

# HISPANIC INITIATIVE

## Dialogue on Science and Addiction



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*The Addiction Technology Transfer Center Network*

*Funded by Substance Abuse and Mental Health Services Administration*

*A Center of the Institute of Research,  
Education and Services in Addiction*

# Acknowledgements

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### Produced in Collaboration with the Following Addiction Technology Centers:

Central East  
Great Lakes  
Gulf Coast  
Northeast  
Southern Coast  
Southeast  
Pacific Southwest

**Published in 2006 by the Caribbean Basin and Hispanic Addiction Technology Transfer Center (CBHATTC)**  
Universidad Central Del Caribe

PO Box 60-327 Bayamón, Puerto Rico 00960-6032

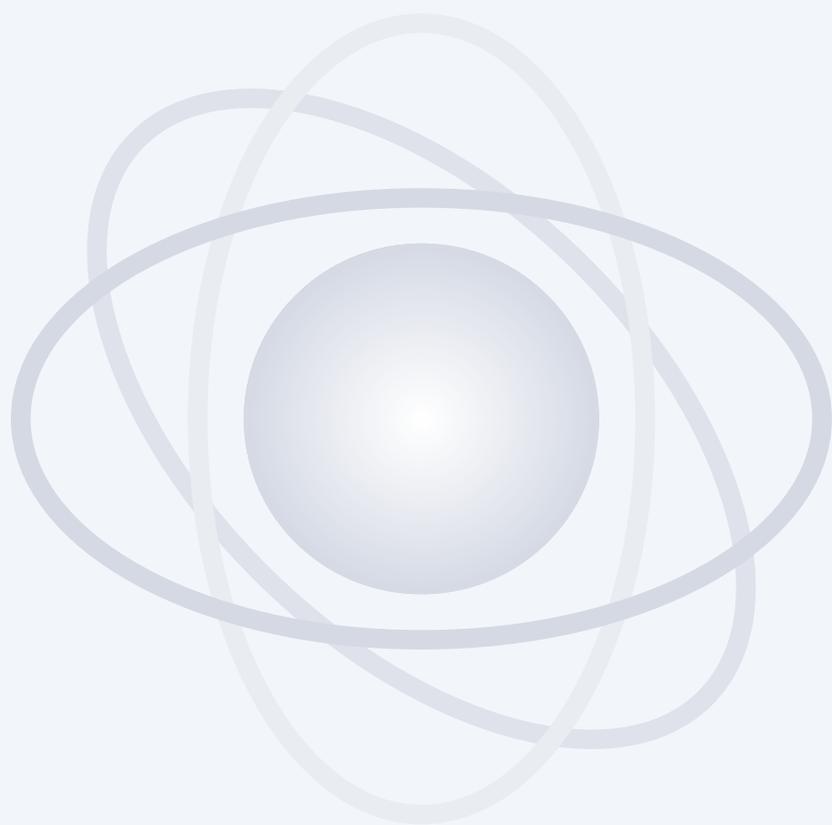
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At the time of this printing, Charles G. Curie, MA, ACSW, served as the SAMHSA Administrator. H. Westley Clark, MD, JD, MPH, served as the director of CSAT, and Cathy Nugent, MS, MS, LGPC served as the CSAT Project Officer.

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## INTRODUCTION

Hispanics/Latinos (H/L) now comprise the largest minority group in the United States. As a group they are young (e.g. 40% are under the age of 21), have a disproportionately low-income level (e.g. 23% live below the poverty line) and a low level of educational attainment (e.g. more than half of H/L under the age of 25 have not graduated from high school) (U.S. Census Bureau, 2003). Data from the U.S. Census Bureau show that in 2001 the growth rate for the H/L population was 4.7%, compared with 0.3% for whites and 1.5% for African Americans (U.S. Census Bureau, 2004). Yet, this growth rate has not been paralleled by the development of information and services that effectively reach H/L.

It is well known that the above characteristics of the H/L population portend increases in rates of drug use and abuse (Vega and Steven, 2001). While elements of the Hispanic culture, especially familism, have been associated with restraint from drug use among its members, it has been posited that those features of the Hispanic culture that restrain drug abuse among the immigrant population are weakened among H/L born in the United States (Vega, Sribney & Achara-Abrahams, 2003). Poverty, stressors, and losses sustained in the exodus from their home countries and entrance into the U.S., are all elements that influence drug-use trajectories among this population. These characteristics, which place the H/L population at risk of drug abuse, are worsened by the fact that H/L frequently depend on service models and information that may have succeeded with non-Hispanic populations but does not necessarily meet the needs or respond to the circumstances of H/L. This mismatch between the population's needs and the service models available results in:

- (a) Reduced access to and participation in drug treatment programs
- (b) Low retention rates in programs
- (c) Absence of effective community strategies to help diminish cultural barriers and promote the use of culturally-appropriate, science-based treatment models in drug use services to Hispanics/Latinos.

Consequently, this population has been hit disproportionately hard by the negative consequences of drug use behavior (e.g. HIV/AIDS), as well as other health problems. However little is known regarding the conditions and circumstances under which H/L drug-using individuals and their communities currently receive services (e.g. the science-based needs of the providers and the organizational structural processes and culture under which services are provided) (Alegria, et al., 2002).

The need has never been greater for transferring culturally-appropriate and science-based models, to help drug treatment providers and organizations serving H/L communities enhance their programs and address drug treatment and prevention needs. The proposed initiative aims to help drug-use-related health services organizations and providers address the drug-use-related problems of the Hispanic populations they serve.

### **The Initiative's goals are as follows:**

1. Assess the need for cultural and science-based information among providers serving H/L populations in selected sites in the U.S. mainland, the U.S. Virgin Islands, and Puerto Rico;
2. Address the needs based on the need assessment findings.

