Clinical Psychology and Psychotherapy
Clin. Psychol. Psychother. **24**, 987–1001 (2017)
Published online 15 December 2016 in Wiley Online Library (wileyonlinelibrary.com). **DOI:** 10.1002/cpp.2062

Cultural Competence in the Treatment of Addictions: Theory, Practice and Evidence

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Culturally and linguistically diverse (CALD) populations often have high rates of addictive disorders, but lower rates of treatment seeking and completion than the mainstream population. A significant barrier to treatment is the lack of culturally relevant and appropriate treatment. A literature review was conducted to identify relevant literature related to cultural competence in mental health services delivery and specifically treatment for addictive disorders. Several theoretical models of cultural competence in therapy have been developed, but the lack of rigorous research limits the empirical evidence available. Research indicates that culturally competent treatment practices including providing therapy and materials in the client's language, knowledge, understanding and appreciation for cultural perspectives and nuances, involving the wider family and community and training therapists can enhance client engagement, retention and treatment outcomes for substance use and gambling. Further methodologically rigorous research is needed to isolate the impact of cultural competence for the treatment of addictions and guide research to determine treatment efficacy within specific CALD populations. Training therapists and recruiting therapists and researchers from CALD communities is important to ensure an ongoing focus and improved outcomes for CALD populations due to the importance of engaging these populations with addiction treatment. Copyright © 2016 John Wiley & Sons, Ltd.

Key Practitioner Message:

- The treatment needs of culturally diverse individuals with addictions are often not met.
- Theoretical models can guide therapists in incorporating cultural competence.
- Culturally targeted treatments increase recruitment, retention and treatment outcomes.
- Cultural competence includes matching clinicians and clients on linguistic and cultural backgrounds as well as being mindful of the impact of culture on client's experience of addiction problems.
- Few methodologically rigorous trials have been conducted to guide treatment practices and research needs to be incorporated into existing culturally relevant treatment services.

Keywords: Culture, Ethnic, Competence, Addiction, Treatment, Therapy

INTRODUCTION

Culturally and linguistically diverse (CALD) populations are a high-risk group for problems with alcohol, drugs and gambling (Esser *et al.*, 2014; Gainsbury, Russell *et al.*, 2014; Huang *et al.*, 2006; Raylu & Oei, 2004; Substance Abuse and Mental Health Services Administration, 2011). Treatment uptake and completion is also significantly lower among CALD as compared with mainstream populations (Guerrero *et al.*, 2013). Treating CALD populations is an important humanitarian goal to ensure equality of service provision and reduced burden of mental health issues. Furthermore, treating addictions and mental health disorders has a positive economic impact, e.g., in terms of work force productivity, increased taxes, associated health care and social work costs, fewer crimes and incarceration (Curry, Grothaus, McAfee, & Pabiniak, 1998; Masson *et al.*, 2004; Rehm *et al.*, 2009). For example, a meta-analysis found that the economic costs attributed to alcohol were at least one percent of gross domestic product and 2.7% in the USA (Rehm *et al.*, 2009). Similarly, full coverage for smoking-cessation programmes can be achieved for less than 5% the annual cost of medical treatment for hypertension or heart disease, which is usually incurred for the life of the patient (Fishman, Von Korff, Lozano, & Hecht, 1997). Despite this, there is relatively little research focusing on cultural competency in treatment. Although best-practice treatment is often predicated on a non-judgmental attitude, openness and tailoring treatment to individual clients, specific efforts to provide culturally competent therapy are needed. Furthermore, efforts to enhance the provision of culturally competent therapy also demonstrate an understanding of the importance of providing appropriate treatment for an at-risk group.

Client retention and successful outcomes depend on providing culturally competent therapy (Hall, 2001), an

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Clinical Psychology & Psychotherapy

under researched area in the field of addictions. For example, a systematic review of risk factors for failing to complete addiction treatment did not investigate the role of cultural background (Brorson, Arnevik, Rand-Hendriksen, & Duckert, 2013). Most clinical trials include too few CALD individuals to enable any specific analyses to be conducted and ethnic minorities continue to be missing from the research from which evidence-based treatments are drawn (Hwang, Myers, Abe-Kim, & Ting, 2008; Muñoz & Mendelson, 2005). The lack of cultural diversity specifically examined in trials makes it difficult to determine treatment efficacy within specific CALD communities. Within the limited research on addictions among CALD populations, outcomes are restrained by a singular focus on a specific population. This reduces the ability to apply the research outcomes to the broader field and clinical settings. The aim of this paper is to review the literature to inform the practice of culturally relevant and competent therapy for addictions, including disordered gambling.

METHODS

A literature review was completed to compile and present the existing academic research on the impact of culture on addictive disorders and ways to adapt treatment services to achieve effective outcomes with CALD populations. A literature review was conducted using key search terms to identify relevant literature focusing on peer-review publications related to cultural competence in mental health services delivery and specifically treatment for addictive disorders. Key search terms included the following: culture, cultural competency, ethnic, minorities, addiction, addictive disorder, alcohol, tobacco, gambling, substance use, drug, treatment, therapy and mental health. Databases searched included the following: PsychInfo, GoogleScholar, Scopus and Web of Science. Inclusion criteria were articles that included discussion of culture or ethnicity in relation to mental health and treatment seeking. Exclusion criterion included articles that focused on adolescents and young people as well as indigenous peoples. A specific focus was placed on articles that were related to the provision of treatment for addictive disorders; however, due to the relatively small number of articles in this area, articles that focused on other mental health disorders were also included as relevant. Emphasis was also placed on articles published since 2006. The initial review was conducted December 2015 to January 2016 and updated in July 2016.

This review attempts to cover the complexities of culture; however, for the sake of brevity and due to the lack of empirical evidence of nuances, simplifications are often used. As such, caution is necessary when generalising results presented to wider populations.

