Georgia Opioid Strategic Planning, Multi-Cultural Needs Assessment

May 2020

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Data Collection

data collected December 2019–March 2020

Executive Summary

An interdisciplinary team of Kennesaw State University researchers captured the voices of Georgians related to resources, services, and treatments for opioid and substance misuse disorder through a Multicultural Needs Assessment Project.

Georgia has attempted to respond to the current opioid and prescription drug abuse crisis by developing a coordinated multi-stakeholder and multi-system strategic plan. However, the voices and experiences of populations from diverse cultural backgrounds were not adequately understood, captured, or represented in the state's strategic plan. Consequently, the Georgia Department of Public Health initiated a state-level Multi-Cultural Committee to conduct preliminary research to better understand the experiences and needs of African Americans, Latinos, seniors, college students, transgendered persons, individuals who are homeless, and veterans. This understanding was captured from the perspectives of the individuals representing these sub-populations as well as the service providers who serve these groups. The researchers employed systems thinking and design thinking orientations to guide this study.

Some of the key findings and recommendations from participants are as follows:

- Emotional pain was a major trigger for starting substance/opioid misuse.
- Participants were sensitive to the level of judgment they experienced while accessing services, resources, or treatment. They discussed the importance of their counselors/therapists being more empathetic and offering culturally appropriate care that responds to their specific needs and situations.
- Spirituality was an important component in the participants' recovery process.
- Participants identified barriers to accessing housing due to prior convictions, lack of employment, federal policies, and stigma associated with substance misuse.
- Participants would like for physicians to be better trained in making appropriate diagnoses and referrals for care/treatment.
- Information about prevention and interventions should be disseminated through culturally appropriate mediums.
- Participants recommended strategies to reduce the stigma surrounding substance and opioid misuse disorder.
- Peer support should be consistently available across all cultural groups.
- Treatment programs need to address poly-substance misuse and also provide harm-reduction strategies (e.g., clean-syringe exchange).

With this research we have captured some of the voices and experiences of populations from diverse cultural backgrounds that were not adequately understood, captured, or represented in the state's strategic plan. This study lays the groundwork for additional, and more in-depth, research to understand the experiences of the populations (since we only captured the voices of 56 participants). Additionally, this report's findings and recommendations can be used by the stakeholders and service providers implementing the state's current strategic plan.

Keywords: Multicultural, culture, substance misuse, opioid misuse, substance use disorder, systems thinking, design thinking

Acknowledgments

In 2017, the President of the United States designated the opioid and prescription drug overdose crisis a public health emergency, setting the stage for broad and sweeping governmental action. This crisis has adversely impacted the nation, our states, our communities, our families, and countless individuals who have succumbed to its devastation. In an effort to help mitigate the ravaging effects of this epidemic, the State of Georgia developed a multi-faceted collaborative strategic plan, which includes the following domain areas: surveillance, prescription drug monitoring, law enforcement, education and prevention, treatment and recovery, risk reduction, maternal abuse, palliative care, and a multi-cultural committee. The latter was developed to make sure that traditionally underserved communities were included in the state's opioid and prescription drug overdose strategic plan.

The above strategic plan is the result of a Centers for Disease Control-funded cooperative agreement that included surveillance, collaboration, coalition building, and the development of a statewide strategic plan. The multi-cultural committee was awarded funding to conduct a community needs assessment examining the needs of underserved communities related to the opioid and prescription drug overdose epidemic in the state of Georgia. This project was led by a team of dedicated researchers from Kennesaw State University including Lawrence Bryant (PI), Monica Nandan (co-PI), and Sherrie Cade.

The project team would like to thank all of the community-based organizations, key informants, and individuals who provided valuable input for this project. We would also like to acknowledge Bianca Anderson (GDPH), members of the multi-cultural committee, the Dean and staff of the WellStar College of Health and Human Services, and the Grants Office at Kennesaw State University for their tireless leadership in supporting the goals of this project.

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Introduction

The opioid and prescription drug overdose crisis is one of the largest epidemics in American history; according to the President of the United States, this catastrophe represents a National Public Health Emergency and affects every ethnic and racial group (Ketura & Jordan, 2018). In fact, the rate of overdose deaths since the year 2000 has nearly quadrupled, with over 500,000 deaths in just under 20 years. According to the Centers for Disease Control (CDC), this epidemic occurred in three distinct waves (see Figure 1). In the 1990s, the first wave began with the systematic increase in the prescribing of opioids. In 2010, the second wave was marked by a rapid increase in the number of overdose deaths attributed to heroin. The third wave saw a dramatic increase in overdose deaths due to synthetic opioids, specifically, the illegal manufacturing of Fentanyl (CDC, 2018).