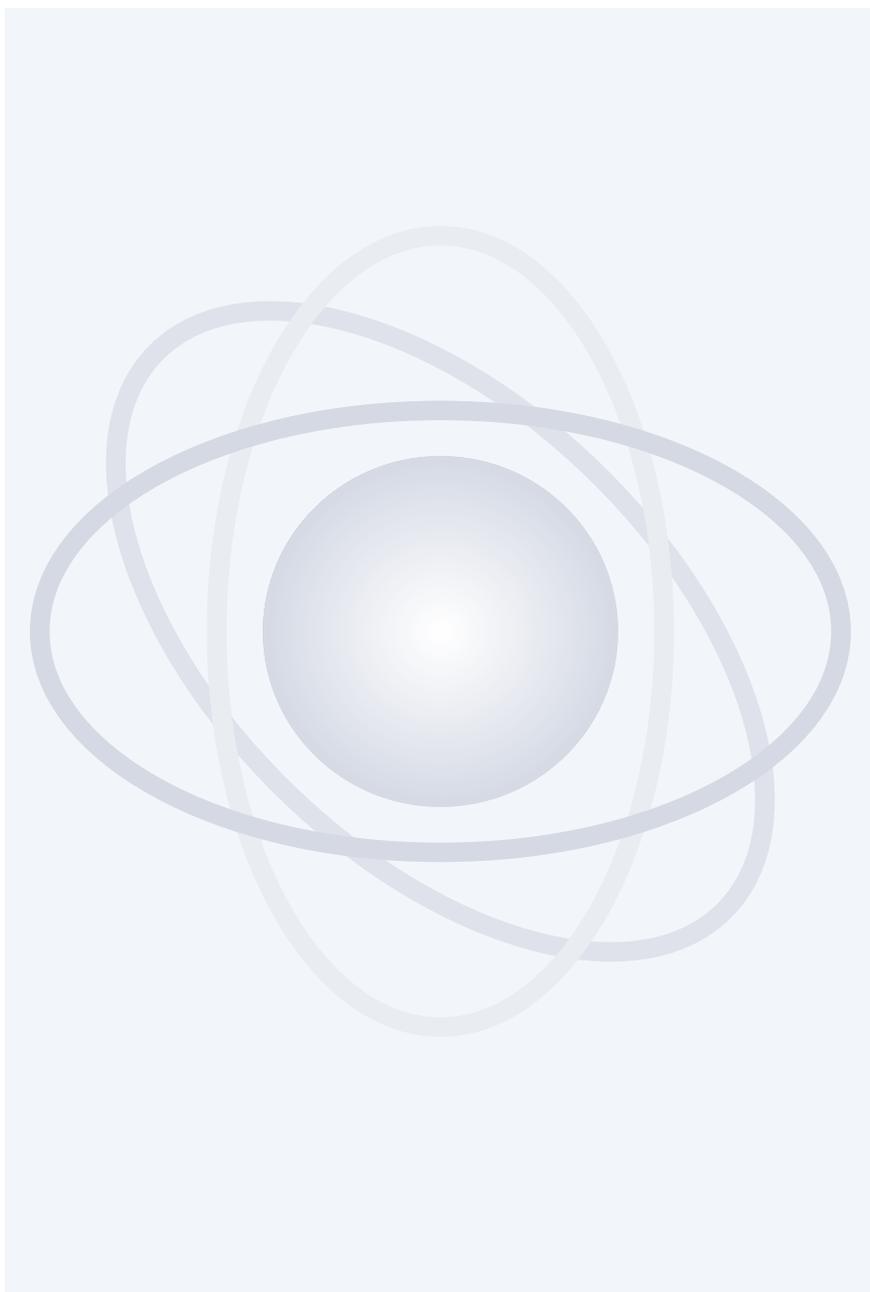
In 2005 pilot assessment of H/L subgroups, conducted through focus groups and individual interviews among providers of mental health and drug treatment services for H/L in California, New York, Puerto Rico, and the U.S. Virgin Islands, showed that H/L in the various sites, with different native origins (Mexican-American, Cuban, Puerto Rican), share similar basic needs for science-based information and guidance. The findings of this pilot assessment indicate that participants need more knowledge specifically about working with H/L families at levels of treatment and prevention; working with couples--particularly the role of gender relations in family violence; intergenerational problems; and acculturation.

### **Initiatives specific aims:**

1. To conduct a nationwide needs assessment to detect/determine the necessity for culturally-appropriate and science-based information for H/L providers.
2. To identify and document for dissemination, H/L cultural elements that need to be addressed in H/L prevention and treatment program to enhance access, continuity, and completion of goals

3. To search, document, and disseminate tested treatment and prevention protocols that have been proven effective among H/L.
4. To assess organizational priorities, motivation and readiness to engage in the initiative, and resources needed for organizations to begin fulfilling their responsibility to provide effective science- and culturally-based services for H/L.
5. To develop multiple strategies for dissemination of treatment protocols and other products, for its promotion in multiple geographic sites and H/L subgroups.
6. To produce a science-based and culturally appropriate program to help address the needs of H/L organizations and providers for culturally appropriate training and protocols (protocols assessment instruments) to enhance their programs.
7. To create and/or adapt culturally-appropriate, user-friendly needs assessments, surveys, and program evaluation instruments, to promote the use of these science-based strategies by organizations, in developing or expanding their programs serving H/L populations.
8. To prepare annotated bibliographies on specific themes relevant to the needs of the H/L population (e.g. family, trauma, how to address acculturation across generations).
9. To compile a contact list of experts, nationwide, who can be used as lecturers or for technical assistance regarding H/L cultural elements or culturally-appropriate and science-based treatment protocols.

10. To develop a source book of publications from different national centers (CSAT, CSAP, SAMHSA, NIDA) and private organizations, containing information related to drug use among H/L.
11. To evaluate the Initiative's activities using CSAT performance measures and other strategies to assess program effectiveness.



# METHODS

## Participants and Procedures

Data for this report was collected from seven focus groups conducted between January and April 2005 in seven cities representing the following ATTC regions: Southeast (Atlanta), Great Lakes (Chicago), Pacific Southwest (Los Angeles), Southern Coast (Miami), North East (New York), Gulf Coast (Texas) and Central East (Washington, DC). A total of 62 individuals attended these focus groups. Table 1 shows the distribution of participants by city.