IMPACT OF CULTURE ON ADDICTIONS

Epidemiological studies have demonstrated that prevalence rates of many addictive disorders differ across ethnic groups. Non-Caucasian ethnicity, speaking a language other than English, and immigrant status has been found across international studies to be a risk factor for gambling-related harm (Clarke *et al.*, 2006; Dowling, Jackson, Thomas, & Frydenberg, 2010; Gainsbury, Hing, & Suhonen, 2014; Raylu & Oei, 2004; Rossen, 2015; Wardle *et al.*, 2011; Welte, Barnes, Tidwell, & Hoffman, 2011). In the USA, epidemiological trends suggest that substance abuse among Latinas/Latinos has increased in recent years (Substance Abuse and Mental Health Services Administration, 2011). Native Americans are at higher risk of alcohol dependence than other racial/ethnic groups (Esser *et al.*, 2014), and Black and Hispanic populations are more likely to report having a lifetime diagnosis of alcohol use disorder and substance use disorder (Burnett-Zeigler, Bohnert, & Ilgen, 2013). Onset risk for alcohol dependence has also been identified for younger minority men suggesting that age and gender play a role in mediating the impact of ethnic differences (Grant *et al.*, 2012).

In addition to higher rates of addiction problems among some CALD communities, there are also cultural disparities in seeking help and completing treatment for addictions. CALD gamblers and their family members are reportedly often reluctant to seek help outside their family network due to suspicion of mainstream services, shame and 'loss of face', language barriers, concerns about trust and confidentiality, suspicion of and a lack of understanding about mainstream services and a lack of culturally appropriate services (Feldman, Radermacher, Anderson, & Dickins, 2014; Gainsbury *et al.*, 2014; McMillen *et al.*, 2004). Similarly, members of racial and ethnic minority groups are more likely than Whites to experience difficulty entering and remaining in alcohol and drug treatment (Guerrero, 2013; Saloner & Lê Cook, 2013). A commonly identified barrier to treatment across CALD groups and disorders is a lack of culturally appropriate treatment to meet the needs of these populations.

As CALD groups are increasing within increasingly heterogeneous populations, there are substantial benefits to developing therapeutic interventions capable of addressing their needs (Muñoz & Mendelson, 2005). The provision of culturally and linguistically specific services is highly important to increase the likelihood of people from CALD communities seeking help for addictions. Although evidence is growing to support the best practice for treatment, questions regarding their relevance and efficacy among CALD clients remain (Hwang *et al.*, 2008). These concerns are particularly acute given the shifting demographics of communities as diversity is increasing in many countries and increasing evidence of the need for addiction treatment services within CALD communities.

CULTURAL COMPETENCE IN THEORY

Culture is a heterogeneous construct that is defined and operationalised in multiple ways (Small, Harding, & Lamont, 2010). Le and colleagues describe culture as 'a dynamic phenomenon' that 'represents ways of living that have been developed by a group of people to meet their biological, psychological, and emotional needs' (Le *et al.*, 2008, p. 164). Hays (2001) refers to cultural identity as a multidimensional construct informed by an individual's gender, age, religion, ethnicity, race, socioeconomic status, sexual orientation, national origin, heritage and disability status. The concept of culture is complex and changes over time and between generations and within social contexts (Finno-Velasquez, Shuey, Kotake, & Miller, 2015).

According to Jacob and Kuruvilla (2012), cultural competence in therapy has become an explicit goal. In theory, culturally competent health care services should benefit clients with diverse cultural assumptions, expectations and life routines as well as address health disparities (Weisner & Hay, 2015). Cultural competence in clinicians should improve their ability to build rapport and positive rapport is associated with better client outcomes (Beach, Saha, & Cooper, 2006). Cultural competence models of therapy assume that treatments must be compatible with a client's cultural needs and therapists must have an awareness of cultural and apply this knowledge to effectively achieve optimal outcomes (Betancourt, Green, Carrillo, & Ananeh-Firempong, 2003; Huey, Tilley, Jones, & Smith, 2014; Lakes, López, & Garro, 2006; Whaley & Davis, 2007). However, the literature lacks consistent definitions and recommendations for how to operationalise and evaluate culturally competent therapy (Huey *et al.*, 2014). Considering the sociocultural context is important for clinicians working with CALD clients to maximise outcomes (Bernal & Scharró-del-Río, 2001; Hall, 2001).

There are several models of cultural competency; skills-based models emphasise the provider's cultural self-awareness and knowledge of other cultures and ability to recognise how different beliefs and attitudes impact the therapeutic relationship (Sue *et al.*, 1982). Culturally competent therapists are mindful of their own biases and are able to understand client's worldview and intervene in an appropriate manner (Sue, Arredondo, & McDavis, 1992). One controlled outcome study found mixed levels of effectiveness for this model whereby staff trained in cultural sensitivity issues showed superior effects in the treatment of depression in black youths, but not Latino or white youths (Ngo *et al.*, 2009).

Adaptation models involve systematic modifications to service delivery, therapeutic process or treatment components to make interventions more congruent with client's cultural beliefs, attitudes or behaviours (Bernal, Jiménez-Chafey, & Domenech Rodríguez, 2009; Huey *et al.*, 2014). Existing interventions can be adapted in terms of language, people, metaphors, content, concepts, goals, methods and context. Modifications can be made at a surface (e.g., developing materials in client's native language) or deep (e.g., integrating traditional healing practices) level. Lau (2006) proposes that cultural adaptations be made selectively and only where there is evidence of a poor cultural fit with existing evidence-based therapies. In one trial of an adaptation model, Chinese immigrant families who received a culturally adapted intervention for physical discipline showed greater gains in parental involvement, discipline and child behaviour (Lau *et al.*, 2011).

Finally, in contrast to the above models that emphasise therapist and treatment characteristics, process-oriented models focus on the dynamic mechanisms underlying treatment, such as client–therapist interactions, and consider the cultural meaning ascribed to treatment contexts and specific behaviours (Huey *et al.*, 2014). That is, the focus is on how the client's culture impacts their understanding of treatment, as opposed to the view of the therapist. The clinician aims to understand the client's cultural perspective and integrate this with their own perspective, thus capturing the nuances of culture within specific ethnic groups (López, 1997). As an example, in a trial of methadone maintenance treatment for opiate addiction, a visual mapping tool was used to pictorially represent client's issues, which showed greater treatment retention and drug abstinence among ethnic minorities than for White people (Dansereau, Joe, Dees, & Simpson, 1996).

