



TREATMENT TRAJECTORIES OF DRUG USERS FROM ETHNIC MINORITY GROUPS

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1. PROBLEM SITUATION AND HYPOTHESES

1.1. *Problem situation*

International research has shown that drug abusers from ethnic minority groups experience various difficulties when contacting (specialised) treatment services (Ashruf & van der Eijnden, 1996; Longshore et al., 1997; Verdurmen et al., 2004; Curtis et al., 2006). Moreover, as compared with the distribution in the general population, a disproportionate (low) number of substance abusers from ethnic minority groups utilizes substance abuse treatment services. This is particularly true for high threshold, residential facilities (Braam et al., 1998; De Leon et al., 1993; Vandeveldel et al., 2000; Haasen et al., 2001).

Still, epidemiological research has demonstrated that ethnic minority groups are more vulnerable to (ab)use substances due to, among others, higher unemployment rates, limited language skills, less educational opportunities, intergenerational conflicts, acculturation difficulties and higher peer pressure (Reid et al., 2001). Also, various ‘institutional’ barriers may influence accessibility of drug treatment services for ethnic minorities, such as language and communication problems (Fountain et al., 2002; Schneider, 2001) and lack of ‘cultural responsiveness’ (Castro & Alarcon, 2002; Ja & Aoki, 1993). In addition, drug users from ethnic minority groups often hardly know about the wide range of existing treatment facilities (Reid et al., 2001; Salman, 1998) and are suspicious towards the western-oriented treatment offer (Broers & Eland, 2000; Eland & Rigter, 2001). Moreover, the stigma on substance abuse among (some) ethnic minority groups leads to numerous attempts to hide the problems for the surrounding social network (Vandeveldel et al., 2003).

Except the accessibility of services, also other elements of the treatment trajectory of substance abusers from ethnic minority groups seem to be problematic. Research has shown that clients from ethnic minority groups are more eager to drop-out and are less likely to complete treatment successfully (Finn, 1994, 1996; Verdurmen et al., 2004; Vrieling et al., 2000), since specialized substance abuse treatment services do not adequately meet the needs of (problem) substance abusers from ethnic minorities (Yildiz & Keersmaeckers, 2001). This observation includes an unfavourable prognosis for successful outcomes after treatment (Verdurmen et al., 2004).

In Belgium, few information is available on the prevalence and type of drugs used by ethnic minority groups on the one hand, and on the representation of drug users from ethnic minorities in substance abuse treatment and the treatment trajectories they follow on the other hand. From two small-scale studies, indications can be found that ethnic minorities experience various barriers (language, religious, cultural, social, ...) towards treatment, and that drug users from ethnic minority groups rather contact low-threshold medical services (e.g. methadone maintenance treatment) than long-term residential treatment (Vanderplasschen et al., 2003; Vandeveldel et al., 2003). In addition, drug addicts from ethnic minorities are overrepresented in prison populations (Vandeveldel et al., 2005).

1.2. *Hypotheses of the study*

The central **research question** we want to address in this study is whether drug abusers from ethnic minority groups do use the existing services less and/or differently, and – related to this – to what extent they make use of ‘alternative’ treatment methods that are not part of the regular treatment system. We assume that this population utilizes relatively less often specialised (residential) treatment services, but rather contacts medical services or specific programs for ethnic minorities and is more often incarcerated. In order to understand these difficulties concerning the accessibility of services and clients’ treatment trajectories, we put forward the following **hypotheses** that will be tested during this study.

A *first hypothesis* concerns the ‘dual exclusion’ or ‘dual isolation’ of (some) ethnic minority groups with substance abuse problems. Persons from ethnic minority groups that are closely incorporated in the network of the own community (sometimes based on close family bonds) are at risk of dropping out of this protecting network or of being expelled in case of substance abuse problems, due to the stigma that is

associated with substance abuse in some ethnic communities. Moreover, they often do not access existing services or supportive organisations, since they do not know these initiatives or these appear to be inaccessible or irrelevant to them.

