Race and gender in the delivery of drug services

These notes were originally made to support Nugget entries in Drug and Alcohol Findings drafted in 2002 and 2003 and do not constitute a full or systematic review of the literature

These notes focus on recent studies relevant to the issue of whether matching client and counsellor by race, broader cultural competence measures, or gender matching improve outcomes for problem drug or alcohol users. For ease of reference major studies are numbered.

Combined race and gender matching studies

1 One of the main research efforts has taken place in a poor area of Philadelphia. Researchers found that in a group therapy setting, gender- and/or race-matching of patients and counsellors did not decrease the number of early dropouts, increase the proportion of treatment completers or reliably improve 9-month follow-up outcomes.[1] Subjects in this study seem to have been drawn from the same larger study as the subjects in a later study **(2**) and (with the exception of larger sample sizes – 1018 for the intake sample, 369 for the retention analysis and 269 for the follow-up analysis) the same limitations apply. A yet earlier study at the same facility on a separate sample of 634 African-American clients found that gender or race matching to the intake counsellor did not increase the numbers who returned for therapy.[2]

2 There was a clear reason why the findings in **1** might have been negative – the group therapy context. The researchers reasoned that matching effects were most likely to emerge from undiluted one-on-one counsellor-client encounters. They set out to test this expectation at the same facility and with similar patients, but found that even then, matching clients to therapists of the same gender or race does not improve retention or outcomes.

The study involved 116 African-Americans (two-thirds men) newly admitted for outpatient treatment of cocaine dependence.[3] As part of a larger study, they had been randomly allocated to 12 weeks of individual therapy. Ten counsellors (including three women and six African-Americans) conducted intake interview after which clients were allocated to one of them for therapy. Whether the client's first impression of the agency had been a person of the same gender or skin colour made no difference to the return rate; matched and mismatched rates were all within a few % of the 85% average.[4]

73 clients returned for a second session. On average they stayed in therapy for nearly eight weeks and attended 5–6 sessions; on neither measure did matching by race and/or gender make any noticeable difference. Six months after scheduled completion of therapy, 50 of the 73 patients were interviewed over the telephone. Just three out of 32 tests of whether matching made any difference to outcomes (including drug use, social and psychological problems, ongoing treatment, and occupational and legal status) were statistically significant, two of which favoured *mis*matching. These results could have occurred by chance. The conclusion was that there was no evidence supporting matching.

For several reasons this study was in itself weak evidence against gender or race matching. It was a test only of how black, largely unemployed[5] cocaine dependents respond to a limited range of therapists whom they will be seeing just once a week for 12 weeks. A broader set of race-on-race matching possibilities with enough therapists to submerge

individual differences, and/or more intense therapeutic contact, might have produced different results. The potentially crucial impact of the first encounter with one's allocated therapist was excluded from the analysis.

However, the findings do confirm earlier studies at the same agency on larger samples as well as limited evidence from controlled studies elsewhere which find at best a limited effect of race/gender matching. The limited effect seemed to be apparent in statistically insignificant follow-up results which suggested that race mismatched clients *were* more often continuing to use cocaine regularly and (perhaps as a result) tended more often to have been imprisoned or to have needed further treatment.

3 The other major research effort relevant to gender and race matching for (mainly) stimulant dependents was undertaken in Los Angeles in a similar treatment modality and again with a mainly minority group caseload, but this time the majority were women.

All 419 clients entering outpatient drug-free addiction treatment services in Los Angeles in the third quarter of 1994 were asked to participate in the study.[6] All but two completed intake interviews and 356 were re-interviewed eight months later, when for most treatment will have recently ended. Only the 302 clients for whom outpatient drug-free was their sole treatment modality and who returned for treatment after intake were included in the follow-up. Given the nature of the services, most clients used stimulants (mainly crack and methamphetamine) rather than opiates. 43% were black, 30% of European extraction, and 23% Latino. Due to deliberate targeting, two-thirds were women.