Although these models are discussed in the literature, there are very few controlled trials with clinical samples to test these (Huey *et al.*, 2014). Field trials are often conducted in a specific context with specific populations, limiting the extent to which results can be applied more broadly. Further, there is little data indicating whether clinicians can and do actually apply these models to their practice, and there is little evidence of model specificity (Huey *et al.*, 2014). The lack of rigorous tests and supporting evidence limits the validity of any particular model of cultural competence. As such, there are no specific hypotheses about the expected effects of the theories and models on treatment within individual cultural groups, including treatment of addictive disorders.

CULTURAL COMPETENCE IN PRACTICE

Many recommendations have been made with regards to increasing effective mental health treatment outcomes when working with CALD clients. It is important that clinicians understand a client's cultural background and identity and its impact on mental issues (Alarcón *et al.*, 2009). Culture can have a powerful impact on the triggers of issues as well as levels of symptom severity. Cultural

factors may impact the expression of clinical symptoms as well as an individual's response to these. Many important elements of culture can be assessed as part of a well-structured clinical interview, which would enable clinicians to understand how culture may impact treatment (Alarcón *et al.*, 2009). Specifics about language, religion or spirituality, gender, traditions and beliefs should be assessed. However, although the Australian Psychological Society (APS; Khawaka, 2011) and American Psychological Association (2003) maintain that therapists must provide culturally sensitive services, cultural factors are generally not considered as part of psychiatric diagnostic practice (Alarcón *et al.*, 2009).

Clinicians are one of the primary sources of racial/ethnic disparities in mental health treatment outcome (Hayes, Owen, & Bieschke, 2015; Imel *et al.*, 2011; Larrison, Schoppelrey, Hack-Ritzo, & Korr, 2011; Owen, Imel, Adelson, & Rodolfa, 2012). Owen *et al.* (2015) argue that racial/ethnic disparities emerge mainly when differential outcomes between CALD and mainstream clients within therapist caseloads are examined. For example, Imel *et al.* (2011) found that variability in client's reduction of cannabis abuse was related to cultural factors of clients within therapist caseloads; i.e, the clinicians had better outcomes with CALD than mainstream clients, or the opposite. Hayes *et al.* (2015) analysed a sufficiently large sample and found that client distress was not influenced by counsellor ethnicity, gender, age, professional position, education or experience. To date, no clinician-level variables have been identified that influence outcome disparities between clients.

Therapists need to take a culturally humble approach with clients, by being curious, non-assuming, open and respectful of client's cultural identities (Hook *et al.*, 2013; Owen, 2013). Services need to be friendly and welcoming to CALD clients, and clinicians must have an open and non-judgemental attitude before service provision for CALD communities can be successful (Reid, Crofts, & Beyer, 2001). For example, Arab clients who present as dependent, indecisive or nonverbally emotional may be labelled as resistant because they do not exhibit behaviours valued by mainstream society (Nassar-McMillan & Hakim-Larson, 2003). In practice, this would see clinicians assessing for cultural markers during therapy and creating opportunities to discuss these and bring them into treatment as relevant. It is important that counsellors avoid assumptions, but instead form hypotheses about the potentially culturally based behaviour or statement a client may mean and then verify these, e.g., by asking the client to explain, consulting with family members or reviewing the case with informed colleagues (López & Hernandez, 1987).

Seeking information about family is also important, which may include the wider family and community for some CALD clients, as well as help-seeking patterns and the involvement of families in the development and maintenance of problems (e.g., through familial gambling habits and provision of money to continue gambling) as well as the help-seeking process (whether family members are supportive or not). It has been suggested that family ties among CALD youth are often fundamental reasons to either comply with treatment or to drop out of treatment (Martin & Zweben, 1993). Fong and Tsuang (2007) suggest that working with families separately, even before the client is ready to attend treatment, may help reduce enabling behaviours and negative emotions towards the client while increasing understanding of the family. The influence of culture on the experience of addiction and reaction to problems must be considered as an important part of the treatment narrative. The client's strengths and weaknesses are likely influenced by cultural factors, including acceptance of problems, goals for treatment outcomes, coping styles, familial and community support and the environment for overcoming addiction problems (White & Sanders, 2008).

In all counselling relationships, building trust and rapport is important. This may be particularly so when there are cultural differences between clinicians and clients. For example, some CALD clients may believe that therapists harbour racist attitudes towards them or that they will not understand their backgrounds and experiences (Finn, 1994). Finn (1994) recommends building trust by disclosing personal information as appropriate, such as experience with CALD clients, matching the client's in some respects, e.g., in the manner of expressing emotions, and explaining in detail about how confidentiality will be maintained in therapy. Using a direct communication style or visual cues may be an effective way to communicate with some clients. Confrontational counselling styles may not work well with some clients, while some clients may benefit from greater direction or practical advice. Being aware of the impact of difference communication styles is important to be sensitive to clients' ability and wiliness to discuss their emotions. Nassar-McMillan and Hakim-Larson (2003) discussed how clinicians working with Arab and Chaldean Americans sometimes conducted home visits and personalised their relationships as a means of developing rapport.

Some clinicians make the decision not to address differences in culture as they do not believe this is important and treat all clients equally or are concerned that this may heighten awareness of differences (Bell, 2002). However, if clinicians fail to address relevant cultural issues the treatment may not be effective. Openly acknowledging, querying and addressing cultural issues can resolve these in a way that reduces any barriers to recovery. For example, Sue and Sue (1990) recommend discussing clients' expectations for therapy and the recovery process, what barriers may exist, supporting factors and potential barriers related to cultural and familial factors, issues

around cultural identity and the role of the wider community to may be associated with addiction and recovery. Throughout the therapeutic process, it is important for clinicians to be mindful of the client's own understanding and attitudes about treatment (Khawaka, 2011). Towards the conclusion of therapy, it is important to be mindful of cultural factors that may represent potential stressors or supports for clients in maintaining treatment gains and avoiding relapse.