A *second hypothesis* is the following: “Competition between preventive and supportive efforts concerning substance abuse problems by (self-)organisations and mosques on the one hand, and by ‘regular’ treatment services on the other hand”. Various North African and Turkish clubs and (self-)organisations report in their regulations about activities and initiatives concerning drug prevention and treatment (Jacobs, 2005). Also, several mosques state explicitly that they are involved in dissuading substance use and helping persons with substance abuse problems. It is extremely difficult to estimate the real extent and impact of this kind of (self-)organisations, but it might be that these initiatives interfere with initiatives taken by ‘regular’ treatment agencies or that they reach – in a complementary way – other target groups which are underrepresented in ‘traditional’ in- and outpatient treatment facilities.

A *third hypothesis* is the one of ‘cultural blindness’ of existing treatment and prevention programs, resulting in a lack of attention for cultural influences (Castro & Alarcon, 2002). It seems in any case important to integrate cultural variables, in order to establish ‘culturally-sensitive’ treatment programs that address specific treatment needs of ethnic minority groups (Castro & Garfinkle, 2003).

This research assumes three **aims**.

A *first aim* of this research proposal is to compare the treatment trajectories of substance abusers from ethnic minority groups and substance abusers from the ‘Belgian’ population, and to look for differences concerning treatment access, participation and retention in medical and specialized substance abuse agencies.

Once these differences concerning the treatment trajectories have been studied quantitatively, these will be analysed – as the study’s *second aim* – more thoroughly based on qualitative research. Thus, we want to identify which factors and mechanisms (may) hinder or stimulate the treatment trajectory of ethnic minority groups, and to which extent.

The *third objective* of this study consists of the formulation of concrete recommendations, pathways and solutions for countering the difficulties concerning the accessibility of services and (treatment) trajectories of ethnic minority groups.

1.3. Study design

First, a **literature study** has been performed to make an overview of already existing studies about the central research theme and the theoretical frameworks concerned. For this purpose, we chose to analyse both Dutch and English literature on the one hand, and French and Spanish literature on the other hand, since we suggested the hypothesis that the research theme is approached differently in both language communities. This might be reflected in a potentially diverse approach of this theme in the two Belgian language communities. The literature study was complemented with explorative interviews with key figures from various agencies, both in the Flemish- and French-speaking part of Belgium.

Secondly, a large **quantitative study** was set up, consisting of three parts, in which existing data sets were analysed to gain more insight concerning the central research questions described above. As each of the data set has its limitations, we have chosen to combine three different data sets in order to have a reliable view on the representation of ethnic minority groups in mainstream and specialised health care.

The first data set was gathered during a research project executed by the Department of Orthopedagogics of the Ghent University and the University Scientific Institute for Drug problems of the University of Antwerp concerning the *characteristics of alcohol and drug users with a treatment demand in the province of Antwerp*.

A second chapter analyses the data of 1,880 clients registered in one of the treatment facilities of vzw De Sleutel, a large organisation providing substance abuse treatment and prevention in Flanders. In this chapter, we focus on the problem severity concerning different life-domains, based on data from the *European version of the Addiction Severity Index*.

The third chapter of the quantitative research part involves a secondary analysis of data from the three biggest *health insurances companies* in Belgium. We assessed the health care consumption of a randomised sample of 2,000 persons who have been in substance abuse treatment between January and June 2004. In all three secondary analyses, a comparison was made between clients from ethnic minority groups and the rest of the study population.

Despite the large quantitative part of this study, this perspective also includes some limitations. Therefore, we chose to complement and deepen the quantitative research with a **qualitative study**. This qualitative study was executed simultaneously in the French- and Flemish-speaking part of Belgium in four large cities (Antwerp, Brussels, Charleroi and Ghent). Given the parallel study in both language communities, it was necessary to attune the research methodology optimally. Therefore, much time has been spent on the development of a common *research methodology*, especially for making up the interview scheme for the qualitative interviews and the guidelines and statements of the focus groups, and for the data-analysis of the interviews and focus groups.