For both men and women, how the client perceived the service (as recalled at the follow-up interview) was far more strongly linked to engagement than what the client brought to treatment (as measured at intake). There were however some gender differences in the precise mix of active ingredients. For both genders the client-counsellor relationship was important, but in different ways: women who thought their counsellor cared about them engaged more in treatment while for men the significant factor was how helpful they thought the counsellor had been. However, some 70% of what made for engagement remained unexplained even by the wide array of variables measured.

4 A second report of the same study found that another aspect of the client counsellor relationship, empathy (how far the client feels the counsellor understands them), was also generally and strongly related to engagement with treatment and to abstinence from illicit drugs in the six months before follow-up.[7] Only among Latino clients were these links absent. The researchers then analysed the dataset to see if empathy had been greater (and engagement and outcomes improved) if counsellor and client had been of the same gender or from the same ethnic group. Due to smaller numbers from other groups, only white clients, African-Americans and Latinos were included in the ethnic matching analysis. Whether there was an ethnic match was judged by the client, a potentially important difference from the Philadelphia studies.

There was a strong positive link between gender or ethnic matching and the client's perception of empathy and this was consistent across genders, ethnic groups and age ranges. However, this did not consistently or strongly feed through to improved engagement in treatment or follow-up abstinence outcomes. In terms of abstinence outcomes, gender matching was moderately influential for women and slightly more influential for Latinos and older clients. Ethnic matching was moderately influential for women. Except for Latino clients, assigning clients to a counsellor they scored as above

average in empathy (regardless of race or gender) would lead to better outcomes than assigning on the basis of race and gender. At any given level of empathy, also having a counsellor of the same race or gender did not improve outcomes. In other words, the key factor was empathy, and though in some cases (especially relevant for the UK are the findings for women and older clients) matching by gender or ethnic groups helps generate a perception of empathy, generally other features of the client-therapist match are more important. One (speculative) way to understand this dislocation of empathy and outcomes is that empathy generated by physical characteristics (skin colour and gender) does not necessarily relate to the depth of the communication and trust between client and counsellor, the key feature in improving outcomes.

Other race matching studies

5 Race was the focus of a study of 15 US Veterans Administration (meaning clients were overwhelmingly men) intensive residential rehabilitation facilities.[8] 962 out of 1316 veterans (about half black and half white with severe alcohol and/or drug problems) were interviewed at intake, at one month into the programme, and three months after discharge. Reasoning that in this setting the resident group is the main therapeutic tool, the study compared treatment engagement and outcomes for black and white residents at facilities where most residents were black against those where less than 30% were black or where the race mix was between these two points. Though this was not intended, staff too tended to reflect the racial mix of the residents.

After baseline characteristics of the clients had been taken into account, at one month the proportion of black participants at the site had no impact on engagement whether in terms of the feelings of the clients or objective measures of compliance. At post-discharge follow-up there was a significant tendency for clients treated at facilities where the racial balance matched their skin colour to have more often remained sober.[9] However, an adjustment for the fact that seven comparisons were made rendered this finding insignificant. On the other six measures, including addiction severity and employment and housing status, there were no significant differences.

One factor may have especially mitigated against positive findings. The quarter of patients not included in the analysis would have included all those who left before the one-month interview could be completed. It is possible that the racial balance of the facility they had recently entered would have had its greatest impact at this early stage, contributing to early drop out. Patients kept in the analysis had all been sufficiently comfortable in the environment to stay for at least a month.

6 A major US multi-site study of non-residential cocaine addiction treatment randomised clients to several treatments including individual counselling plus group therapy.[10] In this condition 9 of the 12 counsellors were white and three African American, while 55% of the clients were white. There was no attempt to randomise to race-matched or mismatched counsellors. With the ASI drug use composite as the post-treatment outcome measure, there was no indication that "minority" therapists (ie, African American) had better outcomes with "minority" patients (presumably this means better than with white patients). This issue was not reported on for the other treatments probably because either none or just one of the therapists were non-white.