INTEGRATING CULTURAL CONTEXT INTO EVIDENCE-BASED CARE

Based on a review of the efficacy of cultural competence in therapy, Huey *et al.* (2014) suggest four possible options for addressing cultural issues, which are summarised in Table 1. These approaches highlight the benefits and potential drawbacks from various models of cultural tailoring. There is no optimal approach for services because of the differences between these. Consideration is also needed for treatment fit within the wider service system, including availability of funding, time for training and appropriate trainers and locations, the range of clients seen within each service and by individual therapists, type of disorder being treated and type of treatment being provided. In addition to empirical support for efficacy, feasibility is an important consideration. Therefore, approaches that offer a more flexible method may be preferable in many treatment contexts. Approaches that require considerable training, complex protocols, extensive monitoring, substantial costs and are applicable to a narrow client demographic are less likely to be adopted and provide an appropriate level of care for a diverse population (Huey *et al.*, 2014). Inexpensive, easy to adopt protocols that maximise benefits should be considered. As culture is a very broad concept and there are many different cultural groups to consider, cultural competence training may be either overly complex or lacking sufficient specificity to be effective. On-job training for those working with specific CALD populations may be more effective by limiting training to the cultural groups and presenting problems most likely to be seen in treatment.

EVIDENCE FOR THE EFFECTIVENESS OF CULTURAL COMPETENCE IN ADDICTION TREATMENT

Reviews indicate that psychotherapy is generally effective with CALD youth and adults (Bernal *et al.*, 2009; Ho, McCabe, Yeh, & Lau, 2011; Horrell, 2008; Huey & Polo, 2008). There appear to be benefits of cultural tailoring of treatment, such that ethnic minorities have favourable outcomes when compared with conventional control groups (Huey *et al.*, 2014). Minority-focused therapies appear to be effective across a broad range of

Table 1. Possible approaches to integrating cultural context into evidence-based care (adapted from Huey *et al.*, 2014)

Strategy	Possible advantages	Possible disadvantages
Adopt cultural elements only when embedded within an existing evidence-based treatment protocol	Cultural elements already vetted	Constrains clinician to adopt specific cultural elements Within-group heterogeneity may not be considered Some elements may not make sense for CALD groups not included in validation studies
Adopt a well-specified empirically based cultural adaptation model	Several models have good support	New adaptations may be required for each client demographic encountered Cultural knowledge with current research may be necessary
Adopt an empirically supported skills-based or process-oriented cultural competence model	Flexible Several models have good empirical support	Requires specific training in that model
Individualise treatment to match the client or CALD population	Maximum flexibility Most consistent with current practice Many treatment models and evidence-based treatments claim to facilitate this already	Unstructured emphasis on cultural elements could distract from core treatment Evidence for treatment individualisation is mixed

mental health problems including anxiety, depression, externalising problems, schizophrenia, substance use problems, smoking, trauma and other issues (Huey *et al.*, 2014). In a review of 23 Latino outcome studies published between 1999 and 2005, the majority of culturally tailored studies reported positive outcomes associated with measures of health, substance abuse and mental health (Jani, Ortiz, & Aranda, 2009). Studies have also suggested that culturally sensitive interventions can improve engagement and retention of CALD youth and their families (Kumpfer, Alvarado, Smith, & Bellamy, 2002).

Culturally-tailored psychosocial interventions appear to attract CALD clients into treatment, keep them involved in therapeutic activities, improve the client-therapist relationship and prevent premature treatment termination. Evidence from the few trials that involve treatment-as-usual or placebo controls shows that minority-focussed treatments are effective at reducing clinical symptoms at post-treatment and improving treatment engagement (Huey *et al.*, 2014). Reviews of research suggest that CALD clients are more likely to remain in treatment when the services are responsive to their needs (Guerrero & Andrews, 2011). Culturally competent practices such as matching clients with counsellors based on race/ethnicity and language have been linked with increased retention in health care, particularly when combined with other practices such as congruence with regional culture, socioeconomic status and/or belief systems (Sue *et al.*, 1992). However, the increasing diversity of communities and the many differences in social class, educational status, language and dialects suggests that strict matching is not practically possible (Jacob & Kuruvilla, 2012). Subsequently, all therapists should aim to be aware of local cultural groups including their worldviews and values as well as impact of culture on the experience of addiction problems. Cultural competence among staff has been linked to better communication, more accurate diagnosis, positive therapeutic alliance and higher client satisfaction (Brach & Fraserirector, 2000; Cross, Bazron, Dennis, & Issacs, 1998; González, Vega, & Tarraf, 2010; Saha, Taggart, Komaromy, & Bindman, 2000; Saha, Komaromy, Koepsell, & Bindman, 1999). This includes using ethnic matching and cross cultural training (Sue *et al.*, 1992; Wade & Bernstein, 1991).

Outpatient drug treatment managers in the USA reported that specific knowledge about CALD groups was more important for successful treatment than the actual race/ethnic background of the treatment staff (Guerrero & Andrews, 2011). Providing treatment in client's language and/or dialect was also rated as more important than matching clients and staff by race/ethnicity, a finding substantiated by Griner and Smith (2006) who found that matching clients with therapists who speak their native language also improves treatment outcomes. Similarly, treatment utilisation by Asian Americans increased substantially when bilingual and culturally appropriate personnel provide the treatment service (Zane & Kim, 1994).These are important findings as matching clients with staff based on race or ethnicity is one of the more common cultural competence practices found among treatment organisations. This may suggest that although race/ethnicity is not necessary to provide effective treatment, managers believe that matching clients and staff on these variables may be beneficial due to shared beliefs and experiences an in-depth knowledge of client's language, culture and background (Guerrero & Andrews, 2011).

Studies have found associations between therapist's cultural humility and counsellor's ability to attend to cultural opportunities within session and therapy outcomes, including changes in psychological distress and interpersonal functioning (Hook *et al.*, 2013; Owen et al., 2014). Owen *et al.* (2015) examined racial/ethnic comfort, i.e., observable levels of ease that clients with varying racial and ethnic backgrounds perceive their therapists to demonstrate when engaged in a range of therapeutic conversations. For example, calmly and openly discussing cultural identities and being positively engaged even when differences in personal values make this difficult. The results demonstrated that therapists differed in their retention rates with clients based on clients' racial/ethnic status. Therapists' racial/ethnic comfort was a meaningful predictor of therapists' variability in the association between clients' racial/ethnic status and termination status. These findings suggest that therapists who have greater comfort with CALD populations are better able to retain both mainstream and CALD clients. Similarly, treatment outcomes may improve when there is client–therapist congruence on therapeutic goals and metaphors that match client's worldview and beliefs as well as incorporating client's beliefs about symptoms, aetiology, consequence and appropriate treatment (Benish, Quintana, & Wampold, 2011).