The qualitative research part consists of semi-structured interviews with drug users from ethnic minority groups. In total, 45 persons have been interviewed. Because of the heterogeneity of the research population, we have chosen to limit these interviews to respondents from Turkish and Moroccan origin, since these are the two biggest groups of non-European ethnic minorities in Belgium. During the interviews, we focused on the diverse ‘trajectories’ of these persons, their trajectory into drug use, their trajectory within the treatment system, and their own life trajectory, with special attention for aspects related to the participant’s migration process.

In addition, the interview findings have been discussed with several key persons and experts from the health care, social welfare and judicial system during *focus groups* in the four above-mentioned cities.

Finally, some ‘*interesting practices*’ have been visited in neighboring countries, in order to gain insight into some specific and successful initiatives for drug users from ethnic minority groups. In total, three interesting practices were visited in various European countries.

Since this study project included the analysis of private and sensitive data (such as data concerning participants’ health status and ethnic origin), we asked the Ethical Committee of the Faculty of Psychology and Educational Sciences of the Ghent University for advice (permission dd. 10.10.2006). Further, for the secondary analysis of the data from the health insurance companies, we needed the permission of the Committee for Social Security and Health which is part of the National Commission for the Protection of Persons’ Privacy (permission dd. 08.05.07, authorization n° 07/020; for the entire order, see: http://www.privacycommission.be/nl/docs/SZ-SS/2007/beraadslaging_SZ_020_2007.pdf).

2. MAIN RESEARCH RESULTS

2.1 *The system of trajectories of ethnic minority groups*

During this study, it became clear that the treatment trajectory of drug users from ethnic minority groups cannot be separated from their drug use trajectory or from their individual life trajectory, background and history. Therefore, we suggest to use the term ‘**system of trajectories**’. If we want to gain more insight into the similarities and differences between the treatment trajectories of drug users from ethnic minority groups and from Belgian origin, we have to take into account this entire system of trajectories.

All separate parts of this study have shown that the system of trajectories of ethnic minorities cannot be interpreted univocally. Consequently, no consistent findings were retrieved concerning the prevalence and type of substance use and service utilisation by ethnic minority groups. Therefore, one of the main conclusions of this study is that mainly **individual factors** determine the differentiated course of persons’ trajectories, both concerning drug use and concerning service utilisation. Scheppers and colleagues (2006) came to similar conclusions in their study. However, this conclusion is strongly influenced by the central idea that the group of ‘ethnic minorities’ is a very difficult group to define, leading to various criteria that

can be applied (such as nationality, country of birth, country of birth of the parents, name, ...). Moreover, we want to emphasize that this population is very **heterogeneous** group. For example, a lot of differences concerning nationality, country of birth, background, migration history, current socio-economical status, et cetera can be observed. Further, we want to stress that the use of criteria such as 'nationality' and/or 'country of birth' does not imply homogeneous groups, since also within these groups, there are important intra-group differences (e.g., educational degree, urban or rural background). Consequently, it is not at all easy and certainly not desirable to define a univocal trajectory for drug users from ethnic minority groups. At any time, we have to be aware that this group encloses an enormous **diversity**.

If we compare the trajectories of drug use and of treatment utilisation of ethnic minorities with those of persons of Belgian origin, we find as well many differences as many similarities. Therefore, the question whether the system of trajectories of ethnic minorities differs importantly from the system of trajectories of clients from Belgian origin cannot be answered univocally. Moreover, the answer to this question seems to depend largely from whether one chooses to stress similarities or dissimilarities. Despite the prudence needed when discussing and interpreting the study results, we will present some striking findings and conclusions. We will primarily focus on differences between drug users from ethnic minorities and from Belgian ethnic origin concerning their system of trajectories. Ultimately, we want to provide some recommendations in order to better meet the specific needs of drug users from ethnic minorities.

2.1.1 Treatment demand and demographic and social characteristics of drug users of non-Belgian origin

The quantitative research part gives us an idea of the **number** of clients of non-Belgian ethnic origin in substance abuse treatment. Despite methodological differences and the use of different criteria to define the group of 'persons from ethnic minority groups' throughout the three quantitative analyses, we found that approximately 12 to 20% (depending on the criteria that were used) of all clients in drug treatment have non-Belgian origins, mainly Moroccan and Dutch. This percentage is comparable with the total number of persons of non-Belgian origin in Belgium (cf. NPDATA, 2007).