**Table 1**

### Distribution of Participants by Center

ATTC Regions	Site	Date	No.	Percent
South East	Atlanta	2/18/2005	12	19.4
Great Lakes	Chicago	1/26/2005	9	14.5
Pacific Southwest	Los Angeles	2/14/2005	10	16.1
Southern Coast	Miami	2/23/2005	7	11.3
North East	New York	4/13/2005	11	17.7
Gulf Coast	Texas	1/28/2005	8	12.9
Central East	Washington	1/24/2005	5	8.1
		2/16/2005		
<b>Total</b>			62	100.0

Focus group participants were health providers of substance abuse prevention/treatment organizations with 33% of their clientele is from Hispanic/Latino (H/L) origin. Organizational profiles were developed for service organizations in each region to target potential candidates. The Executive Director or the Human

Resources Manager of each organization selected representatives of these organizations for the focus groups. Participants of the focus groups are not a probabilistic-representative sample of the population of substance abuse health providers in their respective organizations or their regions; however the targeted selection of the individuals helped to shape a set of groups that enabled researchers to explore topics of interest. Table 2 shows the profile of the participants to the focus groups.

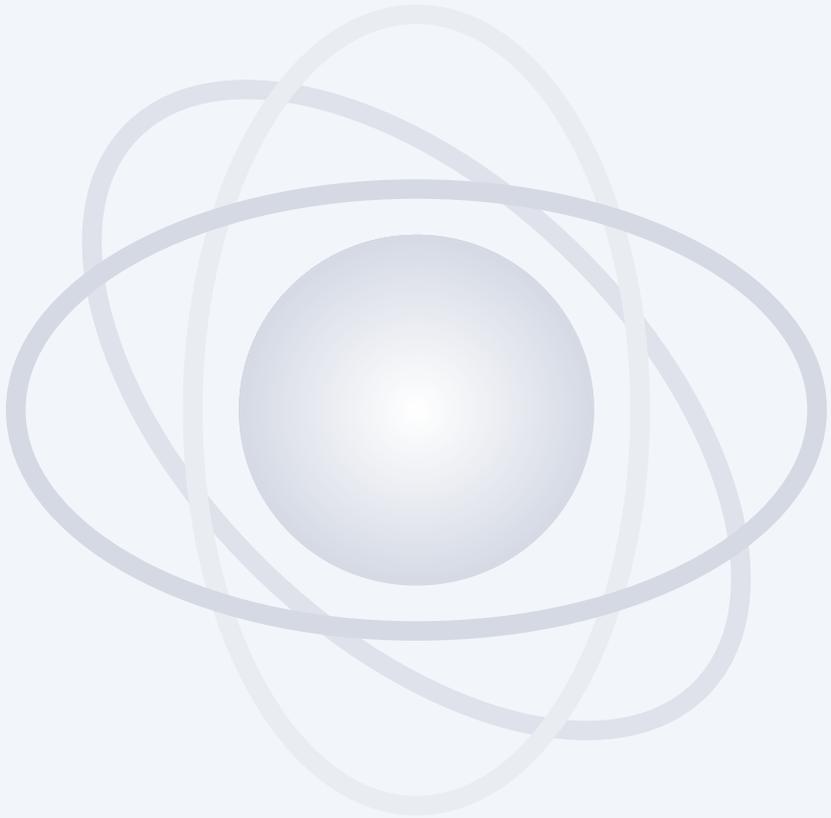
**Table 2**

**Demographic Profile of Participants**

Variable	Category	Frequency	Percent
Gender	Male	24	38.7
	Female	38	61.3
Hispanic/Latino	Yes	43	69.4
	No	19	30.6
Nationality	South American	9	20.9
	Central American	7	16.3
	Cuban	6	14.0
	Mexican	13	30.2
	Puerto Rican	8	18.6
Age Group	18-24	1	3.2
	25-34	2	6.5
	35-44	8	25.8
	45-54	16	51.6
	55+	4	12.9
Years of experience in the Substance Abuse Field	(Mean ± SD)	11.5±10.9	

Open-ended questions were asked to elicit responses about the training needs of substance abuse health providers serving H/L populations in the US. Inquiries also explored participants' ideas and opinions on strategies to deal with H/L cultural traits

that require being addressed in substance abuse prevention and treatment programs to enhance access and continuity. Focus group questions were reviewed by email and telephone correspondance with ATTC directors from all-participant regions to get their feedback regarding discussion topics and the proper language to be employed. To increase consistency and minimize bias in the process of conducting the focus groups an anthropologist working in collaboration with the CBHATTC served as moderator in all seven groups.



## Data analysis

All focus groups except one were conducted in English; the exception was conducted in Spanish. Group interviews were taped and transcribed verbatim. Transcriptions were assigned to three different coders. The narrative data was analyzed using a categorical-content approach (Lieblich, Tuval-Mashiach, & Zilber, 1998). This type of approach is recommended when the primary problem or phenomenon of interest is shared by a group of people. With this approach used in all interviews focus groups were treated as a single analytical unit. A code scheme was developed based on a detailed revision of the transcripts using an iterative and inductive process. The resulting book of unique codes with mutually exclusive definitions was developed following the model suggested by the CDC (MacQueen, McLellan, Kay, & Milstein, 1999) and separated utterances of the text were extracted, classified, and gathered into these categories/codes.

Coded transcripts were entered into the QSR NVivo qualitative software to generate summaries of individual codes. These summaries were analyzed to identify major themes and relationships among groups.

A first-level of analysis was performed by scrutinizing the distribution of codes by group. Codes were counted as they emerged within and across the groups. This analysis allowed the investigators to map the interviews in terms of research questions and to identify the recurrent themes in participants' descriptive accounts.