The sustained recovery management (RM) model suggests that historical, political, economic and socio-cultural circumstances play an important role in the aetiology of addictions (White & Sanders, 2008). Integrating discussions about culture, including cultural pain such as trauma, migration and racism, can be used for catharsis and to enable healing and recovery (Green, 1995). For example, a drug treatment programme culturally tailored for African American women to increase culture-specific empowerment approaches reported more effective outcomes than generic treatment (Wechsberg, Lam, Zule, & Bobashev, 2004). This content was embedded as focus groups indicated that the women viewed drug dependence as a form of bondage, leading to the programme components to facilitate greater independence and feelings of personal power and teach control over behavioural choices.

Cultural tailoring aimed at a specific group appears to be more effective than tailoring targeting a mixed group

(Griner & Smith, 2006). Adapting an evidence-based treatment programme and converting it to fit the needs of a culturally specific environment has been demonstrated to be efficacious in addressing addictions in CALD communities. However, there are few adequately powered rigorous studies to support the use of cultural adaptation for addiction treatment. In one such study, Dansereau *et al.* (1996) found that using visual mapping within counselling led to greater treatment retention and drug abstinence than standard counselling, but only for ethnic minority addicts. Similarly, culturally-adapted one-session treatment was found the be more effective than standard one-session treatment at reducing phobic symptoms among Asian Americans, particularly less-acculturated clients (Pan, Huey, & Hernandez, 2011). Therapists used motivational interviewing strategies to help clients establish and accomplish treatment goals. It was important for clinicians to address the issue of resistance to seeking addiction treatment. Follow-up with clients after 6 months of being admitted to the programme found that clients demonstrated improvement in use of alcohol or illegal drugs and other life areas indicating improved overall wellbeing and functioning.

INVOLVING THE FAMILY IN CULTURALLY COMPETENT TREATMENT

Integrating a client's wider community and family into the treatment and recovery process is one way that therapy can be adapted for CALD populations, given the importance of family relationships for some CALD communities. Familial relationships can impact therapy in many ways, e.g., family loyalty or cohesion may inhibit clients from discussing family problems with counsellors. There may be distinct and rigid roles for family members and family members can be very influential in clients' decision making. For example, interviews with recovered problem gamblers demonstrated the critical role that significant others can play in supporting the gambler to get professional help, and to effectively use self-help strategies to better control their gambling (Hing, Nuske, & Gainsbury, 2012). The interviews with the family members of these recovered gamblers also showed how attending treatment with the gambler can assist significant others to provide the most helpful kind of support. However, some CALD participants reported the opposite effects, where families extending funds to the gambler appeared to exacerbate the gambling problem, lead to more widespread harm, and delay professional help-seeking and use of self-help measures. This highlights the need to involve families in treatment or address these issues to avoid behaviours and environments that may interfere with recovery.

Recovery management models allow for multiple pathways for long-term recovery, recognising differences between CALD communities. For example, clients from abstinence-based cultures and religions may have different treatment goals from clients whose cultures embrace consumption of alcohol or gambling as an appropriate activity. RM models also emphasise the importance of involving family, communities and cultures more broadly in the change process to achieve long-term resolution of problems (White & Sanders, 2008). This is suited to the close family relationships within CALD communities, which RM models seek to use to provide support for individuals with addiction problems. Sustained recovery is anchored within the client's natural environment. In contrast, some models of addiction treatment assume that individuals have internal and external resources to sustain recovery and assume full social functioning following treatment. White and Sanders (2008) argue that these models are poorly suited to CALD clients who may not have achieved successful social functioning prior to their addiction problems and have few supports within their families and social networks.

Family therapy may be appropriate for some CALD clients (Finn, 1994). The emphasis on the family as a whole rather than a particular individual can minimise potential feelings of threat to power and authority, e.g., of male adults (Sue & Sue, 1990). The focus on concrete issues within the family may also help those from collectivist cultures. In cases where it is difficult to involve family members, treatment can also empower clients to bring about change within their families (one-person modality; Finn, 1994). In a study of Hispanic families with drug-abusing adolescents, both family counselling and one-person family counselling were effective in reducing substance abuse among clients and achieving and maintaining significant improvement in family functioning (Szapocznik, Kurtines, Santisteban, & Rio, 1990). Abudabbeh (2005) discussed that for some Arab Americans, couples therapy may be important and an accepted treatment method due to the strong motivation to maintain marriages as divorce is discouraged. However, they noted that due to feelings of shame with discussing personal issues outside of the family, family therapy may be more challenging for some individuals. It is essential that where family are involved in any way with an individual's therapy that the client provides clear authorization for this, and the privacy of the client is respected by the clinician.

INVOLVING THE WIDER COMMUNITY IN CULTURALLY COMPETENT TREATMENT

Involving community and religious institutions may assist some CALD clients to enter treatment and maintain their recovery progress. Integrating traditional indigenous

healing practices into Western treatment methods has been associated with increased effectiveness of addiction practices (Rowan *et al.*, 2014). An evaluation of a gender-specific addiction treatment programme in the USA found that a significant number of recovering and recovered African-American women were using the Black Church as their primary sobriety-based support structure, but did so only months after initiating their treatment due to issues of shame (White, Woll, & Webber, 2003). These findings suggest that involving the community may be utilised more for supporting recovery than initiating treatment. White and Sanders (2008) suggest that including non-traditional treatment providers in supporting roles for individuals dealing with addictions is a useful way to increase treatment success. Similarly, counsellors working with an Arab American population reported the importance of approaching mental health service delivery from a community perspective as obtaining support and endorsement of community leaders for the services would lead to a greater acceptance among community members (Nassar-McMillan & Hakim-Larson, 2003). The community leaders were recommended to be proactively involved and to help provide education about mental health and other services available to individuals and families. Local media were also sought out to promote acceptance of help services as well as religious leaders.