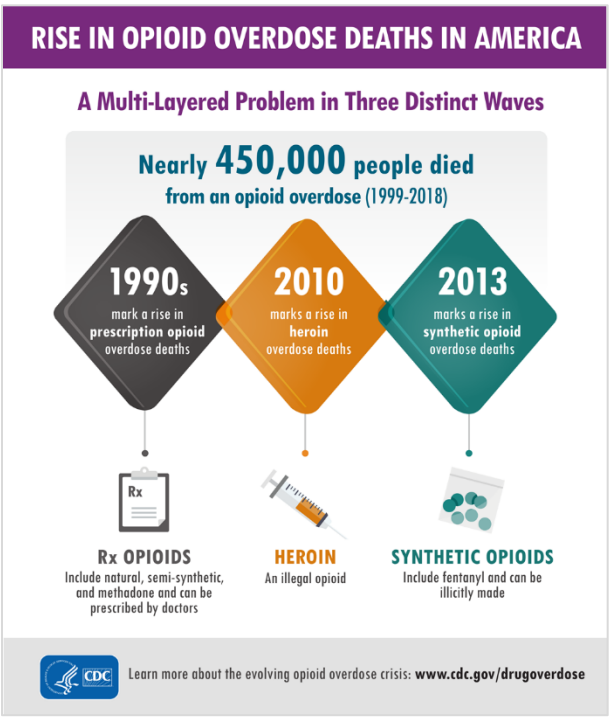


Figure 1 – Wave of Opioid Overdose Deaths

https://www.cdc.gov/drugoverdose/images/data/2018-DataVis-3-Waves-450K_2.png

Recent surveillance data from the Georgia Department of Public Health revealed that opioid-overdose death rates involving males decreased from 2018 quarter 1 to 2018 quarter 3, then increased in 2018 quarter 4. In contrast, opioid-involved overdose death rates among females decreased in 2018, except in quarter 3 (Figure 2), (Georgia Department of Public Health, 2018).

According to the Georgia Department of Public Health (GDPH) Surveillance Report, between 2016 and 2018, Whites were 3.5 times more likely to die from an opioid related overdose than Blacks; however,

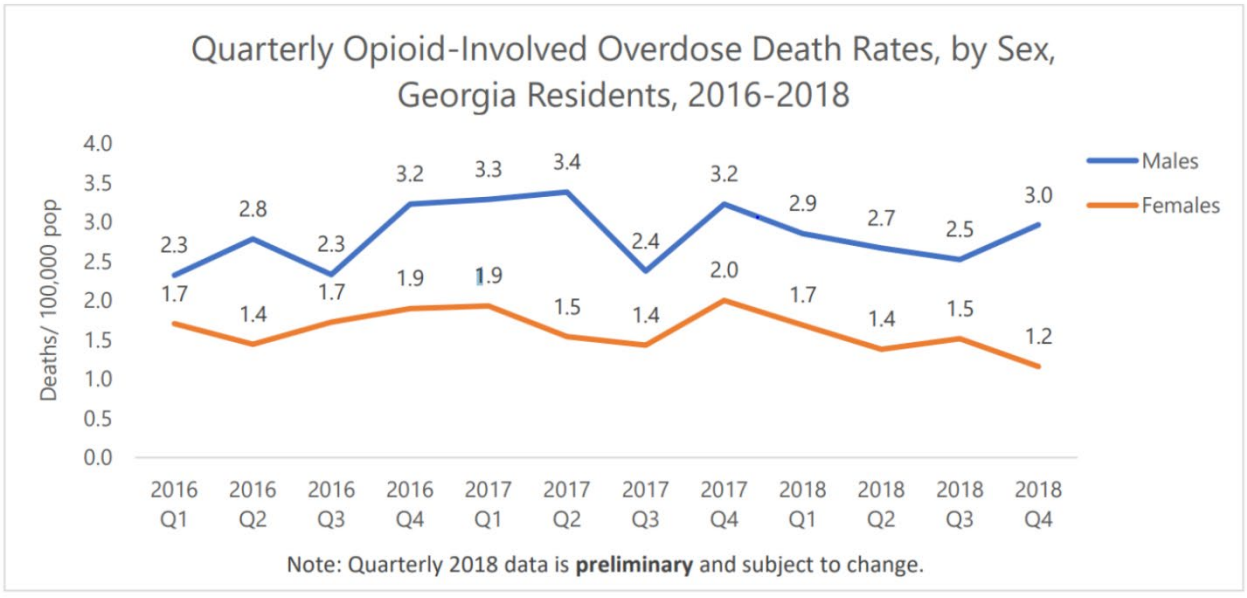


Figure 2 – Georgia Department of Public Health, 2018 Surveillance Report

during this same period, the trend among Whites was downward, while remaining steady in the Black community (Figure 3). This trend has far-reaching implications for the Black community because the focus of the opioid epidemic has mostly targeted Whites (James & Jordan, 2018).