Based on a comprehensive scrutiny of the coded interviews, the first-level descriptive codes were grouped in two major thematic domains based on theme commonalities:

- (1) **Education issues**
- (2) **Training needs assessment**

The first thematic domain includes three sub-themes:

- **Educational materials**
- **Clients' educational issues**
- **Providers' educational issues**

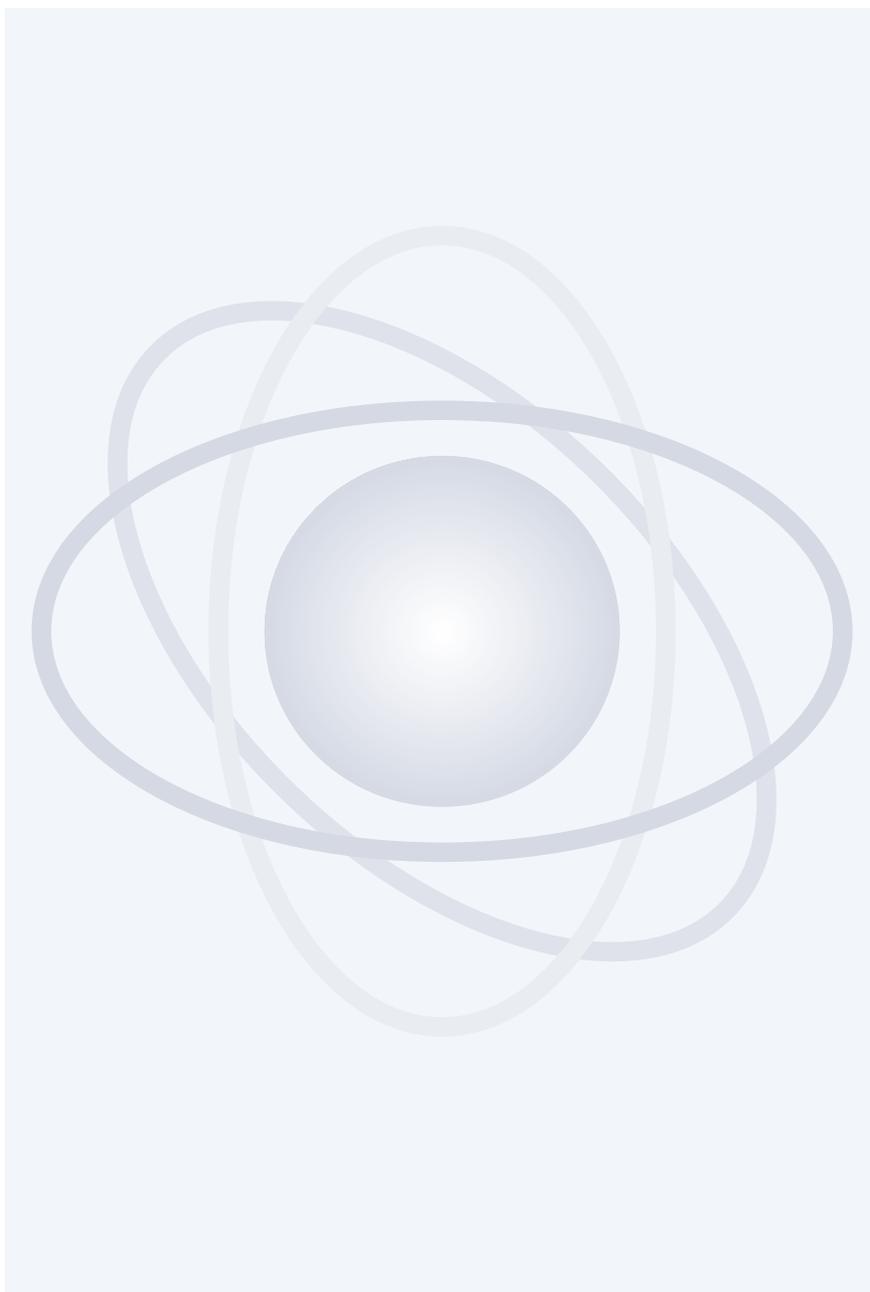
The second thematic also encompasses three sub-themes:

- **Training themes**
- **Training issues**
- **Training approaches**

This last sub-theme is divided in:

- **Culture-oriented approaches**
- **Culture of addition (individualistic orientation)**

These domains, however, are not entirely independent of each other since there is a great deal of thematic overlapping. Collapsing the first level codes into thematic domains reduces data but amplifies its meaning. These constructs summarize a large volume of information using a small number of categories.



## RESULTS AND DISCUSSION

Focus groups provide direct access to the language and concepts individuals use to structure their beliefs and ideas about a designated topic. Textual analysis of the responses permits us to identify relevant themes for each group. This provides a map for further elucidation of health providers' assessment of their own needs regarding culturally sensitive training. Qualitative analysis of each thematic category allows investigators to recognize commonalities and differences among groups that quantitative analysis cannot distinguish.

### **Educational Issues Domain**

Themes related to education amply dominated the conversations of all focus groups. Analysis of education subthemes showed a notable interrelation. In assessing their needs for developing a culturally sensitive approach to drug treatment, focus group participants displayed two different positions regarding the role of literacy and culture. On the one hand, participants pointed out that the development of educational materials for H/L clients needs to consider the educational level more than the cultural traits of the population. Participants reported that the literacy level of their clients tends to be quite low. This applies for both Spanish and English speakers. In some instances, participants reported beginning to see an influx of clients from Central America from indigenous origin that possess little or no command of English. Additionally, the vocabulary of the current materials is highly technical which makes it very difficult for clients to understand and for providers to transfer the information effectively. The following are two

passages that illustrate this discussion:

*About the information provided to participants, we just got a bunch of DMH books that educate participants on what drug use does, and what kinds of drugs they are using, and [unintelligible] on mental health illness. Half of my participants they were reading them and were totally out of the loop of what they were talking about. And I had to sit there and explain to them what they meant. I mean the language they use...is very technical. Even for educated people. Is very technical. So I think it needs to be little... you know, I know whoever wrote it maybe they have an ego thing, have a Ph.D. or have that but let me get dressed and put a tie on and here, you read it, and this is what's wrong with you. But they don't understanding it. So, you need to keep it in simple terms. (Los Angeles Focus Group)*

*For us one of the issues that we face is lack of materials that are elementary for our population to understand. Mostly our clients read or write in Spanish. Some never went to school or they only have up to third grade education. And some of the material that is out there, published by [unintelligible], some of the people, even by CSAT, it's very sophisticated Spanish. It's not elementary. So that's one of the things we're dealing with and trying to help these people with certain concepts about alcoholism as a disease, addiction as a disease. (Washington, DC Focus Group)*

Therefore, focus group participants suggested educational materials of more visual nature, that is, posters, instructional comic books or videos – soap-opera-like formats that provide a familiar medium to pose complex ideas by using life-like situations with appealing characters that can facilitate identification. There is

a perception among focus group participants that H/L learn by watching. Participants also emphasized that current educational materials, especially videos have to be updated so Hispanics clients can identify with the situations they depict. Videos and other materials generally portray middle-class Anglo-Americans, which severs any possibility of identity connection with H/L. They recommended using Hispanic celebrities or community leaders.