Translating a culturally appropriate screening instrument for substance abuse into different Asian languages greatly enhanced the applicability and efficacy of the intervention and helped screen large numbers of targeted communities within New York City (Yu *et al.*, 2009). Modifications made that may have increased the effectiveness of the intervention included implementing screening with culturally sensitive measures in informal as well as form settings when reaching out to the community and this helped educating potential clients about substance abuse (Yu *et al.*, 2009). Individuals who were screened were also given flyers in relevant language informing them of services available in their neighbourhood. Those conducting the screening intervention were trained to increase their cultural competence and were able to refer individuals to appropriate resources and treatment options.

However, it is important that community members supporting an individual's recovery have nonjudgmental attitudes, knowledge of the culture and demonstrated resourcefulness (Sue & Sue, 1990). Furthermore, although many CALD communities have a strong relationship with religious leaders, not all members of CALD communities are religious or spiritual, so integrating these elements into treatment approaches needs to be carried out with caution (Nassar-McMillan & Hakim-Larson, 2003). Counsellors in Arab American communities also cautioned that while involving the community in promoting treatment was useful, this also increased levels of confidentiality concerns (Nassar-McMillan & Hakim-Larson, 2003). That is, individuals may be more reluctant to share private information with someone they know is well connected within their community.

Treatment agencies may provide some training or information about addictions to relevant community members to increase their ability to effectively support those within their communities in formal and informal capacities. Peer-support services may also be established within CALD communities for people who have been through similar experiences to support each other. Interviews with Australian CALD gamblers suggested that peer-support programmes would be especially effective if they involved people from their own culture (Hing *et al.*, 2012). These stories can act as cautionary messages, develop understanding of the nature of gambling problems and their impacts, help destigmatise problem gambling and encourage and advise people on help-seeking. Further, this sharing of stories can have therapeutic benefits for the recovering problem gambler.

However, caution is needed when involving non-professionals in a recovery programme as these individuals may inadvertently offer advice that is unhelpful (e.g., by reinforcing irrational beliefs) or may be transient, leaving a gap in a person's recovery programme if they are no longer available (White & Sanders, 2008). Another concern is that individuals develop dependent relationships or poor coping habits if they rely on another person for their recovery. Ongoing engagement and relationships between involved community members and professional service should minimise these potential disadvantages of the RM model.

In addition to including the broader CALD community in supporting roles for people managing and recovering from addictions, community consultations may also assist with the development of culturally appropriate treatment strategies. Several culturally tailored programmes for drug abuse with demonstrated effectiveness for CALD populations were developed with feedback of the targeted communities, e.g., through focus groups (Newman Giger & Davidhizar, 2007).

ESTABLISHING CULTURAL COMPETENCY IN TREATMENT PROGRAMMES

A review of outpatient substance abuse treatment programmes in the USA examined the most commonly practiced cultural competence organisational practices (Guerrero & Andrews, 2011). The three major categories of organisation practices tended to be endorsed in tandem and included community services and cross-cultural training, racial/ethnic representation among treatment staff and diversity within management-level positions. These services were most likely to be endorsed by treatment managers. The most frequently adopted and endorsed

practices included involving community leaders and offering cross-cultural training for staff and the least prevalent practices was the employment of CALD individuals in management positions (Guerrero & Andrews, 2011). This likely reflects the greater ease of integrating cross-cultural training and community involvement into practices, while recruiting qualified CALD staff to management positions may be a challenge for many organisations (Howard, 2003a, 2003b). This is an important area for practices to focus on as research suggests that CALD leadership can improve implementation of culturally competent practices (Guerrero, 2013; Harper *et al.*, 2006). Furthermore, the proportion of CALD staff was relatively low, suggesting that further efforts may be required to recruit CALD trained staff into treatment practices.

Out of all the organisational variables assessed in outpatient substance abuse treatment programmes in the USA, only the measure of practice manager's culturally sensitive beliefs significantly predicted average wait time and retention; i.e., manager's culturally sensitive beliefs were associated with decreased average wait time to substance abuse treatment entry and an increase in average retention (Guerrero & Andrews, 2011). This is consistent with studies suggesting that mangers can play a vital role in implementing and promoting culturally competent practices (Guerrero, 2013). It may be that managers who more strongly endorsed beliefs in the importance of culturally competent practices may be more committed to adopting and implementing these within their organisations (Guerrero & Andrews, 2011). Other practices and variables about treatment programmes did not significantly predict wait time or treatment retention for CALD clients (Guerrero & Andrews, 2011).

The location of treatment services is also important, because if they are located too far away from relevant populations, then clients may be less likely to attend (Fong & Tsuang, 2007). However, if they are located directly within a local, insular CALD community this may introduce concerns about shame, self-disclosure and loss of anonymity. Due to the greater acceptance of medical help rather than psychotherapy, CALD clients may be more willing to accept addiction screening and care from general practitioners than psychologists and counsellors (Fong & Tsuang, 2007; Hing *et al.*, 2012). However, most general practitioners are not specifically trained to provide assistance for addiction problems and may not recognise or screen these. CALD clients may expect physicians to come up with solutions at first presentation of problems, which is not consistent with how therapy and recovery for addictions work. Greater training for a broad range of health professionals about addictions, how to screen for these and make appropriate referrals or manage shared-care would enhance engagement of CALD populations with appropriate treatment resources, including self-help strategies.

CULTURAL COMPETENCE TRAINING

Increasing the number and capacity of CALD workers, along with the retention of those currently employed in addiction treatment services has been identified as vital for ensuring CALD clients' access to effective and appropriate treatment in other reviews (Robertson *et al.*, 2006). To achieve this goal, it has been recommended that efforts are needed to enhance education in the secondary and tertiary sector for the CALD community, including identifying career pathways and offering introductory level health and psychology courses (Robertson *et al.*, 2006). Supportive working environments are also vital, including support for ongoing training and normalisation of CALD frameworks, practices and values. Efforts may also be needed to increase the recruitment and retention of male counsellors, as a large number of gambling treatment service users are men, while the mental health workforce is often comprised largely of women.