Some striking differences could be observed concerning **social and demographic characteristics**. We found a significantly lower number of female clients in the group of clients of non-Belgian origin, as compared to the group of clients of Belgian origin. Drug users from ethnic minorities also seem to be older when they come into contact with the specialized (residential) drug treatment system. Given these age differences, it is not surprising that clients of non-Belgian origin live more often together with their partner (and children), while clients from Belgian origin live more frequently with their parents or with their partner alone. Drug users from ethnic minority groups also live more often in big cities as compared with clients of Belgian origin.

Another striking difference concerning clients' socio-economical status is that drug users of non-Belgian origin are often in a less favourable and more precarious situation as compared to clients of Belgian origin, since significantly more persons from the former group receive social security benefits, are unemployed, have an unsteady employment status and have debts. This less favourable socio-economic situation of drug users from ethnic minority groups has also been confirmed in other studies (see e.g., Haasen, 2007; Jackson et al., 1996; Schneider, 2001).

2.1.2 Patterns and trajectories of drug use

Our literature study concerning the prevalence and type of drug use among ethnic minorities revealed rather conflicting results: some studies stress some big differences (Argeriou & Daley, 1997), while other publications did find few or no differences at all (Adrian, 2002).

Based on our study, we found some indications that drug users' of non-Belgian origin treatment demand is related to **other substances** as compared to clients of Belgian origin. The quantitative research part shows that clients of Belgian origin use and misuse more often alcohol, as is the case with misuse of XTC and amphetamines. On the other hand, clients from ethnic minority groups report more frequently heroin, cocaine and methadone use and are usually older when they contact treatment. Also, some important within-group differences were observed concerning substances of abuse (cf. Haasen, 2007): the

use of alcohol is less common among persons of Moroccan origin, while the prevalence of alcohol use in clients of Dutch and Eastern-European origin is comparable to that of persons of Belgian origin. Still, it is impossible to report univocal results concerning differences in patterns of drug use among various ethnic minority groups based on this study, due to – amongst other reasons – the exclusive focus on persons in treatment and the small number of persons from some specific ethnic minorities.

Rather conflicting findings are reported concerning the way drugs are administered (e.g. intravenous drug use), since one analysis (treatment demand-study in the province of Antwerp) revealed that intravenous drug use was more common among clients from non-Belgian origin, while a second analysis (EuropASI-data De Sleutel) could not confirm this observation. This may be explained by the fact that some ethnic minority groups with high prevalence of intravenous drug use (e.g. drug users of Eastern-European origin) are underrepresented in the database of De Sleutel.

Given the limited number of Belgian studies concerning patterns and trajectories of drug use and given the fact that results from foreign studies can hardly be generalised to the Belgian context, we cannot formulate firm conclusions concerning differences in substances use and the way these are administered. Consequently, these findings should be interpreted cautiously.

2.1.3 Service utilisation and treatment trajectories

Based on our findings, we cannot confirm the hypothesis that drug users from ethnic minority groups are underrepresented in drug treatment and also leave drug treatment more quickly, as is often stated in the literature. Although this study cannot provide definitive answers about the prevalence of ethnic minorities in residential drug treatment, we found some clear indications that drug users from ethnic minority groups contact drug treatment services to a similar extent as drug users from Belgian origin, although some qualitative differences can be observed. Furthermore, it is clear that certain subgroups, such as women, adolescents and persons originating from Eastern-Europe and Africa are represented to a limited extent in the study samples. This might indicate that these – and maybe also other – subgroups within the population of drug users from ethnic minority groups make less use of residential (drug) treatment. However, our observation may be an indication that the population of drug users from some ethnic minority groups is composed differently as compared to other ethnic groups.

The study in the province of Antwerp shows that drug users of non-Belgian origin contact treatment services – on average - at an older age, and they also tend to stay in treatment longer. This may have to do with the fact that drug users from ethnic minorities are rather registered in **outpatient programmes**, such as methadone programmes, individual support services, medical assistance and low threshold agencies. Another striking finding is that clients of Belgian origin consult more frequently a psychiatrist as compared to other ethnic minority groups. In addition, they receive more often a prescription for anti-depressant medication, although the prevalence of psychological problems (e.g. depression) does not seem to be different between the ethnic groups studied. Utilisation of **residential treatment** was lower among some ethnic groups (e.g. drug users from Eastern European and Turkish origin), but this finding was not applicable to persons of Moroccan origin.