On the other hand, some participants argued that education materials have to be culturally sensitive, thus they need to address the cultural traits that distinguish H/L from other groups. Participants also brought to the discussion that educational materials should take into consideration the cultural hybridity produced by both assimilation and/or acculturation processes. According to participants, racially- and ethnically-mixed individuals and families are bringing a whole new set of issues to substance abuse treatment. In the first place, participants criticized that there is a lack of educational materials for substance treatment in Spanish. In that regard they pointed out that the problem should be addressed not by translating existing materials from English but by adapting or developing educational materials in Spanish in order to address H/L cultural idiosyncrasies. Translations from English to Spanish, in participants' words, are of poor quality, which becomes a challenge for treatment since it requires providers to spend a considerable amount of time explaining to clients the contents of the educational materials. Furthermore, participants argued that Spanish dialect differences, which effects tends to intensify with low education individuals, adds another layer of complexity to this linguistic predicament. Participants pointed out that to remedy this more research on H/L issues needs to be conducted.

Here is a passage that exemplifies these ideas:

*...there's too much translated material. We need to find a way of developing material from scratch, from the very basic... take the research for our groups and translate into material. And even agencies that have a little bit more cultural competency, like even my own, [organization's name], we just put out these pledge cards, I think we sent some around to some organizations. After we sent them out we realized, wait a minute, we just did the translation. And we looked at them, it wasn't just a translation of something in English. And in fact we couldn't find the translation of some words so they put parenthesis around them and called them the same thing. And I think there's too much of that happening either in the substance abuse field or the mental health field and some of the other fields, we're not developing our own materials and marketing...I think we're finding out that some of the corporations in terms of their marketing are realizing we can't translate a Burger King commercial any more into Spanish and put it out there, we have to develop something that's going to attract Latino people from the perspective of...commercial needs to reflect their culture. And we're way behind in that. (San Antonio Focus Group)*

Focus group participants also raised questions regarding the training and language skills of substance abuse health providers. Participants indicated that there is a broad variation in the type and level of education of providers. According to them there are a lot who have no formal training in any substance abuse counseling-related field but are hired because they are fluent in Spanish. Participants claimed that this situation originates a great deal of misdiagnosis. In addition, participants reported that

some of these professionals do not have an adequate command of English which limits their ability to take advantage of trainings and education, and to deal with educational materials written in English. Some focus group participants reported that there are also a limited number of bilingual substance abuse health providers. Being bilingual, participants argued, does not necessarily mean the person is culturally competent to adequately handle, for example, linguistic nuances of Spanish dialects. Participants also claimed that both a lack of formal training and language limitations hinder providers' ability to transfer information to clients with low levels of education.

Focus group participants also suggested strategies to deal with some of the issues described above. To face the lack of educational materials that cover the basics of substance abuse issues in pedagogical and culturally sensitive ways, a focus group participant from Austin proposed designing a comprehensive substance abuse curriculum adapted to clients' educational and cultural realities. Here is her proposal:

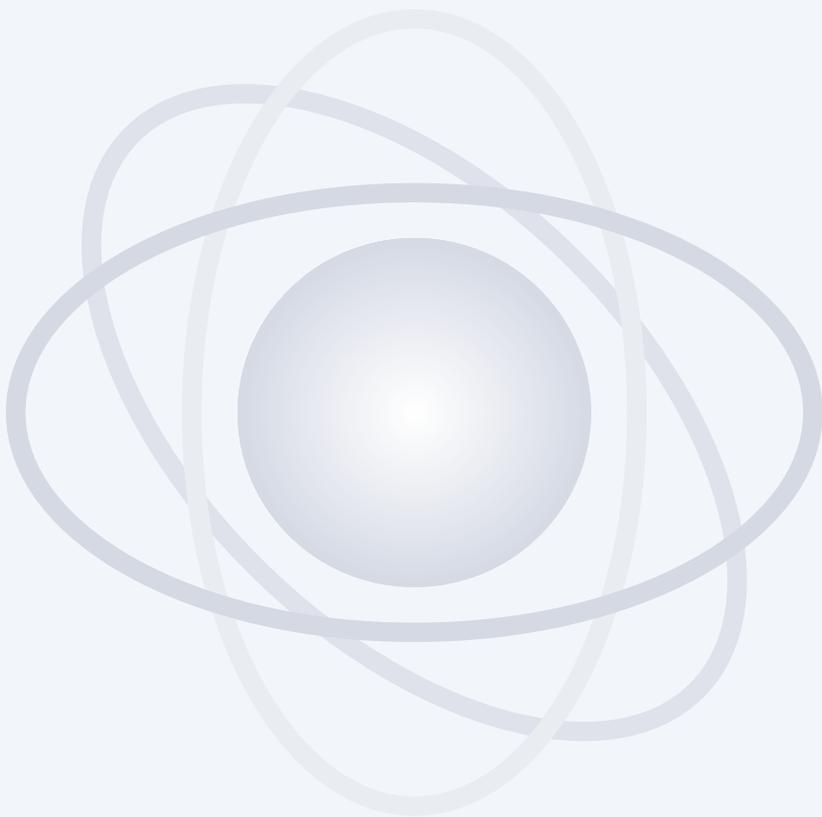
*Something that the addiction field is sorely lacking, whether it's in English or Spanish--it needs to be in both--is an actual curriculum written at a level that this population can understand, that deals with the crucial issues of addiction, the concepts they need to grasp while they're in treatment, whether it's an outpatient or residential setting. We have a limited amount of time, and there are certain concepts these people have to get as addicts to be able to go back out and stay clean and sober. And there needs to be...what we've done is develop our own, but there needs to be some kind of curriculum that sets up and teaches: first session, let's talk about enabling and codependency in addiction; second session, let's talk about addiction as a disease; third session,*