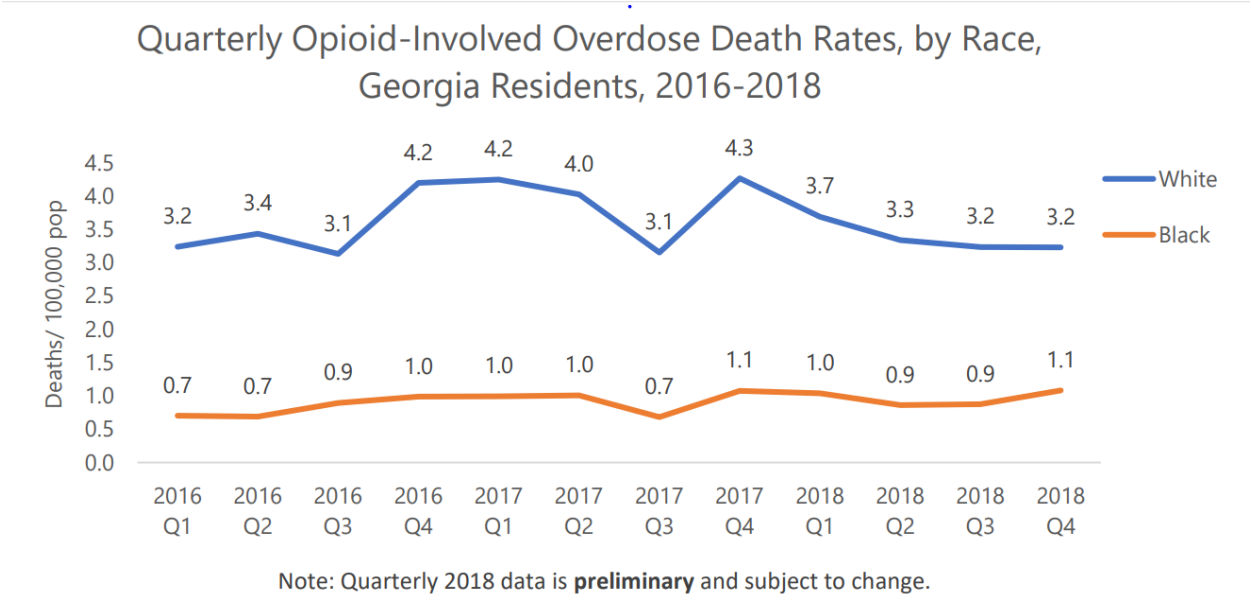


Figure 3 – Georgia Department of Public Health, 2018 Surveillance Report

In 2017, over 200 community stakeholders from all areas of Georgia convened in establishing the formative phase of the statewide plan. Stakeholders included consumers, intermediaries who make referrals to services, service providers, educators, advocates, legislators, community-based organizations, and state and federal representatives. One issue was consistently identified by multiple stakeholders: limited representation of members from diverse ethnic and cultural backgrounds in developing the plan. Data, treatment options, services, etc. were reported predominantly from the point of view of the White population in Georgia. Research has clearly shown that individuals from African American, Latino, and the Lesbian, Gay, Bisexual, and Transgender (LGBTQ) communities have very low substance treatment completion rates (Guerrero et al., 2013). Furthermore, there are several gaps in addressing the mental health needs of underserved populations (e.g., Latino), especially as those needs relate to substance use disorders (Villalobos & Bridges, 2018). Additionally, the southern and western United States report lower rates of implementing strategies that address behavioral health in traditionally underserved populations of less than 50,000 people (Shah et al., 2016). Consequently, the GDPH created a Multicultural Committee to identify and incorporate the voices of diverse populations into the state level planning process.

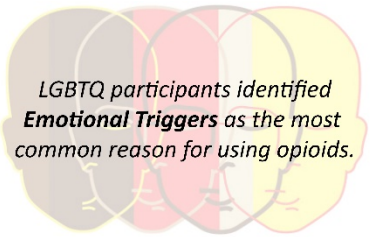
Three faculty members from Kennesaw State University (KSU)—members of the Multicultural Committee—co-authored a grant proposal to understand the lived experiences of individuals or their family members who had experienced substance and opioid misuse. Two Graduate Research Assistants and one Graduate Assistant (GRAs/GA) also were part of the research team—all were CITI trained. The research proposal was approved by the KSU Institutional Review Board, and data was collected between September 2019 and November 2019.

This report describes the background for the study, provides a literature review, describes the methodology employed for data collection, outlines key findings, and concludes with recommendations for researchers, service providers, and policy makers.

Background: Problem and Significance

Much of the media and political focus surrounding overdose deaths from the opioid and prescription drug epidemic centers around the middle-class White population (James & Jordan, 2018). We have not adequately examined the epidemic's impact on other ethnic, racial, and cultural groups, and thus, we do not completely understand the experiences and needs of these different communities based on their context, their culture, and the systems that impact their access to services (Alegria et al., 2015). For example, African Americans are 14% less likely to initiate substance abuse treatment than Whites (Acevedo et al., 2012), but the reasons why are not entirely clear.

We also do not know much about the experiences that lead diverse sub-populations towards substance use disorders (SUD) and opioid use disorders (OUD), nor do we know much about their experiences when they seek help, treatment, or information. Understanding the barriers that these populations face is especially important for vulnerable populations, such as people with mental illnesses and the elderly (Bauer, et al., 2005, p. 13).



Interestingly, there appears to be a significant gap between resources and information needed by individuals from different cultural and racial groups, and what is available in communities. This mismatch seems pervasive among all groups, particularly based on the Surgeon General's report, which states that only one in 10 suffering from SUD nationally receives the treatment they need (SAMSA, 2016). Also, among people who access treatment or services, African Americans and Latinos are more likely to have unsuccessful initial treatment sessions, which can discourage them from returning to the setting (Guerrero et al., 2013).

The Problem

In Georgia, notwithstanding the Multi-Stakeholder Opioid and Substance Use Response Plan, the understanding about lived experiences of individuals from different cultural groups is still sparse (e.g., African Americans, people who are homeless, Latinos, elderly, veterans, and LGBTQ persons). In other words, we have not adequately examined the experiences of different ethnic and racial groups within Georgia to incorporate into the GDPH Opioid Strategic Plan.

Purpose

The primary purpose of the study was to address the following question:

> *What are the experiences of people from different cultures (African Americans, Latinos, and people who are homeless, college students, elderly, veterans, and LGBTQ, especially transgendered persons) as they relate to opioids and substance misuse?*

The secondary purpose of the study was to share key findings with state level strategic planning working groups for them to design strategies and policies that are more responsive to, and inclusive of, different voices from across the state. We used a qualitative research methodology (particularly Human Centered Design), focus groups, and key informant interviews with samples from the aforementioned cultural groups and providers who serve these populations.