Focus is also needed on therapist training to work with CALD populations. Training therapists in cultural competence and providing culturally tailored services resulted in more successful engagement of Asian clients in substance abuse treatment than mainstream services (Yu *et al.*, 2009). Cultural training generally is limited to a very small component of psychiatric training, although psychologists may undergo greater training and those working in predominately CALD populations may take further elective training (Alarcón *et al.*, 2009). In a study of psychiatrists in New Zealand, only 40% of the 247 surveyed believed that their training had prepared them to work effectively with Maori (Johnstone & Read, 2000). Although health professionals are taught to consider cultural factors, in practice in busy services, other than attention to language, little attention may be paid to these. Comfort in working with CALD clients is essential for successful treatment outcomes. For example, a study of one addiction treatment for African American clients found that staff failed to respect client's cultural values, which was in a large part responsible for high treatment dropout (Finn, 1994). Staff disagreed with clients that their church could support their recovery and instead directed them to 12-step programmes they did not feel met their needs. Staff were also upset at what they perceived as loud and confrontational manners of the clients, compared with the restrained style of most of their clients. Following specific training about the importance of cultural differences, many of these issues were addressed within the organisation.

In an analogue study, Gunter (2002) found that therapist trainees reported lower levels of comfort with CALD clients as compared with mainstream clients. This indicates that cultural competence is a skill that is both learned and practiced over time. Cultivating a sense of safety and working with ease and calm with all clients is likely

to have benefits for retaining clients, e.g., by dispelling cultural trust beliefs. Owen *et al.* (2015) also suggest that cultural comfort is likely to be enhanced over time and with increased exposure to CALD clients. They highlight the need for therapists to be comfortable in culturally uncomfortable settings. For example, if a client has different beliefs about women's rights to a therapist. Therapists need to be able to fluidly engage with clients who express a range of worldviews or behaviours (Owen, 2013). Comfort may be cultivated as clinicians develop awareness of their own identities and biases (Owen *et al.*, 2015). Given the importance of increasing the capacity of CALD treatment providers, training and education programmes also need to be compatible with cultural practices (Robertson *et al.*, 2006). It is also important to consider the overlap between clinical and cultural competence and organisation development (Robertson *et al.*, 2006). It may be desirable and economical to have fewer workers with a broad range of cultural competence; however, it may be more feasible to have a larger team with complementary expertise.

POTENTIAL DISADVANTAGES OF CULTURAL TAILORING

Despite positive indications, it is unclear whether culturally adapted interventions are always more efficacious than unadapted interventions. The limited evidence suggests that some role for cultural competence is warranted in treatment as cultural tailoring may increase session attendance and treatment retention among CALD populations (Huey *et al.*, 2014). However, mainstream treatment strategies can also be effective with CALD clients. Studies and reviews of cultural competence training intervention programmes generally across mental health treatment show no conclusive impact on provider behaviours and attitudes or client health outcomes (Beach *et al.*, 2006; Huey *et al.*, 2014; Lie *et al.*, 2011; Price *et al.*, 2005; Thom, Tirado, Woon, & McBride, 2006; Wilson, Lipsey, & Soydan, 2003). A meta-analysis of culturally tailored compared with generic treatments found that tailoring effects were negative nearly as often as they were positive (Huey *et al.*, 2014). It was concluded that cultural tailoring can be efficacious, but 'support for cultural competence as a useful supplement to standard treatment remains equivocal at best' (Huey *et al.*, 2014, p. 305).

Despite these counter indications for cultural tailoring, based on the previous evidence presented, there remain important benefits from these considerations. It is possible that many of the addiction treatment programmes considered in the current review were excluded from previous systematic reviews (Huey *et al.*, 2014) due to a lack of research rigour or other exclusion criteria. Huey *et al.* (2014) notes that existing reviews address only a fraction of the total number of treatment outcome studies that target ethnic minorities, e.g., due to insufficient information for effect size calculation or lack of appropriate control group or randomised design. Thus, the lack of research to appropriately isolate and identify the impact of cultural competence within treatment may account for the failure to recognise the benefits of this within systematic reviews. Many treatment programmes are culturally neutral, i.e., effective therapy generally considers the best fit with a client's background, beliefs, attitudes and sociocultural context (Jacob & Kuruvilla, 2012). For example, motivational interviewing, commonly used in addiction therapy, is culturally sensitive by nature as it is person centred and nonjudgmental, mindful of the client's own assumptions and experiences and based on the client's own beliefs and goals (Miller & Rollnick, 2012). Nonetheless, when addiction treatments are considered separately from other mental health issues, ethnic disparities were more apparent; One meta-analyses of substance use treatment ($n = 12$) found that 33% showed no ethnicity effects, 25% showed superior outcomes for whites and 42% reported better outcomes for ethnic minorities (Huey *et al.*, 2014). This provides support for continued focus on developing CALD-specific addiction treatments.

It has been argued that excessive and unstructured focus on cultural adaptations could lead to inefficiencies in the conduct of treatment (Castro & Alarcón, 2002; Kumpfer *et al.*, 2002). In one example, violence-exposed African-American youth used enhanced expressive writing to describe their experiences with their peer based on the African-American cultural oral traditions and focus on the spoken word (Kliewer *et al.*, 2011). The enhanced writing was significantly less effective than standard writing at reducing aggression, and the authors speculated that youths may have focused more on the creativity than processing their thoughts and feelings. Epstein (2007) argues that policies which are justified using racial and ethnic health disparities may end up precluding direct attention to reducing inequalities by focusing on individuals and cultural differences. Shaw and Armin (2011) similarly caution that focusing on individual cultural factors may take the attention away from systemic issues that are causing greater levels of problems among CALD communities. For example, focusing on CALD treatment options, rather than preventing problems from developing by increasing healthy ways of integrating new immigrants into the community.