*let's talk about addiction in the family; fourth week, let's talk about how addiction affects the children; fifth week, let's talk about relapse prevention; sixth week, let's talk about...you know, certain concepts these people have to get. There is no curriculum I have seen where all of this information is laid out in a format, appropriately, a level the clients can understand, that teaches this. I know that there are some that touch on, like, addiction in the family, but that covers all the concepts that they have to grasp. You guys know what I'm talking about because you all work with this every day. There are certain things that they have to get while they are in treatment or they're not going to stay clean and sober, and you can't find all of those concepts in one place in one curriculum at an appropriate level, already set up in lesson plans that you can take into a group and teach. That's just not...there are a lot of curriculums that are out there, that Straight Ahead, the Texas Christian University curriculum, but they're all certain... one is like cognitive behavioral thinking, another one is women's issue thinking, Cornia[?] Black has some stuff out there about fam-/adult children, Terry Kellog[?] has a lot of stuff, Pam Dorsey has all those relapse curricula. But nowhere in any place is there one curriculum to deal with addiction. I would like to see that be [unintelligible] something like that. And then make it culturally appropriate or in Spanish, or appropriate to work with different cultures (Austin Focus Group)*

A recurrent suggestion in all focus groups was developing a local and regional database of health and social services providers, especially those who speak Spanish. Likewise, participants suggested creating a catalogue with educational materials and other resources both in English and Spanish. They

suggested putting together this information in WebPages to be available for everybody.

Finally, focus group participants pointed out the need for designing educational materials to teach clients' family members the fundamentals of substance abuse. Participants stressed that educating family about basic issues in substance abuse would help to modify the domestic environment which is usually sustained by cultural norms and values that fuel and stimulate substance abuse.



## Training Needs Assessment Domain

Themes in this domain generally overlaps with the ones described above since conversations about assessing training needs are ordinarily aligned with the identification of information and educational deficiencies. There is a major schism among participants in regards to the proper approach to develop training strategies to deal with the cultural and social complexities of H/L groups. On the one hand, some participants believe that the key point of a culturally sensitive training for providers resides in focusing on H/L commonalties. They argued that H/L share the same:

- **Language**
- **Religion**
- **Family roles (familismo)**
- **Gender roles (machismo, marianismo)**
- **Migratory patterns**
- **Common cultural history.**

Supporters of this orientation believe that considering resource limitations and the complexity of cultural phenomenon it is more pragmatic to focus on shared traits to develop a culturally appropriate approach to substance abuse treatment. Here is a passage that exemplifies these issues:

*Well, I merely had a question or a comment along those lines, because actually I think the commonalties, to me they probably are important at least for a person like myself to get at least some watered down generic background about a major ethnic or population group. But the real question I had, if you tried to break down all the subpopulations within the Mexican group or whatever, that's going to be a pretty tremendous task and probably take a lot of work and money*

*to do because you'd literally have to send somebody out to really go to all different regions, and you're probably going to have subpopulations within those regions. So it's like, how far do you want to go in developing culturally competent materials, I mean, how far can people realistically go and yet still somehow be sensitive to the subpopulations that are in there. I think you have to compromise somewhere, unless you've got a lot of time and money and people who can go out and do all that which I think would be great, but I think it would be, it's pretty much [unrealistic] (Chicago Focus Group)*

*Another thing that takes place, as a provider is the whole cultural competency awareness: As a provider, how do I feel about Spanish speakers? How do I address them--you know, do I have any stereotypical ideals about who it is I am dealing with? And how does that affect how I provide my services to them? So all of those aspects definitely come into play.*

There are those who argued that H/L are not any longer a culturally and linguistically homogenous group and that incorporating a cultural awareness orientation in drug treatment is absolutely crucial to develop a culturally sensitive approach. Training, according to these participants, should be designed to enable substance abuse health providers to deal with cultural diversity of H/L produced by acculturation, interracial marriage and migration. Differences in gender roles, age groups, and first and second generations in the US were the main sources of diversity mentioned in the focus groups that stem in substance abuse treatment. Participants pointed out a level of cultural specificity and/or regional idiosyncrasies that would affect the way treatment is conducted.

For some participants, focusing on commonalities for ethnic groups so heterogeneous would mean diluting any attempt to create a culturally appropriate training/intervention. For this set of participants the central question is: how does one deal with subcultures and countercultures? These participants identified this topic as a training imperative.

Participants indicated that trainers for these trainings need to be culturally competent, that is, be knowledgeable not only on substance abuse issues but also on these regional and ethnic differences and commonalities. Participants proposed that the training of trainers must be planned in a culturally sensitive fashion in order to be effective. In fact, participants mentioned that they prefer H/L trainers. The following are two examples of these conversations:

*And I think that's the issue that we have been trying to create and cultivate a trainer of trainers program in the Midwest. Because we've had good trainers in the Southwest and maybe in the Caribbean with Puerto Rico, but we are different. You know, the population here, the Mexican population, the people who live in Texas or San Antonio or people who live in, the Cubans who live in Miami, or New Mexico, are totally different than us.*

*F: In what way?*

*Culturally...subcultures. The majority of people from the Southwest, they are second, third, fourth generation. They [unintelligible] Hispanics. They might be bilingual, totally different, think different. The majority of Midwest people, we've seen the transition, second generation, but the majority if you ask people in here, my clinicians, the majority of people are migrants, first generation. So we, when a good trainer*