Theoretical Framework

This section outlines the conceptual underpinnings of the Multicultural Committee's project and describe how these ideas guided the project.

Systems Framework

SUD, like many other mental health behaviors, do not occur in isolation; they are affected by people, places, environments, circumstances, policies, and communities. Systems theory best captures this interconnectedness. According to this theory, the various sub-systems surrounding individuals interact and influence the experiences of the individuals experiencing SUD and behavioral health challenges. As defined by Meadows (2008), systems thinking has three salient components:

1. a multidisciplinary group of interrelated component parts that integrate to achieve a unified goal;
2. interactions of the independent parts that drive the system (every interaction creates new properties that are specific to the system and are not caused by any one part by itself); and,
3. a holistic approach to analysis (the system must be studied as a whole entity, not just by merely analyzing individual parts).

Not only does a systems approach look at smaller influences, it captures how other systems and sub-systems impact each other (McNeece, 2012). In their groundbreaking work, Teerikangas and Hawk make the following sweeping proclamation: "Given the holistic, flux-like, and complex nature of the concept of culture, it seems apparent that any meaningful study of culture will require multiple approaches to recognizing its multiple characteristics. It seems clear that systems thinking helps us see and appreciate the multi-faceted nature of culture" (2002, pg. 1). The DPH strategic plan was based on systems thinking.

Conditions of Systems Change

The "Water of Systems Change" inverted-triangle framework (see Figure 4) helps us think systematically about SUDs and forces us to examine the minute nuances below the surface in promoting change and solutions in a more holistic manner (Kania et al., 2019). The following six salient features emanate from this perspective:

- **Policies**: Rules, regulations, and priorities (formal and informal)
- **Practices:** Organizational and practitioner activities targeted to addressing and making progress
- **Resource Flows:** How money, people, knowledge, and information are allocated and distributed
- **Relationships and Connections:** Quality of connections and communication occurring between actors

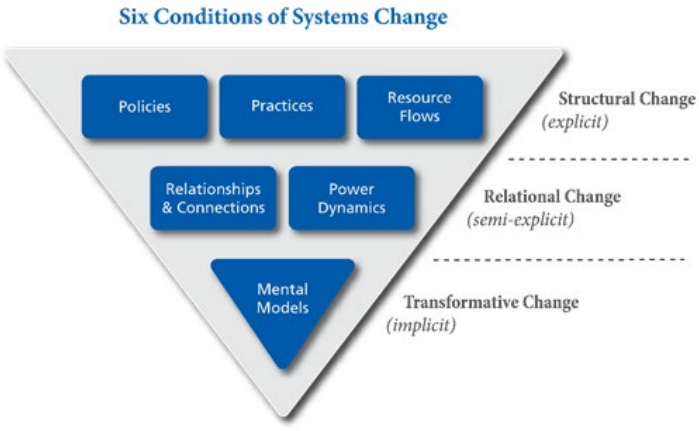


Figure 4 – Six Conditions of System Change
Water of Systems Change *(Kania, Kramer & Senge, 2019)*

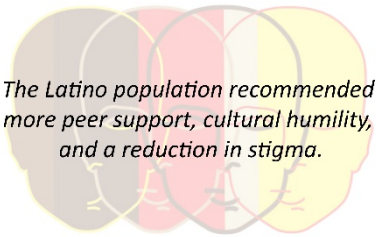
- **Power Dynamics:** Which individuals and organizations hold decision-making power, authority, and influence (both formal and informal)
- **Mental Models:** Deeply held beliefs and assumptions that influence people's actions

This framework clearly illuminates many of the elements associated with the Georgia Department of Public Health's strategic plan for dealing with the substance, opioid, and prescription drug overdose epidemic. For example, on December 17, 2017, the Department of Public Health, in keeping with the CDC cooperative agreement, hosted and facilitated its first strategic planning meeting, with over 200 organizations, individuals, governmental entities, and national figures in attendance. This gathering brought together stakeholders (who organized in workgroups) from across the state and nation to make recommendations, provide solutions, and combine resources in combating the opioid epidemic. The strategies designed by the various workgroups addressed several explicit and semi-explicit levels of system change noted in Figure 4. The development of the state level Multicultural Workgroup was an effort towards creating transformational change. This study is the first such effort towards understanding the experiences of diverse groups in order for the state to design strategies for transformational change.

Multicultural Systems Perspective

As suggested by Kania et al. (2019), quality of connections and communication, when working with clients of different cultures, is of paramount importance; furthermore, the provider should be aware of the dynamics of the helping relationship with hopes that the cultural influences of the client can affect the therapeutic relationship. Diller (2015) suggested that the provider should respect the client, develop rapport, and pay attention to verbal and nonverbal communication.

While (and before) designing strategies and interventions for addressing the epidemic at a systems level, it is very important to understand the differential experiences of the subpopulations that are non-white, middle-class suburban. Understanding the issues within diverse communities and examining their access to information, treatment and recovery can better guide Georgia's strategic planning process. Despite recent advances in treatment modalities and improved access to care, there appears to be a significant mismatch between the treatment/information/resource needs and treatment/information/resource provision. We have not adequately studied the different ethnic and racial groups, for instance, to understand the different experiences and needs, based on their context, culture, and systems that they access (Alegria et al., 2015).



