (26/1,330 – 1.9%). Also, the difficulties (30/1,330 – 2.2%) and pathways (3/1,330 – 0.2) associated with the policy of institutions and/or the government was a less prevailing topic in the sense that the participating professionals indicated that they have little or no insight into nor influence on this topic.

These tendencies can be identified for clients as well. The majority of the coded statements focused on difficulties (206/1,330 – 15.4%) and pathways (369/1,330 – 27.7%) regarding treatment. As in the case of the professionals, perception (10/1,330 – 0.7%) and policy issues (73/1,330 – 5.4%) were less frequently mentioned in the clients’ statements. This is the main reason why the analysis is limited to the statements concerning treatment issues.

Furthermore, it is important to stress that the clients talked more about possible pathways (407 statements against 251 pertaining to difficulties), whereas the professionals expressed more thoughts on difficulties (370 statements against 302 on pathways) (cf. Table 1).

Difficulties
Of the 329 statements concerning the bottlenecks in the current treatment of clients from ethnically/culturally diverse backgrounds that were most frequently talked about by the professionals, the main topics can be summarised as follows: roughly a quarter of the problems mentioned were related to communication problems, nearly a quarter on difficulties involving the social network of the client (e.g. reaching family, friends, peers . . . ) and almost a quarter of the statements involved the sometimes destructive impact of clients’ cultural background on the treatment process (e.g. the perception of honour and status, and the preference for short-term care). Furthermore, some 15% of the statements focused on difficulties regarding accessibility and distribution of information together with the lack of cultural responsiveness.

Of the 206 statements most frequently talked about by the clients concerning difficulties in connection with their treatment, more than half of the statements focused on the influence of cultural and religious background on the treatment process, especially the perception of honour and status. Nearly 20% of the statements involved difficulties regarding accessibility and distribution of information and cultural responsiveness. Communication problems and the lack of ethno-cultural peers in treatment facilities were mentioned in 12% and slightly under 8% of the statements, respectively (cf. Table 2).

Pathways
Of the 273 statements concerning possible pathways in current treatment of clients from ethnically/culturally diverse backgrounds that were most frequently talked about by the professionals, the main topics can be summarised as follows: roughly 22% of the statements focused on pathways to involving the family and nearly 20% on pathways to improve communication. Pathways to taking cultural background into account and
implementing cultural responsiveness accounted for 15% and nearly 13% of the statements, respectively.

Of the 369 statements concerning suggested pathways regarding their treatment that were most frequently talked about by the clients, more than half of the statements focused on the influence of cultural background on the treatment process, followed by suggestions for addressing such problems as lack of staff (roughly 13%), absence of peers (more than 10%) and difficulties in involving social network members (nearly 10%) (cf. Table 2).

Qualitative analysis
A more thorough qualitative analysis highlighted additional aspects that, according to the clients and/or professionals, could promote or jeopardise treatment. Although these preliminary findings will not be discussed in depth here in that they require more comprehensive study, the most important results will be briefly summarised.

Difficulties
The results reported above show that both professionals and clients regarded communication difficulties as being of central importance. Because of the importance their culture attaches to the notions of honour and respect, most minority clients (especially the male clients) found it hard to talk openly about emotional problems. The clients themselves acknowledged this problem and regarded it as important to pay attention to seemingly ‘small’ aspects of treatment as well, rather than always focusing on major (structural) changes. An example is to occasionally use words from the client’s mother tongue. In this context, it is important to note that the inevitability of communication problems does not make them any less important. Besides the technical problem of being unable to understand one another (in the sense of speaking a different language), there is also a real risk of misunderstanding.

Clients from ethnically/culturally diverse backgrounds often perceive the nature and treatment of substance abuse differently from the (predominately Western) treatment staff. Furthermore, concepts such as status and (family) honour often have different connotations that can conflict with present-day (Western) practices in substance-abuse treatment. Clients stressed that the absence of ethno-cultural peers in substance-abuse treatment facilities made it hard to maintain the effort necessary to successfully complete treatment.