*comes from the Southwest to present some of the issues...not really fit our development of materials or development of treatment, sensitive or acculturated to our needs. And yet, we don't have enough trainers to do trainings. The reason they're not good trainers is people are not sensitive, because we don't have a good trainer here in the state [unintelligible]. We have a couple, but they're booked all the time, they're [unintelligible] trainings, trainings, trainings. So that's one of the ideas we are trying to create, trainings in the Midwest so that we can be able to develop techniques, and addressing the Hispanic population from here, from there... which is different from Puerto Ricans on the island, and the Southwest. (Chicago Focus Group)*

*But I think that in the southwest or Puerto Rico they don't realize the variety of different Latino groups that come together here, because we do come together for the trainings and for work situations and for treatment. I do think that when you have the treatment group you have Puerto Ricans in there, you have Mexicans in there, you have all kinds of groups. And how do you treat that group, and how you take into account those different levels of ethnicity and acculturation and all those things are different than if you are dealing with a more homogenous group from the Southwest or from Puerto Rico, where you know that most of them are Puerto Rican and most of them speak Spanish also. So it's different and so that's why we need to develop something that's specific to the Midwest. (Chicago Focus Group)*

Those participants who believe that H/L culture should not be the focus of a training to enhance the substance abuse treatment but what they call the culture of addiction represent another dimension of this debate. This group of participants' argue that substance abusers share a kind of subculture (language, behaviors, practices, rules, etc) that equalizes them as a group and outweighs other major characteristics such as ethnicity, gender, age, etc. Therefore, these participants affirmed that training should be designed on cultural traits to make substance abuse health providers competent in the culture of addiction and to teach them how to incorporate this knowledge into treatment.

A common ground among the proponents of these positions is that more research on H/L shared and unique cultural traits is very much needed to provide an empirical platform for developing trainings in cultural competence. Participants proposed to identify individuals in universities or research centers conducting studies on H/L issues to create an academic research group, which can provide the baseline data for developing educational products, including trainings. They recommended developing a national and regional research agenda to understand what H/L cultural elements are wide-ranging and which are more restricted to particular areas and groups. They also advocated for a short and a middle-term research agenda, such as these focus groups, which would facilitate transferring research data into practice and would provide the research questions for long term investigation. Finally, participants raised their concerns with the feasibility of conducting research to develop culturally sensitive trainings for substance abuse treatment by posing the following question: how do we stimulate H/L researchers to recognize substance abuse as a valid research area? The following is a passage that illustrates the points discussed above:

*[Unintelligible] to see that research and I'm not sure if it's short or long term. I don't know what your goals are, where you're working, what the resources are. But the research somehow has to be developed so it has this matrix of questions, because you really want to define the culture. And even if you define the Hispanic culture in the Midwest, you have to define the subgroups as well. And you also have to realize that the responses to those research questions, even though they should be the same for each major culture as well as the subgroups, they're going to change over time and they're going to be changes as history moves along. So the person's definition of what really happens to them from a cultural standpoint may change. Right now you're dealing with the migrant issue more than anything else, or people coming in and their culture is sort of a specific kind of thing, versus the generational thing. So I guess in the long term I'd like to see the research matrix with standardized questions so then you're going go out to these large groups as well as the subgroups and see what the results are going to be, what those responses are going to be, so that in fact we'll know what to be training our staff on. Because we are probably pretty unclear right now. All we're doing now I would guess is that each of us tends to come from our own background and that's what we tell people about our culture, or what we've heard about somebody else's culture, and that's the way it is. But I'm not so sure we really have much of any factual information. It's like that whole family thing. [Unintelligible] we don't have a lot of family participation where I'm at, and we probably don't have a whole lot of African Americans now. Unfortunately we don't treat a lot of Latinos but I know if we did our staff perception is that we'd have a lot more family participation. I don't know where all that stuff comes from I'd like to see the data behind it I guess. I like the idea*

*of the national agenda and the regional agenda, because I think with the research, we all have an idea more or less of what we would like to see in the research, but I think that we have to really look into what it is we're going to be able to [unintelligible] our research. Also, from what I hear there are a lot of people doing research, and I know there's a lot of research going on... it would be good to do a study on who is doing research on Latinos and what are the commonalities that maybe we want to identify. But I would like to hear the outcome of the focus groups. I think that also that is going to provide a lot of information that can help to prioritize. I think for me short term is impacting the training that's going on, and middle is getting the research going, getting the specific questions that need to be answered by research.*

Focus group participants recommended a number of topics for trainings. Some participants argued that the right approach for a culturally sensitive training requires focusing neither on cultural commonalities nor on cultural diversity but how to ask the right questions to assess the manifestations of the client's individuality within his/her culture. Here it is an example:

*I think that...I agree with [participant's name] that we have to know what those similarities are across groups. We have to have an understanding that there are different groups. We have people that come into this and think that all our females are one subgroup, you know. I mean if we can get past that, if we can get some people to understand that there are different groups, and then I think that just basic assessment has to kick in. That we have to ask the individual, you're from Puerto Rico, do you, have you been a traditional Catholic in your life or has your family...? Because there has been a big growth of the Pentecostal community. **I think***

*that that's where we have to teach people what questions to ask that gets to the individuality of that person within his culture. To understand the culture of that person and of the subgroups that they may belong to. I think it's a matter of knowing what questions to ask. So the training has to be around not assuming certain things but asking the questions.*  
(Chicago Focus Group)