Design Thinking

In addition to using multicultural systems thinking to guide our understanding of the lived experiences of diverse cultural groups, our research team also employed a design thinking perspective and process.

This unique perspective and process has several qualities which complement systems theory. For example, its tenets are human centered, possibility driven, option focused and iterative. In other words, the focus is on people, not merely demographic and numerical representations. In its purest element, design thinking delves deep into the experiences, problems, and lives of those we want to help; this process sets the stage for meaningful solutions and conclusions (Liedtka, et al., 2019).

Though individual elements of design thinking have been used in management, the entire process "brings together both creative and analytic modes of reasoning, accompanied by a process and set of tools and techniques" (Liedtka, 2015, p. 929). It is a useful mindset, orientation, and toolkit for countering the

various forms of cognitive biases that decision makers often yield to, such as projection bias, egocentric empathy gap, hot/cold gap, hypothesis confirmation bias, and availability bias, to name a few (Liedtka, 2015). Hence, for tackling "wicked problems" that are non-linear, not easy to define, context sensitive, and have a high degree of uncertainty (Rittle, 1972)—such as the opioid overdose crisis—design thinking holds great promise as a useful tool.

Literature Review

The literature review covers sources published since 2010, and search terms included the different cultural groups (college students, seniors, veterans, LGBTQ, homeless, African Americans, Latinos), with regard to their experiences in seeking information, resources, and treatment. Based on the aforementioned conceptual frameworks that guided the study, this section is categorized into: a) reasons for misuse of substances; b) help seeking behaviors and accessing services; and c) completion of treatments.

Reasons for Misuse of Substances (Alcohol, Drugs, Opioids)

College students face higher levels of stressors than their counterparts in the general population, which lead to mental health challenges (Hubbard et al., 2018). Understanding these challenges and how college students seek assistance is important in designing a more responsive service delivery system. Moreover, among college students, prevalence of mental illness was highly correlated with substance misuse, specifically non-medical use of prescription drugs and alcohol (Lo et al., 2013). Students with mental health challenges continue to face barriers in receiving services and accommodations to continue and excel in their academic journey (National Council on Disability, 2017).

U.S.-born Latino populations tend to have a higher rate of alcohol and drug use disorders than immigrant Latino populations; furthermore, Latino men have a higher SUD rate than women (Villalobos & Bridges, 2018). These findings were confirmed in another study, where lifetime prevalence of drug use was greater among U.S born Hispanics than immigrants, after controlling for age, gender, income, education, urbanicity, parental use of drugs, and DSM IV mood (Mancini, Salas-Wright & Vaughn, 2015). Childhood physical abuse among Latino men, feeling discriminated against, and being born in the U.S. were positively correlated to lifetime substance abuse (Ai, et al., 2016).

The homeless population in Atlanta, GA displays a correlation between substance misuse and three factors: childhood abuse, early exposure to drugs, and chronic pain. (Flanagan & Briggs, 2016). Based on these findings, Flanagan et al. recommend that in order to facilitate change, the homeless population's lived environments must promote positive social supports that incentivize positive routines and practices.

The mental health of diverse populations is highly correlated with contextual situations—neighborhood quality, safety, economics, access to affordable health care, etc. In particular, the stress that African American males face in terms of systemic oppression and blatant racism influences their overall mental and physical health. Williams and Jackson (2005) recommend that policies and practices need to address disparities through a "cultural lens" rather than a one-size-fits-all approach. Unfortunately, even though greater attention is being paid to cultural competency for reducing health disparities, and providers are developing initiatives in cultural competency, "the motivations for advancing cultural competence and approaches taken vary depending on mission, goals, and sphere of influence" (Betancourt, et al., 2005, p. 499).

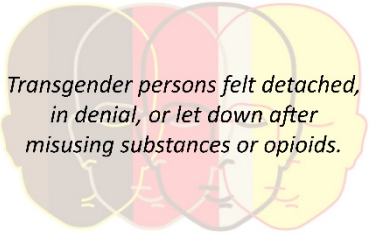
Among older adults, substances are used to manage isolation and loneliness. Among LGBTQ adults, multiple types of discrimination affect use of substances and accessing treatment of SUD (Li & Caltabiano, 2017). Transgender individuals are far more vulnerable to SUD than cisgender, heterosexual, and their non-transgender LGBTQ counterparts (Oberheim, et al., 2017).

Help-seeking Behaviors and Accessing Treatment

Vulnerable populations, particularly veterans with mental health problems, disabilities, and severe physical problems can and do access care, but they still experience significant barriers (Bauer et al., 2015). Military norms of stoicism and self-reliance reduce veterans' likelihood of seeking formal services, and veterans dealing with mental health symptoms often try to use self-coping strategies. Negative encounters with the health care system (e.g., service providers' assumptions about veterans or the nature of their military service; the insensitive nature of questions posed by health care providers that re-traumatize the veterans), and difficulty in driving to and from health care appointments all contribute to veterans abandoning mental health treatments (True et al., 2015).

Level of trust (attitudes), disparities in access to mental health care, and especially the stigma attached to mental health dissuade African Americans and Latino population from seeking help and accessing services (Fripp & Carlson, 2017). A study of the African American churchgoing adults revealed that knowledge about signs of mental illness is positively related to help-seeking behaviors and is negatively correlated with stigma. Individuals who do not stigmatize mental illness are more likely to seek assistance for themselves or their loved ones (Neely-Fairbanks, et al., 2018).