Pathways
Although there may seem to be few statements about improving knowledge of the clients’ cultural background, the professionals suggested some interesting pathways. Besides traditional educational programmes (such as in-service training, symposia and so forth), cooperation and ‘networking’ particularly were seen as important ways of increasing knowledge about the cultural background of ethnic minority groups. In one of the focus groups it was suggested that different centres (e.g. substance-abuse treatment centres and centres for integration of minorities) could work together on selected ‘cases’.

Both professionals and clients mentioned the use of interpreters as the most commonly used methods – to date – for overcoming the communication problem between staff and clients. This, however, created new problems; for example, it brought a third person into the staff–client relationship although the argot used during treatment is not always translatable, especially when ‘culturally sensitive’ words and/or customs are involved. Some professionals suggested using family members and peers (even those still abusing drugs) as interpreters. These professionals maintained that whilst it would not resolve all problems, it could certainly influence the degree to which the social network was involved in the treatment, thus tackling another area of difficulty. As well as using the social network as interpreter or ‘cultural mediator’, some professionals also stressed the importance of outreaching.

Several of the professionals pointed out that working through the medical dimension might facilitate the treatment of minority clients, since (emotional) problems are often expressed through physical symptoms. Furthermore, professionals indicated that most minority clients stay in treatment for a relatively short period of time and only return when absolutely necessary (for example, when experiencing problems again, often of a physical and/or practical nature).

Regarding the communication problem, the clients stated that using their native language would help them to express their feelings and emotions more freely, and thus make them feel more comfortable. The employment of staff members coming from ethnically/ culturally diverse backgrounds could play a major role in trying to reach the clients’ social network. It could also contribute in other ways to improving the work with minority clients; for example, it enables a cross-fertilisation of cultural knowledge within the team. The clients indicated that it would be preferable to have staff members from minority groups, although not all participants regarded it as a real necessity. Still, ethnicity was not considered to be enough; knowledge and experience were required as well.

Discussion
Some people maintain that ethnic and cultural origin is not a crucial factor in the treatment of substance-
abusing clients (cf. Finn, 1996). The results of the present study, albeit limited, contradict that conclusion. Finn (1994) gives several reasons why clients’ cultural origins should be taken into account: a person’s cultural background is an important aspect of his/her identity; cultural factors can have a positive and/or negative impact on treatment; the effectiveness of treatment can be diminished by ethno-cultural factors; and, lastly, being a member of a minority group can in itself be a reason to start (ab)using substances. Other researchers (De La Rosa, Vega & Radisch, 2000) have studied the influence of the acculturation process on substance-abusing behaviour in African-American and Hispanic clients. Differences in patterns of substance abuse caused by a person’s ethnicity and cultural background could have a major influence on how treatment should be optimally organised. An American study (Ma & Shive, 2000) reports on differences in perceived risk and reported use of substances among ethnic groups (Whites, Blacks and Hispanics), as well as on differences in preferences for specific drugs, stressing the necessity of taking these differences into account when organising prevention and treatment. Furthermore, British research on the perception of mental health centres (Dein, 1997) emphasises the importance of considering differences in explanatory models of illness as perceived by patients and doctors with ethnically/culturally diverse backgrounds.

Although they agree on the necessity of taking ethno-cultural factors into account, the participating professionals and clients stressed the importance of not organising specific and separate treatment for minority clients, as this would isolate them from other autochthon clients. Instead, they suggested making use of one or more adapted methods and fully integrating them into the general treatment plan of other (autochthon) substance-abusing clients. These methods should take the specific needs of minority clients into account, incorporating such issues as showing respect for the client’s status and sense of honour and respecting the pace at which clients feel comfortable in treatment (cf. Figure 2). Case management aiming at improving coordination and continuity of care (Vanderplasschen et al., 2002), as well as integrated treatment systems (Broekaert & Vanderplasschen, forthcoming) seem to offer promising insights in this respect.