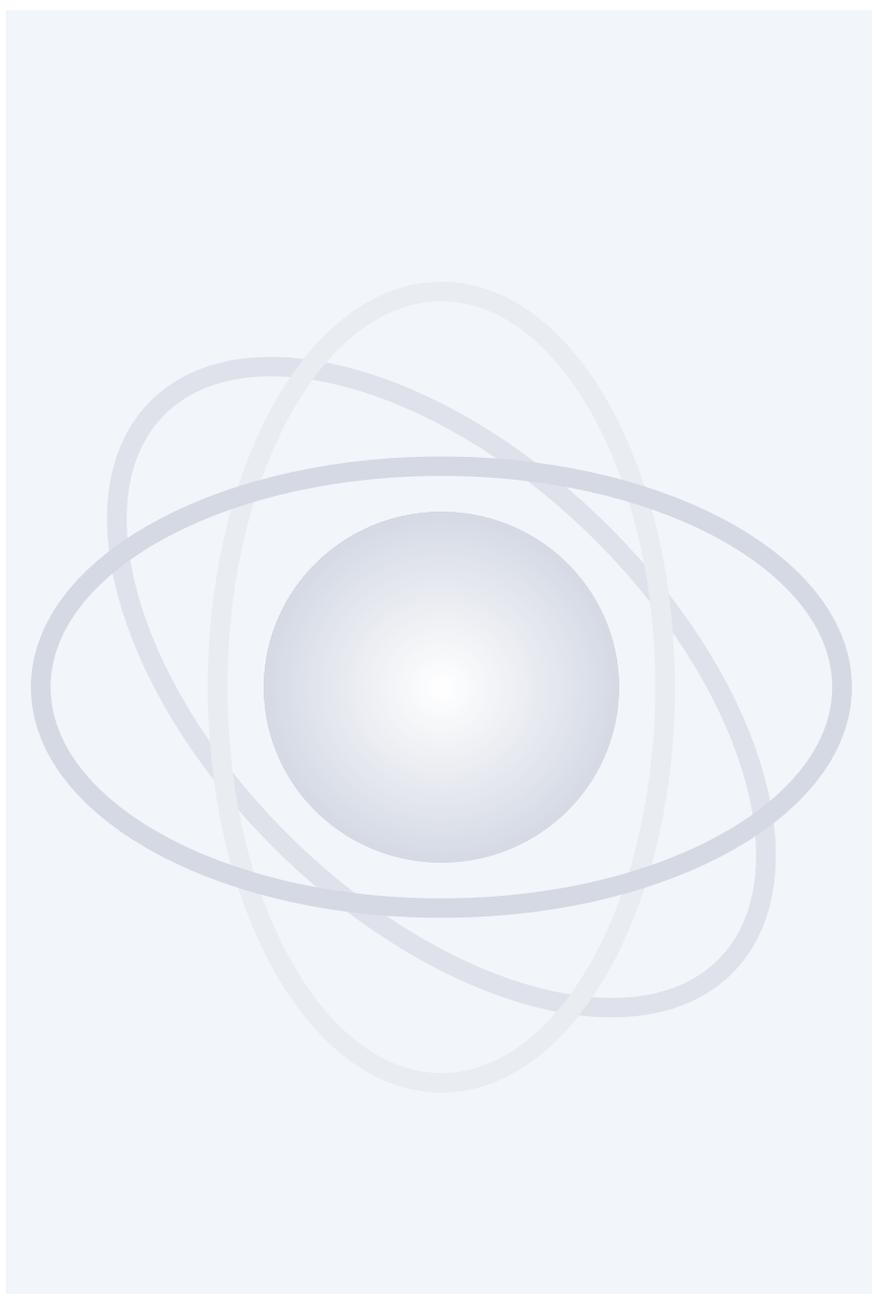
Participants of the focus groups articulated various recommendations for culturally sensitive trainings. The following is a summary of these propositions:

- **Learning effective verbal and non-verbal communication styles:** Participants expressed that although they might be fluent in Spanish, learning language regionalisms and colloquial phrases would help to enhance the effectiveness of interaction. Additionally, knowing the meaning of concepts such as *ataque de nervios* or *empacho*, to mention just two, would help to better understand local categories used by lay people to name physical or mental problems.
- **How to integrate H/L family in substance abuse treatment:** Participants required learning strategies to lessen denial and disapproval from clients' family members and to teach clients tactics to disclose and communicate effectively with their families about their substance abuse problems.
- **Gender issues:** Participants indicated that cultural norms and roles such as *machismo*, *marianismo* and *familismo* promote a climate of even less tolerance for female H/L substance abusers than for males from family and society in general. Tools to deal with these issues are in great need.

- **The United States legal system:** Participants recommended designing a elementary training on how the legal system works in the US, especially those laws related to the consumption of legal and illegal substances. They mentioned that H/L recent migrants are not familiar with the legal system, in particular the rules related to driving under the influence of alcohol. This lack of understanding of the legal system combined with a different set of cultural norms regarding alcohol consumption put H/L at a higher risk of being arrested, having their driver's license revoked, loosing their jobs, facing problem with migration authorities and ultimately heightening substance abuse issues.
- **Social acceptance of alcohol:** Participants stressed that they need strategies to effectively deal with the cultural acceptance of alcohol. Participants indicated that no stigma is attached to alcohol heavy drinking therefore is very difficult for H/L clients and their families to understand alcohol as a problem. Developing educational materials should be done in conjunction with trainings for its application.
- **Continuing education for providers:** Participants suggested a tour of conferences or online courses to train providers in the latest on new theories and treatment models. They also recommended organizing periodic round tables in which providers with similar roles (case managers, outreach workers, counselors, etc) exchanged ideas, experiences and issues.

Finally, participants identified potential barriers for attending trainings providers might confront. Money, time and language were the principal reasons they posed as obstacles in developing trainings for providers. Traveling, the cost of speakers and training materials would be a major burden to

almost every organization according to participants. They unanimously concurred that the tremendous workload of providers would prevent them from attending any activity during regular business hours. Participants claimed that if trainings were offered exclusively in English it would discourage those providers whose command of this language is limited.



## LIMITATIONS

There are some limitations in this study. Individuals in all focus groups were selected from each one of the organizations by different internal processes, therefore it is impossible to know how well these sets of people represent their organizations or for that matter, how well they represent substance abuse health providers in their regions. Focus groups were originally conceived for peers, that is individuals on the same level in the hierarchy of their organizations to create a favorable environment for honest conversations. However, in some instances individuals attended the focus groups with their supervisors. It is not possible to measure the effect this situation might have had on their answers.

Finally, the possibility of researchers' bias in qualitative analysis is always present. The salient patterns identified by investigators could be both artifacts of the research questions and the coding process to map the answers to those questions.

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## NOTES

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