Individual attitudes, subjective norms, and perceived control all influence individuals' accessing substance abuse treatment. Latino men, more than White and Black men, report experiencing attitudinal and subjective norm barriers to accessing treatment (Pinedo, et al., 2018). Unfortunately, African Americans are more likely to be referred to the criminal justice system, and Whites to crisis services, when they seek assistance; further, African Americans and Hispanics are more likely to have drug use disorders and Caucasians are more likely to have alcohol misuse disorders at the time of seeking assistance (Delphin-Rittmon, et al. 2012). James and Jordan (2018) confirm that criminalization of substance misuse is more common for African Americans than Whites. They further note that a lack of discussion in the national opioid discourse on overdose deaths in the Black community further marginalizes Black people.



Since a large percentage of the Latino population is moving to non-metro areas, it is important to note their access to care and their help seeking behaviors in metro vs. non-metro locations (Berdahl et al., 2007). Furthermore, the language abilities, gender, and legal status of Latino individuals with SUD affect these individuals' likelihood of accessing care and treatment (Pagano, 2014).

Often, individuals seeking medical care may also need mental health care, and they may seek this care at the medical center. However, affordability is a major barrier to accessing mental health care even for those individuals who may seek medical care. Almost 40% of participants in the 2009 Health Center Patient Survey reported that they had an unmet mental health need that could not be addressed due to cost. Severity level of mental health needs also inversely impact access to care (Jones, et al., 2014). Since mental health and SUD are highly correlated, understanding access barriers to mental health can shed light on SUD and Opioid misuse.

Completion of Treatments

Individuals who can access treatments sometimes do not complete the treatments or find them effective because the treatment procedures are not responsive to the recipients' needs or styles. Specifically, medicine-based treatments for OUD replaces one addiction for another rather than assisting with addiction behaviors and cravings. Absence of follow-up after treatment also hindered recovery and sobriety (Windsor & Murugan, 2012). Of those who access treatment, Latino populations tend to have a slightly higher

completion rate (10.6%) than African Americans (8.6%) (Guerrero et al., 2013). Even though African Americans and Latinos have lower likelihood of completing treatment than White counterparts, this outcome is further compounded by the fact that individuals who are homeless and are poly-substance users are even more likely to not complete substance misuse treatment (Stahler & Mennis, 2018). Longer time lags between sequential treatment sessions can further exacerbate engagement level of clients in treatment (Acevedo et al., 2012). African Americans have a higher treatment completion rate when referred by their employer and had a lower success rate when they were referred by their health care provider; in other words, a client's referral source makes a difference in successful completion of treatment (Sahker, et al., 2015).

African American consumers' readiness to change (RTC) influences their retention in treatment programs for SUDs. This correlation appears to be higher for men but not significant for women (Montgomery, et al., 2017). The concept mapping conducted by Windsor and Murugan (2012) of community members, service providers, and individuals consuming substances revealed that participants considered available treatments to be ineffective because they all employed similar techniques, and potential clients were seeking treatment techniques that were a better fit for their approaches, styles, needs, and attitudes. Another barrier to accessing treatment was the absence of specific health insurance to access care.

Individuals who are homeless and are misusing substances require a whole paradigm shift in the nature and types of services provided. They need a multi-systemic, multi-level intervention—individual, family/group, community, and society (Flanagan & Briggs, 2016). These individuals also need to feel a sense of agency and autonomy when they access care (Padgett, et al., 2008). For LGBTQ populations, having their significant other participate in treatment can positively influence their experience, increase program completion rates, and produce positive outcomes at the end (Senreich, 2010). Additionally, having a "safe" environment is very important for treatment completion and success for this population (Blume, 2016).

Cultural Humility

As suggested by Kania et al. (2019), quality of connections and communication, when working with clients of different cultures, is of paramount importance; furthermore, the provider should be aware of the dynamics of the helping relationship with hopes that the cultural influences of the client can affect the therapeutic relationship. Diller (2015) suggested that the provider should respect the client, develop rapport, and pay attention to verbal and nonverbal communication.

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As is evident from this review, there is some literature on the reasons for misusing opioids and other substances, on accessing treatments and services or not, on cultural humility, and the reasons for success or failure during treatment experiences. However, we could not locate any studies explaining factors that

played a role in consumption/misuse, where participants sought help, various experiences, and if treatment-seekers could participate in designing responsive services, what those services would look like.

Engaging consumers in the designing of interventions was not addressed in any of the aforementioned studies. Further, only one study attempted to conduct "concept mapping" with various stakeholders. Hence, our study attempted to bridge some of the literature and design gaps.

Methodology

This section outlines the research study's procedures. Topics include the study's purpose and research questions, sampling methods used to select participants, the theoretical basis of the chosen methods, data-gathering and analysis procedures, and interview guides used during the focus groups and the key informant interviews.

The Purpose

The primary purpose of the research study was to assess the needs of underserved populations in the state of Georgia related to the opioid and prescription drug overdose epidemic. This effort will aid in developing a more inclusive strategy in the statewide strategic plan.

Research Question

The following research questions informed this study:

- What were the experiences of people from different cultures and backgrounds related to opioids and other substance misuse?
- What types of creative solutions would they like to help co-create?