It appears that the referring agent to treatment is more often the informal network (e.g. partner, family) and the criminal justice system among drug users from ethnic minority groups. The findings of the treatment demand study in Antwerp indicate that intake interviews with persons of non-Belgian ethnic origin result less often in the start of a treatment episode, as they drop out themselves. This finding has also been shown in a Dutch study (Verdurmen et al., 2004). On the other hand, we found several indications that drug users from ethnic minority groups are more frequently directly referred to another agency by caregivers, which could indicate that these persons do not address the treatment services that are most appropriate to answer their treatment demand. The focus groups further revealed that the referral policy of some drug treatment agencies may be due to caregivers' inability to cope with another concept of addiction and/or another culture and not with the presence of psychiatric disorders among these clients.

The qualitative research part has highlighted the importance of so-called '**alternative coping mechanisms**' of persons from ethnic minority groups to deal with drug problems. It concerns, among other mechanisms, a short- or long-term stay in the country of origin, religious devotion, the use of alternative medication or healing methods and marriage as a last resort to control substance abuse. The application of such 'alternative coping mechanisms' is often done in consultation with or even by force of the family of the drug user. These coping mechanisms can replace or complement institutionalised or mainstream drug treatment services; both types of 'treatment' utilisation can appear around the same time or at different moments in someone's treatment trajectory. This will vary greatly from individual to individual.

2.2 Influencing factors

Differences concerning drug use and treatment utilisation between drug users of Belgian ethnic origin and from ethnic minority groups can be attributed to various factors. Mainly the qualitative research part has illustrated that the latter group experiences various barriers that may hinder the access to and retention in treatment. It is very important to stress that these barriers are very individual. Moreover, these barriers are time-limited and may vary during the course of the treatment trajectory. Also, Scheppers and colleagues (2006) have demonstrated the relative nature of obstacles to treatment. Consequently, the reported barriers cannot be generalised, but they are illustrative for the existing bottlenecks concerning the treatment trajectories of ethnic minority groups in drug treatment.

Lack of cultural sensitiveness among caregivers, language and communication problems, a medical and religion-oriented perspective on drug use and its treatment and the fact that people do not feel attracted and supported by the western-oriented treatment programme, These are only some of the potential obstacles that drug users from ethnic minority groups may experience when contacting health care and drug treatment services. These hindering factors can be of practical, cultural or institutional nature. We try to fit these observed obstacles in a comprehensive framework by referring to the overview made by Scheppers et al. (2006), in which they describe the potential barriers that may be encountered by ethnic minority groups when contacting health care services. They distinguish three kinds of barriers: barriers on client-level; barriers on the level of caregivers or treatment agencies; and system-barriers. We highlight some of the observed barriers that drug users from ethnic minority groups may experience.

2.2.1 Client-level

According to Scheppers et al. (2006) various **demographic variables** can be a barrier to look for help, such as age, gender, not having a family, having children, Based on our study, there is clear support for this cluster of variables: women, youngsters and unmarried persons are relatively underrepresented in the sample of drug users from ethnic minority groups.

Another cluster of barriers concerns **social-structural variables**, such as ethnicity, education, social and economic status, living situation, way of living, family and social support, culture, length of stay, acculturation, language skills, communication and translation. Our research has shown that the precarious social status (education and employment) and the frequent involvement with the criminal justice system of drug users of Moroccan origin is an important potential barrier. Also, language competence appears to be of utmost importance.

Conceptions about and **attitudes** towards (drug) treatment may be other barriers according to Scheppers et al. (2006). They refer to factors such as time in treatment, conceptions about goals and values concerning health and disease, perceptions about and attitudes towards health care services and caregivers, knowledge about physiology and disease. This research has further shown that limited identification with other drug users, negative perception of the quality of care, viewing methadone treatment as drug use, not understanding or appreciating psychology and a lack of belief and trust in treatment are other potential barriers for drug users from ethnic minority groups.