Cultural competence

It is possible that simply matching clients and/or therapists on race is ineffective without at

the same time adapting the intervention to the client group's needs and culture. In its *Models of Care*[11]National Treatment Agency [12] guidelines the English National Treatment Agency for Substance Misuse identifies "culturally competent services" as an essential ingredient of effective treatment. The same concept is emphasised in a recent report on delivering services to ethnic minorities published by the Drugs Prevention Advisory Service.[13] While there are theoretical reasons for believing such approaches should improve outcomes for minority clients,[14] there is also the argument that illegal drug users have almost by definition moved away from cultural norms derived from religion or heritage.

7 A rare attempt to operationalise the concept and to test it on substance users recorded disappointing results.[15] The test was based on the prediction that cultural competence would improve outcomes by improving the take-up of health and psychosocial services. Interviews with leaders of a representative sample of US outpatient services were used to rate each on both dimensions. Cultural competence was operationalised as the proportion of African American staff (presumably on the assumption that most clients would also be African American), whether the unit allowed clients to choose a same-race counsellor, the availability of single race therapy groups, clients, proportion of bi-lingual staff, and proportion of staff trained in working with different racial groups.

When other variables were taken into account, the results were "in contrast to what would be expected theoretically". Just six out of 20 possible ways culturally competent practices might be related to service take-up were significant, and one of these was in the wrong direction. There was no evidence that services characterised by several such practices had higher take-up or that these practices had greater impact in services with high proportions of minority clients. The results gave some backing to the use of single race therapy groups but none at all to offering clients a same-race counsellor.

The main methodological problem in this study was the operationalisation of the cultural competence variable. For example, the training element was not necessarily specifically cultural competence training and the measures related to the ethnic mix of staff and clients and to the match between them effectively measured the potential for race-matched therapy rather than the degree to which this actually happened. There was also the risk that clinical supervisors felt inclined to say, for example, that clients could choose a same-race counsellor when this was not the case or when this was dependent on counsellor availability. The outcome variable measuring take-up of ancillary services may also have been only tenuously linked to clinical outcomes.[16 17]

8 Another study effectively tested the main elements of the cultural competence approach.[18] African-American outreach workers contacted African-American heroin and/or cocaine users in Los Angeles. Contacts using illegal drugs or in need of drug treatment were invited back to a drug and alcohol service for a single session intervention intended to help them address their drug use and other problems. 222 attended and were randomly allocated to one of two interventions.

The control condition was a standard one-on-one assessment ending in referral to appropriate services. The other was a culturally congruent intervention tailored to "traditional" African American culture and communication patterns. A key element was the involvement of a former drug using 'peer' whose contribution was intended to mirror the collective nature of African American culture and to provide a role model by taking on the role of a second client. The session began with a shared meal and informal conversation. Then a motivational video was played and the three (client, paired 'client', counsellor)

participants moved into a counselling session which deployed motivational interviewing techniques to lead the client to make their own decision to move towards recovery. Stress was laid on motivational factors thought particularly relevant to African Americans including the important of one's recovery to the whole community and culture-based alternatives to drug use.

Exit interviews with both clients and counsellors revealed that the clients' assessments of their involvement in the session and of their motivation to seek help with their drug problems were significantly greater after the culturally congruent intervention, but this was not the case with their assessment of the degree of rapport between themselves and the counsellor. However, the differences were very small and only marginally significant, and whilst intake differences between clients were controlled for, there is no mention of a correction for the number of comparisons made. Had this been done it is unlikely that any significant effects would have emerged. Those which did may have been due to features of the experimental intervention other than its cultural congruence such as length, motivational style and the involvement of a 'peer'. It is also unclear whether the exit interviewer was blind to the type of counselling session which had preceded the interview. Given these caveats, the evidence for any benefit from the experimental intervention is weak.