Sampling

We focused on sampling from the following groups: veterans, Latinos, African Americans, seniors, college students, homeless persons, and LGBTQ persons, especially transgendered persons. We identified human service organizations (HSO) that served these cultural groups and conducted five focus groups with representatives from these groups. We also identified executives and administrators within the HSOs and conducted key informant interviews with them.

For recruiting focus group participants, we used the cluster sampling model. We created a flyer that invited individuals who were opioid/substance users or knew of one, and asked the Multicultural Committee and HSOs to review and edit the flyer. The flyer was then distributed to different stakeholders via the Multicultural Committee members and executives/administrators of HSOs. These HSO affiliates distributed the flyer in-house and recruited clients who fit the study's participation criteria.

Our population sample consisted of five focus groups representing individuals from the LGBTQ and transgender communities, African Americans, college students, elderly, veterans, and homeless persons. However, since we were unable to identify an adequate number of Latino populations that could participate in focus groups, we were able to conduct telephone interviews with six Latino individuals who qualified to participate in the study.

For recruiting key informants from the HSOs, we used a combination of purposive and snowball sampling techniques. We invited key informants from the selected organizations to participate in a qualitative interview. If an informant was unable to participate, they made a referral to another similar organization. Six expert interviews were completed with executives/administrators from selected community-based organizations serving the above population groups.

Design Thinking Protocol

We employed a qualitative research methodology, specifically using a Human Centered Design Thinking (HCDT) protocol in focus groups and conducted key informant interviews. Rationale for using HCDT as a research tool is clearly explained by Zimmerman et al. (2007). The need for design research grew from the need "to formally address the increasing complexity" of issues that require non-linear social change solutions (p. 496). This methodology is based on the culture of inquiry to "look at the human condition, and ...understand through reflective practice, intellectual appreciation, and intentional choice" (p. 496). We used the first three of the five HCDT stages: empathy, problem definition and ideation for this research project. Co-Principal Investigators (Co-PIs) were trained in the HCDT protocol.

Data Collection and Analysis Techniques

This section describes how participant data was collected and analyzed. The focus group meetings and personal interviews described below were conducted between September 2019 and November 2019.

Focus Groups – During the focus group sessions, Co-PIs provided the context and, through some self-disclosure, built a "safe" environment for participants to share their experiences and personal journeys. Once the focus group participants were introduced to the purpose of the study and signed the informed consent form, they were invited to respond to nine open-ended questions. The responses were written on sticky notes, in capital letters, with no more than four words per response. They could write as many responses as they desired in the allotted time for each question (8–15 minutes).

After responding to each question, participants were invited to categorize and label their responses (see Figures 5 and 6 in the Findings section). They reviewed each of the sticky notes, discussed which ones were similar and would go together and physically moved the notes on the large poster sheets. They then arrived at a consensus on the label that best described each grouping. This methodology ensured validity of data. For one of the questions related to causal factors, participants were also invited to share their journey between the categories that they labelled, showing the substance use paths that they traveled.

Almost all cultural groups, except the Latino population, participated in focus groups. Given the current political environment, this segment responded to the questions over the phone, and all responses were recorded by the interviewer.

Participants received a $25 gift card for their participation in the study.

At the conclusion of data collection, the Co-PIs and graduate research assistants conducted cross focus-group analysis to identify themes in the category labels. Data collected from Latino participants were not integrated into this analysis because the data collection technique was different. However, data was analyzed, and categories were developed per question by one Co-PI.

Key Informants – Key informant interviews were conducted on the phone or in person, using a qualitative semi-structured interview process (Creswell, 2013; Patton, 2001), and recorded. The purpose of this process was to make the interviews more conversational, while also ensuring to cover the topics in the questions.. Key informants signed a consent form and responded to ten questions; eight were open-ended, and two were demographic in nature.

After each interview recording was transcribed, the researchers placed the responses to the questions requesting for "top three..." in a table (see Appendix I). The Co-PIs compared responses across the key informants and identified emergent themes.

Measurement tools

This section describes the interview guides used during the focus group meetings and the key informant interviews.

Focus Group – Focus group participants were asked nine open-ended questions covering these topics:

- causes for using opioids or other substances
- behavior changes that they noticed after substance use
- what was done when behavior changes were noticed
- where they sought treatment, help, or information
- the outcome or end result for each place they sought information
- what could have been better during their experience
- currently available support or resources in the community
- their ideas for innovative solutions
- topics that the interview guide may have omitted

See Appendix A for the complete Focus Group Guide.

Key Informants – Key informants were asked two questions about their professional positions and eight open-ended questions covering these topics:

- the population(s) served by their organization
- trends they were witnessing related to opioid and substance misuse
- the three top unmet needs related to these substances
- the top three unmet needs that contributed to misuse of substances and opioids
- the top three major barriers they encounter in effectively responding to the needs of the population they serve
- the top three resources that their population needs but are not currently receiving
- the organization's strengths related to serving their population
- topics that the interview guide may have omitted

See Appendix B for the complete Key Informant Interview Guide.

Findings

This section describes the sample for the focus groups and the key informants, and outlines major results drawn from each group's responses.

Focus Groups

This section describes the sample and summarizes the categories from each of the interview questions. In the five focus groups and six phone interviews, a total of 59 participants were present; each focus group had 9–13 participants. Table 1 describes the number of participants in each focus group and the total number of participants from each cultural group.