A further issue for consideration is the potential pitfall of stereotyping. Although cultural groups often share similar values, beliefs and behaviours, the cultural traits attributed to clients can at best be generalisations and if used without caution could alienate the client and compromise treatment effectiveness (Finn, 1994). Issues such as acculturation, gender, birth order, education, immigration and family values produce notable differences within CALD populations. Factors other than culture may also

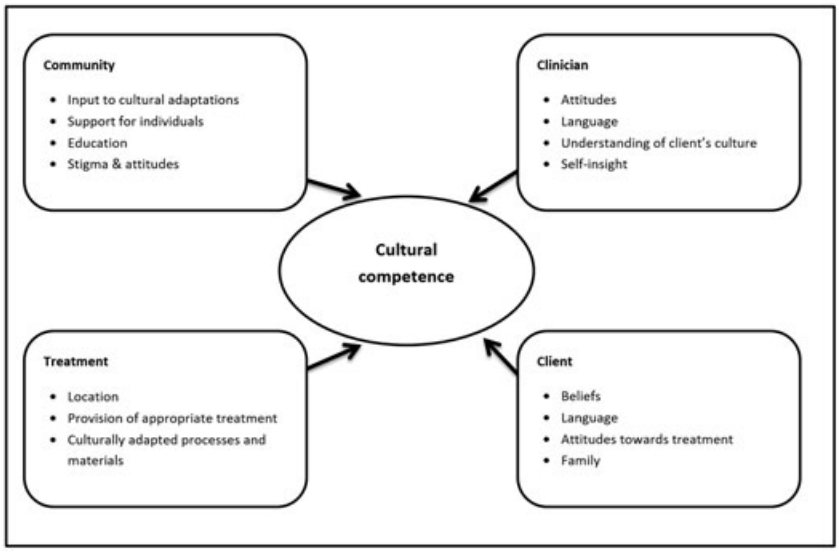

Figure 1. Factors that impact cultural competence in therapy

play a large role in client's response to alcohol, drugs and gambling and the development of addictions, which may be confounded with culture, or presumed to be culturally-based. It is also important that cultural factors that may increase a client's risk of addictions not be used as an excuse. For example, while a client may have experienced trauma and discrimination, it is important that they do not use this as an excuse for avoiding treatment or engaging in behaviours that threaten recovery (Finn, 1994).

Acculturation and generational differences can impact addiction treatment, e.g., when intergenerational conflict causes stress that leads individuals to engage in risky behaviours (Finn, 1994). For example, adolescents and second-generation and third-generation immigrants appear to be at greater risk of gambling problems than first generation immigrants in some CALD communities (Pumariega, Rothe, & Pumariega, 2005; Wilson, Salas-Wright, Vaughn, & Maynard, 2015). Adolescents may want to adopt behaviours they perceive to be part of mainstream society and may test boundaries by acting against traditional cultural values. Consideration of culture rather than cultural tailoring of treatment may be more effective for some clients. For clients who are influenced by traditional cultural backgrounds and western society, cultural tailoring can introduce a source of conflict (Finn, 1994). Tailoring may elicit negative reactions in some CALD clients who may prefer to receive generic treatments (Huey *et al.*, 2014).

LIMITATIONS

This literature review addresses an important issue that has received far too little rigorous research attention. Notwithstanding the significance of the topic, the review is not without limitations. The review was not systematically conducted, but rather employed a rapid evidence review methodology. It focused on articles about treatment for addictions but also included treatment for other mental health issues that included relevant findings regarding cultural competence. The literature is in part limited by the few studies of cultural competence with rigorous methodology, meaning that there is little strong empirical evidence on which to draw. Due to the breadth of the literature included, the review has simplified some issues and findings and made some generalisations. It is important that in practice clinicians are aware of the many differences between cultural groups and the importance of understanding clients as unique individuals. It is hoped that this discussion could serve to increase attention to the issue of cultural competence within clinical services and subsequent efforts to incorporate relevant theories into practice.

CONCLUSIONS

Despite the lack of support from systematic reviews, the research reviewed here clearly shows benefits resulting from cultural competence in addiction treatment programmes. The factors that can impact cultural competence within treatment have been outlined in Figure 1. Although research has increasingly focused on cultural tailoring for therapy to increase effective outcomes among CALD populations, there are many limitations to the available evidence. Most literature focuses on trials conducted in the USA targeting African-Americans, Latinos and Asian-Americas as well as Native Americans.

More research is needed internationally to consider broader cultural groups and acculturation issues. Furthermore, there is little evidence on the most effective treatment components and impacts on distinct CALD populations. Further research is needed to understand the effects of culturally tailoring and determine what components are effective and for which CALD groups. There is a dearth of research and information about the level, nature and impact of cultural competence training for mental health workers, including those working in the addiction field. Further focus on training and outcomes is essential to advance the provision of effective treatment for CALD populations.

In addition to the positive impacts for individuals, families and the community if addictions are properly treated in CALD populations, there are significant economic benefits for doing so. Although research is limited, there is evidence that culturally sensitive treatments are cost effective and result in greater client outcomes (Flores, 2005; Ku & Freilich, 2001). For example, a review of culturally tailored treatment found that interpreter services positively affect preventative screening rates and result in more office visits and prescriptions being written and filled, while clients limited in English proficiency without interpreters or with ad hoc interpreters have more medical tests, higher test costs and a higher risk of hospitalisation (Flores, 2005). Research is needed to quantify the cost of failing to treat addictions in CALD populations and investigate the cost-effectiveness of investments to improve services and outcomes.

In addition to encouraging further research into appropriate addictions treatment for CALD populations, more CALD individuals should undergo training and be brought into the research and clinical communities. This will facilitate the ongoing translation of cultural competence into the development of treatment practices. This may also increase the likelihood of relevant participants being involved in treatment and research programmes due to a greater perceived relevance and legitimacy. The ultimate aim is to enhance successful addiction treatment outcomes among CALD populations. This requires consideration of treatment aims for the specific populations, which may include impact on families and the wider community as well as individuals in treatment. Importantly, rigorous research is required to demonstrate the efficacy of CALD specific treatment to ensure that efforts to tailor treatment are useful as opposed to mainstream treatment. Ongoing evaluation is important to guide the further development of addiction treatment and prevention initiatives.

ACKNOWLEDGEMENT

This literature review was completed on behalf of circa (Cultural and Indigenous Research Centre Australia) to guide a Review of the In-Language Gambler's Help Services. Feedback and comments provided to guide the review from circa are greatly appreciated.

ROLE OF FUNDING SOURCES

Funding for this study was provided by the Victorian Responsible Gambling Foundation: 'Review of the In-Language Gambler's Help Services'. The VRGF had no role in the study design, collection, analysis or interpretation of the data, writing the manuscript or the decision to submit the paper for publication.

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