Also, **personal variables** may cause problems when contacting institutionalised treatment services. Scheppers and colleagues (2006) refer to factors such as migration laws, income and financial means, access to health insurance, sources of advice and support, time available and stress. Our study supports the existence of barriers concerning the knowledge about the treatment offer, accessibility of treatment, entitlement to health insurance and also some other factors such as motivation for change, identification as a drug user, perception of the different cultural background of treatment services, psychiatric comorbidity and the belief in someone's potential to change drug use.

Moreover, the fact that someone has **helping resources** in his/her immediate surroundings or in the community may influence how people experience the afore-mentioned barriers. Scheppers and colleagues (2006) mention the availability and the offer of services, the price of health care services, transportation and travel time to these services. Based on our research, we further add the availability of support, the stigmatisation by the own community and the pressure to keep their drug use hidden.

What is defined by Scheppers and colleagues as **'perception of disease'**, referring to the perception by ethnic minority groups of the causes of addiction, rather appears to be – based on this study – the perception of drug use. It concerns factors such as having information about the substance and its effects, the fact that drug use is taboo, having a medical and spiritual view on drug use and treatment, and having insight in one's problems.

A final cluster of client variables is described by Scheppers and colleagues as **personal health habits**. They refer to self-care and some specific health care practices that are applied in specific cultural groups, as a means of treating drug use. The qualitative study in particular has shown that drug users from ethnic minority groups make use of such alternative coping mechanisms (e.g. return to the country of origin, military service) and self-help in order to deal with their drug problems.

2.2.2 Level of caregivers and treatment services

First, we distinguish characteristics of the treatment services that may interfere with treatment access and retention, such as the medical procedures and practices applied, the orientation towards urgent complaints, the programme-orientation and its adaptation to specific cultural/ethnic habits. Concerning barriers at the level of caregivers, Scheppers et al. (2006) point at cultural sensitivity and cultural skills, the communication style, the way of providing information, the approach of clients, the presence of multilingualism and the availability of translators and interpreters, the cultural knowledge, involvement of family members in the programme, the possibility to profess their religion and spirituality and the presence of parallel sets of convictions and practices. Many of these factors have also been illustrated by our research. Following aspects are further deemed important: the relation with the caregiver and the degree of identification with them, language as a means to express emotions, communication, group therapy, side-effects of medication, experiencing a negative perception of methadone treatment by caregivers, knowledge about and trust in the approach of a psychologist, cultural differences, match between expectations and the actual offer, having the feeling to be taken seriously, appraisal of the competences of the caregiver and the cultural knowledge in the treatment service.

2.2.3 System-level

A third cluster of barriers that may be experienced by drug users from ethnic minority groups when they contact treatment services are situated at the system-level (Scheppers et al., 2006). They state that the **medical model**, that often inspires substance abuse treatment, is a potential barrier for clients with a rather cultural and religion-oriented perception of addiction. Our research supports this finding to a certain extent, but it should be clear that the psychotherapeutic model may also be a barrier, as persons from ethnic minority groups are less familiar with this kind of approach of drug use and treatment.

A second group of system variables concerns the approach of clients by the treatment system, which is often rather formal, impersonal and distant. Our research indicates that drug users from ethnic minority groups often feel not attracted by the selective approach (only oriented at some target-groups) in specialised treatment agencies.

Also, **organisational variables** play a role, such as the referral system, intake procedures and opening hours, procedure for making an appointment, waiting lists and waiting times, duration of a consultation and length of treatment, available education and information materials and the possibilities of translation. This research has shown that especially institutionalised rules in treatment services, the referral system, the standardised approach, waiting lists and waiting times and the intensity of after-care and follow-up conflict with the expectations of drug users from ethnic minority groups.