9 There is some relevant work from outside the drug and alcohol sector. A study of the effects of cultural sensitivity training for counsellors seeing low income, black female clients revealed that clients' ratings were affected more by this training than by the counsellor's race..[19] Four black and four white female counsellors were each randomly assigned to receive or not receive a four-hour cross cultural counselling skills training workshop. The 80 clients were not allocated at random but by counsellor availability. Most were attending in relation to personal concerns, a quarter vocational concerns. Clients gave counsellors who had received the cultural training higher ratings for expertness, trustworthiness, attractiveness, unconditional regard, and empathy than counsellors without the training. Clients who assigned to trained counsellors also had more follow-up visits and expressed higher rates of satisfaction with counselling. The retention advantage was substantial: just 11 of the clients whose counsellors had not been trained returned for the last of the three sessions compared to all but three of the those seeing trained counsellors. Differences in ratings of the counsellor and the therapy were apparent and substantial after the first session when attrition would have had little effect and remained substantial among retained clients. In contrast neither the counsellor's race (effectively also whether this matched that of the client since all clients were black) nor the impact of the training on clients with black v. white counsellors had any significant effects on client ratings though retention was but slightly but significant better among clients seeing black counsellors.

However, it is known that feelings of satisfaction[20] [21] [22] and of empathy generated by race matching[23] do not necessarily feed through to substantially improved retention or outcomes and when they do,[24] the effect may not be causal or may be a reverse causality – good outcomes creating greater satisfaction. In the current study the skills training component included four major elements just one of which seemed specifically cultural in nature as opposed to training of general relevance. Some of the content was relevant to anyone reliant on welfare payments, black or white. The training also included 'dummy runs' with black volunteers from a similar background to the clients the counsellors were later to see. Since no corresponding non-culturally specific training was given to the

control counsellors, the possibility cannot be excluded that it was the extra training in general rather than its cultural nature which improved outcomes. Trained counsellors had a chance to come to grips in advance with the techniques needed to forge a relationship with what previous work[25] described as difficult, hostile and disaffected group.

Gender matching

10 In the US Project MATCH study of alcohol-dependent patients in outpatient one-to-one drug-free treatment, overall whether client and therapist had been of the same gender did not significantly improve outcomes.[26] The one significant finding in a subset of clients was found when 12-step (rather than motivational or cognitive behavioural) therapy was provided as a standalone treatment rather than as aftercare following short-term intensive residential or non-residential treatment. In this condition, women were very slightly more likely to be abstinent from alcohol at follow-up if their therapist was a woman than if they were a man. However, the low level of significance of this finding allied with the very large number of comparisons made mean this exception could have occurred by chance.

11 The most rigorous test of single gender treatment in a residential setting derives from a US 12-step-based long-term residential rehabilitation facility serving a population characterised by low income and homelessness. The facility switched from a single mixed gender house to one for men and one for women, the latter also having only female staff.[27] Apart from consequential changes such as in the topics discussed in group sessions, the programme remained as it was before the split. Retention rates for the 174 clients discharged during the 18 months before the change was announced were compared with 230 admitted during the 18 months after it was implemented. Nearly two-thirds of the samples identified themselves as African American and nearly three-quarters identified cocaine as their drug of choice. Overall, roughly 80% of clients completed the initial intensive four-week programme and roughly half these stayed for at least three months, the minimum stay recommended for all clients. On average clients stayed for about three weeks longer than the minimum. On none of these measures had the change to single gender programmes significantly affected retention overall or of men or women separately. The conclusion was that providing a women-only environment *without also making the programme more gender specific* does not improve treatment retention and completion for women and similarly for men. For technical reasons it was not possible to statistically control for differences between the two cohorts but for women none of these were statistically significant and for men they tended to be small. Significance tests on retention rates were adjusted for the number of comparisons made. Differences in retention were generally small and for women favoured the mixed gender environment, suggesting that even without these corrections the switch to single gender housing would not have been found to have significantly improved retention. It might be argued that a service offering decent housing and employment services would be so attractive to the impoverished client group that any change would have had to have been very radical to affect retention, but this argument is belied by the fact that either side of the change to single gender services about 60% of residents did leave before the minimum recommended stay. The following account of three earlier studies is adapted from the literature review conducted for this study.