Offering staff members the possibility to enhance their knowledge of the client’s cultural background can yield important advantages. Educational activities and networking with ethnically and culturally diverse communities (for example, local community centres run by ethnic minorities) are good ways to gain knowledge of other cultures. The involvement and active participation of professionals from ethnically/culturally diverse backgrounds is extremely important, since it offers the possibility of testing certain ideas, assumptions and presumptions that might be held by autochthon staff members. From this point of view, the previous suggestion of studying individual cases together with professionals from different backgrounds – both cultural and/or occupational – could be very interesting. Although the formal possibility (i.e. during working hours) of learning more about other cultures cannot always be extended to each and every staff member, the

Figure 2. Possible pathways aimed at improving substance-abuse treatment of ethnically diverse clients according to the participating professionals and clients.
cross-fertilisation of knowledge within the team is already a goal worth striving for.

Despite some inevitable difficulties, involving the social network in the treatment process can be considered a promising opportunity – perhaps even the most promising – of finding an ‘entrance’ into treatment. Minority clients often live in relatively small and isolated communities, making the support of significant others extremely important. Case management, including outreach activities, could be used to involve these people actively in the treatment and planning process, thus overcoming resistance (Siegal, Rapp, Li, Saha & Kirk, 1997) rather than passively waiting for them. Cultural responsiveness requires action and commitment, especially from staff members. Again, special attention should be given to the employment of minority-group staff members, although there is a dearth of research on the effectiveness of ethnic and cultural congruent treatment (in which staff member and client share, as far as possible, the same ethnic and cultural background) (cf. Stanley, Lawrence & Beny, 1997). Yeh, Takeuchi and Sue (1994) describe how Asian-American children achieved higher functioning scores when discharged from mental-health centres specifically organised for the Asian community (with bilingual personnel, culturally responsive forms of treatment, etc.) than when discharged from ‘mainstream’ centres. Other research results also point in the direction of a positive influence (for some subgroups) on treatment effectiveness when client and staff member share the same cultural and ethnic background (Fiorentine & Hillhouse, 1999; Lopez, Lopez & Fong, 1991).

The main question of whether these results can be generalised to include all groups of ethnically/culturally diverse people remains unanswered. Ayonrinde (1999) points out that although ethnic pairing of psychiatrist and patient could be beneficial, the congruency of client and caregiver could also cause major problems; for example, staff members might be considered too much ‘one of us’ instead of an independent and ‘objective’ caregiver.

The length of time that clients spend in substance-abuse treatment programmes is accepted as a reliable predictor of treatment success, regardless of client gender, age or ethnicity (De Leon et al., 1993). Because this factor is easily measurable and objective, it is frequently used as a criterion of treatment outcome. Although this seems most appropriate for therapeutic communities, it is also true for other treatment modalities (Shwartz, Mulvey, Woods, Brannigan & Plough, 1997). These findings could explain why past treatment of clients from ethnically diverse backgrounds has often been unsuccessful. As mentioned earlier, ethnic-minority clients are less likely to complete treatment and often remain in treatment for only a relatively short period of time (Finn, 1994, 1996). In this respect, case management could be used to enhance treatment participation and outcomes (Siegal et al., 1997).

In conclusion, both the professionals and the clients stressed the importance of treating minority clients within the ordinary (Western) framework, but also state that special attention should be given to the clients’ specific needs.

Further research is needed to elaborate the suggestions made here and to test them by practical experience (for example, in action research) and – even more importantly – to better implement the feedback from clients with ethnically and culturally diverse backgrounds. Moreover, a thorough and comprehensive study is needed to explore the needs of clients, with special attention given to cooperative research. This involves ethnic minority clients and their social network and recovered addicts. Last but not least, the use of an unequivocal registration protocol in which other indicators besides nationality are indexed seems to offer promising advantages (Cheung, 1993).

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