Another dimension can be added to the system level, namely the **political climate** concerning ethnic minority groups and concerning migration, xenophobia, ... (Fassin, 2002). This research has shown that drug users from ethnic minority groups, particularly persons from Turkish and Moroccan origin, state that they have ever experienced racism in treatment. Whether caregivers take position concerning discrimination and racism or not can be a stimulus or a barrier to further contact treatment services. Existing good practices concerning this topic are appreciated a lot by persons from ethnic minority groups. In the literature, it is suggested that especially the migration trajectory of persons from ethnic minority groups may complicate persons drug use and treatment trajectory. However, we found few indications for such a link in this study.

These insights concerning potential barriers to treatment for drug users from ethnic minority groups can help us to answer the hypotheses we put forward at the beginning of this study.

2.3 *Answers to the hypotheses of the study*

2.3.1 'Dual exclusion'

The first hypothesis that was suggested concerned the 'dual exclusion' or 'dual isolation' of drug users from ethnic minority groups (cf. supra). This hypothesis is partially supported by our study to a large extent. It appears that some drug users from ethnic minority groups have a limited knowledge about drugs, their effects and potential consequences. If persons have insight into their problems, this may conflict with taboos concerning drug use in some ethnic communities. This often results in ignoring and hiding substance abuse and not seeking help. If the persons' substance use and need for treatment come to light, they are at risk of losing the support of their family and social network. This may escalate and lead to a situation in which they have few or no contacts at all with the own community. For many of them, the step towards treatment is a bridge too far, given their limited knowledge about the treatment offer and/or their biased view of it. This may explain why caregivers often experience that drug users from ethnic minority groups are often in a further stage of dependence and marginalisation when they decide to contact treatment. Many clients of non-Belgian origin appear to be supported by their network and community, who stimulate them to change their drug abuse and inform them about and/or refer them to some kind of treatment, either an alternative or institutionalised form of treatment. Consequently, situations of 'dual exclusion' exist and need to be taken into consideration, but will – according to this study – not always be the case.

2.3.2 Competition between self-organisations and mosques and mainstream treatment

The second hypothesis concerns "the competition between preventive and supportive efforts concerning substance abuse problems by (self-)organisations and mosques on the hand, and by 'regular' treatment services on the other hand". Based on this study, it is not possible to answer this hypothesis, since we have found insufficient indications to support this hypothesis. It is not easy to estimate the range and impact of these alternative practices. Still, it is apparent that many drug users from Turkish and Moroccan origin make use of such alternatives and that such approaches can be effective to a certain extent. On the

other hand, the results seem to indicate that drug users from ethnic minority groups are not underrepresented in mainstream drug treatment (as compared with the percentage of persons from ethnic minorities in the total population). Our findings show that making use of alternative coping mechanisms can complement service utilisation in general health care or specialised drug treatment services.

Consequently, we cannot conclude that there is competition between activities by (self-)organisations and mosques and institutionalised treatment services. Moreover, we found some indications that both parties are interested to combine forces and to collaborate more closely in the near future to help drug users from ethnic minority groups more adequately.

2.3.3 'Cultural blindness'

The hypothesis of 'cultural blindness' implies that existing treatment and prevention programs do not take cultural influences into account sufficiently (Castro & Alarcon, 2002). Based on this study, we can confirm the hypothesis of 'cultural blindness'. Several inadequacies have been reported concerning this topic. Although serious efforts have been made by caregivers to improve the cultural sensitivity of treatment programs, several elements still exist that interfere with this cultural sensitivity. It mainly concerns discrepancies about the perception of drug use and drug treatment and implies that clients' perceptions are insufficiently listened to and integrated in the programme. Caregivers seem to show insufficient openness and flexibility towards other conceptions, individualities, needs, values and follow the postulated programs and procedures too rigidly. Drug users of non-Belgian ethnic origin often feel less supported by a treatment program that stresses the importance of introspection, communication of feelings, ... As a consequence, caregivers are often perceived as incompetent and are not trusted by clients from ethnic minority groups.

Institutionalised practices that demonstrate some degree of cultural sensitivity are better evaluated and appreciated by drug users from ethnic minority groups. Such concessions make that these persons feel more attracted to the programme and are recognised in their cultural identity. Consequently, such efforts that are already made or that are planned by caregivers should be further stimulated and supported in order to move towards a culturally sensitive substance abuse treatment.