12 Several evaluations of gender-specific programs have been published, but before the above study only three had involved control[28] or comparison groups.[29 30] In a Swedish study, 200 women were randomly assigned in the early phases of alcohol problems to a

specialised outpatient women's programme or to one of two traditional mixed-gender treatment settings.[31] A two-year follow-up revealed decreased alcohol consumption and improved social adjustment in both groups, with the women in the specialised female unit demonstrating greater improvement. However, there was a significant correlation between length of treatment and outcome in both groups. Because the women in the experimental group were in treatment longer, the apparently better outcomes of this group may have been a result of differences in treatment intensity rather than the gender-specific programming.

13 The second study set in Australia compared changes in alcohol and other drug-associated problems among 80 women (primarily with alcohol problems) from a specialist women's service and 80 women from two traditional mixed-gender treatment services.[32] Six months after treatment there were no significant differences in any measure of outcome between the groups. The authors concluded that simply providing women with an all-female environment without changing the programme content did not substantially improve treatment outcome.

14 The third study compared drop-out rates and changes in levels of self esteem, social support, depression, and severity of addiction among 89 women treated in three inpatient programmes: gender-specific, mixed gender, and a combination mixed-gender/gender-specific treatment.[33] The women were mainly white and identified alcohol as their drug of choice. Results indicated that none of the three groups demonstrated improvement on any of the outcomes examined or in dropout rates.

A limitation of each of these three studies (**12, 13 14**) was that different treatment providers served each group, introducing the possibility that differences among the groups in treatment approaches or philosophy may have contributed to the failure of each study to find significant differences between mixed-gender and gender-specific groups. For example, in one the three groups included a women-only residential programme based on a feminist model; a mixed-gender, residential programme based on a medical model; and a mixed-gender detoxification programme.[34] Furthermore, the treatment groups differed in the recommended lengths of stay, exposure to 12-step groups, and the amount, if any, of individual counselling, health care, and group topics such as parenting and self-esteem.

The broader literature on gender[35] or race[36] matching of client and therapist in psychotherapy is equivocal over whether this improves outcomes, lending weight to the more limited findings from substance abuse treatment.

Beyond matching

Other work and perspectives on race

With respect to mental health services generally including help with drug and alcohol problems, there is accumulated evidence that providing services relevant to the language, culture and expectations of US Asian, Chinese and native American populations greatly increases the uptake of those services and improves retention and outcomes relative to standard services.[37] One example is the prescription of disulfiram for drinkers from cultures and social groups such as American Indians within which the refusal to share a drink is taken as a personal affront. The medication gives patients an acceptable 'excuse' not to join in.[38]

An account of the work a mental health and alcohol counselling service in London staffed

by and run for people of Asian descent describes how when such services become available in an area, demand previously invisible to mainstream services becomes apparent.[39] Whilst each client must be treated as an individual the service finds that an awareness of the cultural backgrounds of clients and of the experience of being a visible minority in Britain is important. Clients able to converse in their first language and who feel at home in the service are more likely to be able and willing to express themselves. In particular, the more collectivist culture typical of Asian communities means services must be aware of the salience of family ties and the possibility of inter-generational conflict especially between first and second generation immigrants. Sometimes the involvement of the family in the counselling process is beneficial. For Asian women in particular, attending a counselling service is often culturally too big a step to take and one which may have repercussions in the form of the reactions of husband and family. In this situation, home visits will be the best way to engage new clients and deliver services. In this and in other work the experience of racism in Britain is seen as a core variable shared across otherwise diverse visible minority groups.[40]

More so than for white clients whose family origins are British, confidentiality is often seen as crucial to services for those minority groups for whom shame in the eyes of the family and their community and shaming those same groups is a powerful motivator for not accessing help.[41] [42] [43] [44] Beyond confidentiality, this dictates sensitive siting and promotion of drug and alcohol services and the availability of staff who do not share as well as those who do share the client's cultural background and group affiliations.

Other work and perspectives on gender

If whether one's counsellor is male or female seems have little impact, the same cannot be said of their interpersonal style, including traits thought of as typically masculine or feminine. In the US Project MATCH alcohol treatment study, in contrast to gender (or age and, except for a *negative* association in 12-step-based therapy, education and years of experience), the interpersonal style of the therapist did affect outcomes.[45] For example, in 12-step-based therapy a higher need for aggression was associated with better outcomes while the reverse was the case in the more non-confrontational motivational therapy, where low masculinity and a high need for nurturance also seemed to help. So whilst in this study actual gender was rarely (if ever) statistically significant, traits commonly associated with masculinity and femininity were. Similarly, a study of 98 addiction therapists in the Netherlands[46] found that their views ('stereotypes') of the typical personality of male and female alcoholics were not related to the therapist's gender but were related to their own self-reported interpersonal style, in particular to how dominant, dependent or conventional and cooperative they were.[47] In turn it was speculated that these perceptions would affect their therapeutic work with male and female alcoholics. The conclusion was that rather than gender, the interpersonal style of the therapist might be relevant for matching client and therapist. From the other side of the table, a US study sought the views of 24 women in treatment at a centre which specialised in female substance abusers.[48] They were mainly former heroin users in methadone maintenance treatment. Each had been through at least two prior treatment episodes. Asked what was important for them in their treatments to date, they reported that while they preferred the option of being able to choose a counsellor of a certain gender or race, above all they wanted counsellors to treat them with dignity, respect and genuine concern. The degree to which this was evident had, they reported, affected the degree to which they participated in and stayed in treatment.

The case is strong for making services more accessible to women by taking account of the access obstacles and service needs which affect women more often and/or more sharply than men. Practical tactics such as providing transportation or home visits have been found to increase treatment uptake among women for whom poverty, childcare responsibilities and fear of being seen entering a drug service preclude normal service access routes.[49] Four in ten of the clients of a Scottish home alcohol detoxification service were women, high compared to other treatment programmes.[50] In Austria and Switzerland expansion of outpatient treatment was associated with a greater proportion of women among alcohol patients in treatment, a trend though to have been due to women's fears about children being taken into care if the mother is admitted to hospital and practical difficulties due to the woman being the main child carer.[51]

Women involved in prostitution and with sexual health problems may be more open about these to another woman[52] and access to women counsellors may be especially important for women from some cultures. Services (especially residential services) which require women to be parted from their children will be avoided by mothers for whom this is not an option.[53] A US study compared drug abstinence outcomes for mainly black, poor cocaine-using women with children in care who were attending either a standard drug treatment facility or one enhanced with a view to making access easier for mothers and providing more of the kind of help they are likely to need.[54] Attending an enhanced facility was strongly related to abstinence. Outreach and transportation services helped the most problematic women access services targeted to their needs and these in turn helped them overcome their drug problems. In another study providing all-female mutual support group for formerly cocaine dependent homeless women was attended most often by women with the greatest psychological and drug-related problems, the ones who tended most often to drop out of the professional female-staffed case management programme.[55] Virtually all the women in this study had been sexually or physically abused by men and some reported that they would have found mixed gender groups less attractive and more difficult to cope with. These studies are instances of the broader finding that providing extra services targeted to the non-drug problem needs of male or female clients such as housing and employment improve outcomes generally and in the areas targeted[56 57 58] and that practical aid such as transportation improves access.[59]

However, some studies have not found this to be the case.[60 61] Sometimes it depends on the precise shape the service takes and the context within which it is offered. In the USA sending a vehicle to pick people up for drug abuse outpatient treatment improved attendance rates but offering to pay transport costs did not.[62] Again in the USA, parenting and/or pregnant mainly heroin-using women referred to outpatient (mainly methadone maintenance) treatment were randomly assigned to normal intake procedures or to these supplemented by phone reminders for appointments and offers of transport and childcare.[63] These neither improved service admission rates nor helped prevent discharge from the service. Transportation was widely used but childcare only rarely, primarily because these new clients had yet to develop sufficient trust in the service.

Conclusion

Studies so far have generally failed to find any or any substantial benefit from matching client and counsellor on race or gender. However, the evidence is slim, limited to what happens once a client has entered treatment, and on race seems mainly limited to US black versus white populations. Matching at this crude level and of populations which may be

well assimilated into the dominant culture seems of little benefit, but this does not eliminate the possibility that matching races and cultures more distant from the dominant culture (for example, newly arrived African immigrants) would have a beneficial impact. The negative evidence is very far from being sufficiently extensive or robust to justify the dismissal of matching but neither has work so far supported its use for major minority populations or in major service modalities.

In contrast to race/gender matching, experience and some research indicates that taking account of the needs and access restrictions often associated with race, culture, language and gender is important both to improve and equalise access to services and to ensure that appropriate services are delivered in an appropriate manner. However, the ability to take these into account is not necessarily or strongly linked to the staff member's skin colour or to the extent to which this matches that of the client. Once someone has attended for treatment, the race or gender of the therapist is generally far less important than their sensitivity to the needs of the individual and their ability to form an empathic and therapeutic relationship with the client. Services cannot assume that simplistic matching of gender or race will in itself create such a bond. Exceptions may include some cultural groups very uncomfortable at not seeing (or sometimes, seeing) people from their own community, certain patients such as those who cannot express themselves adequately in the majority language, and women who have been abused by men, as well as clients with strong preferences. But in general, services do not need to concern themselves over whether clients are assessed by or allocated to a counsellor of the same race or gender.

There is some evidence that the client-counsellor relationship and client motivation can be improved by staff training in race/culture issues but the evidence is weak, often negative, and results are obscured by confounding and uncontrolled variables. At this stage it cannot be said that cultural competence training is an evidence-based means of improving the quality or outcomes of therapy or that it adds value to general counsellor training and experience with the relevant client group. On the other hand, there is a strong evidence base for the importance of the counsellor forging an empathic relationship with the client which makes them feel that their individual needs are being understood and responded to in a constructive manner. To the degree to which cultural competence training contributes to this individual-level communication it can be expected to improve outcomes. However, it may be counterproductive if it encourages a focus on general characteristics associated with race and cultural heritage to the exclusion of factors such as poverty and class or an appreciation of the individual as an individual whose supposed 'origins' may have little to do with where they are currently 'at'.

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[1]Sterling R.C. *et al*. "Therapist/patient race and sex matching: treatment retention and 9-month follow-up outcome." *Addiction*: 1998, 93(7), p. 1043–1050.

[2]Gottheil E. *et al* "Therapist/patient matching and early treatment dropout." *Journal of Addictive Diseases*: 1994, 13, p. 169–176.

[3]Sterling R.C. *et al*. "The effect of therapist/patient race- and sex-matching in individual treatment." *Addiction*: 2001, 96(7), p. 1015–1022.

[4]Also irrelevant was whether they were scheduled to see the same therapist who had conducted the intake interview.

[5]To go by the full sample enrolled in the larger study as reported in an earlier paper: Sterling R.C. *et al*. "Therapist/patient race and sex matching: treatment retention and 9-month follow-up outcome." *Addiction*: 1998, 93(7), p. 1043–1050.

[6]Fiorentine R. *et al*. "Client engagement in drug treatment." *Journal of Substance Abuse Treatment*: 1999, 17(3), p.

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[7]Fiorentine R. *et al*. “Drug treatment effectiveness and client-counselor empathy: exploring the effects of gender and ethnic congruency.” *Journal of Drug Issues*: 1999, 29(1), p. 59–74.

[8]Rosenheck R. *et al.* “Participation and outcome in a residential treatment and work therapy program for addictive disorders: the effects of race.” *American Journal of Psychiatry*: 1998, 155, p. 1029–1034.

[9]It is unclear whether the term “sobriety” used in the paper refers to alcohol or to alcohol and illicit drugs or to the drug which constituted the client’s main problem at intake.

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