Table 2 – Demographics of Focus Group and Phone Interview Participants

Groups	Participants	Veteran	LGBTQ	Black	Hispanic	Student	Senior
FG 1	9	0	8	7	1	0	0
FG 2	10	3	0	10	0	0	0
FG 3	12	1	4	6	2	0	0
FG 4	9	0	0	0	0	0	9
FG 5	13	0	4	1	1	13	1
Interviews	6	0	0	0	6	0	0
Total	**59**	4	16	24	10	13	10

Causal Factors – Participants were asked to identify the causal/contributing factors related to the inappropriate consumption of substances/opioids, group their responses, and label each group with a descriptive category name.

Figure 5 identifies the top two most common categories for each cultural focus group (color-coded to match Table 1) and their contributing factors; the only exception is the Transgender community that identified only one category. The arrows illustrate sequential relationships between categories. For example, LGBTQ participants identified **Emotional Triggers** as the most common reason for using opioids, and specific contributing factors inside that category include ***the death of a loved one***, ***abusive relationships***, and ***traumatic events***. Exposure to these emotional triggers then led the participants into the **People, Places, Things** category, including the specific contributing factors ***proximity***, ***influence***, ***environment***, ***bad excuses***, and ***pain relief***. See Appendix C for complete responses.

Behavioral Changes – Participants were asked to identify and recall what behavior changes they noted after the misuse of substances/opioids by themselves or someone they knew. Participants were then asked to group their responses and label each group with a descriptive category name. Notable categories identified by various groups included

- **Attitudes**
- **Behavior**
- **Escape**
- **Financial Management**
- **Happy**
- **High Risk Behaviors**
- **Lack of Energy**
- **Lack of Responsibility**
- **Morals**
- **Outcomes**
- **Seclusion**
- **Withdrawal**

See Appendix D for a complete list of responses; category labels are in bold, with the corresponding responses below each label. For instance, seniors used the labels **Behavior** (***denial***, ***out of control***, ***stealing***, ***anger***, ***mad rage***, ***hyper***, ***high energy***) and **Withdrawal** (***stopped being social***, ***hiding***, ***hiding***). This level of analysis was not performed with the Latino sample because of the method of data collection; examples of Latinos' responses included ***unresponsive***, ***high anxiety***, and ***isolation***.

LGBTQ	1	Emotional Triggers: Death of Loved One, Abusive Relationship, Traumatic Events.	>	People, Places, Things: Proximity, Influence, Environment, Bad Excuses, Pain Relief
	2	Mental Health: Depression, Anger, Access, Anxiety, Sadness ,Death of Love Ones, Females	>	Unwanted Outcomes: Pain, Stress, The High, Bordem. The High: Peers, To Get High, To Have Fun
Students	1	Emotional Pain: Emptyness, Emotional Pain, To Numb Emotions, Feeling Lonely, Low self-Esteem, Pain Inside, Loneliness, Escape, Avoidance, Anger, Internal Pain, Spiritual Malady, Denial	>	Spiritual Detachment: Fear, Isolation, Lust, Self Centered Isolation, Lack of Connection
	2	Mental Illness: Depression, Anxiety, Sad	>	Physical Pain: Physical Pain, Experienced Chronic Pain, Pain
African American	1	Self Esteem/ Hatred: Low Self Esteem, Self Esteem, Self Stigmatization	>	Financial Hardship: Not Being Able to Work, Bad Life, No Job, No Money
	2	Emotional Distress: Sadness, Depression, Stress	>	Grieving: Suicidal, Death of My Grandma, Grieving, Close Friend's Death
Transgenders	1	Emotional: Down & Out, Depression, Sadness, Fear of Being Hurt/Killed, Grief Due to Death	>	Seclusion/Vulnerability: Isolation, Company, Fear of Being Different, Alone
Seniors	1	Medical Needs: Surgery, Pain, Pain Limited Options	>	Causation: Stress, Peer Pressure, Peers You Associate With, Depression, Job
	2	Causation: Stress, Peer Pressure, Peers You Associate With, Depression, Job	>	Personal Problems: Family, Poor Family Structure, Home Problems, Loneliness; Medical Needs

Figure 5 -- Top two contributing factors for opioid use, per cultural focus group

Actions Taken – Participants were asked about responses to behavior changes after misuse of opioids or other substances. Participants could identify actions they personally took or actions that people they

knew took. Participants were then asked to group their responses and label each group with a descriptive category name.

Focus group respondents agreed upon 27 category labels. The categories with the most entries were **Active User Behavior** (25 observed behaviors), **Disassociation** (17 observed behaviors), and **Treatment** (14 observed behaviors). More specifically, transgendered persons' responses included four categories, of which two were **Detachment Denial** (***nothing***, ***opinions didn't matter***, ***quit worrying***, ***became a savage***, ***blame everyone***, ***ignore***, ***stop worrying about perception***, ***trivialized it***, and ***stop being bashful***) and **Feeling Let Down** (***feel bad for myself*** and ***cried***). Latino participants provided responses of ***didn't care***, ***sexual addiction***, ***hostility and violence***, ***people shooting up heroin***, and other uncategorized responses.

See Appendix E for a full list of responses; category labels are in bold, with the corresponding responses below each label.

Treatment and Resources – Participants were asked to recall where either they or people whom they knew sought treatment or information. Participants were then asked to group their responses and label each group with a descriptive category name.

Responses included ***drug rehab***, ***211***, ***church***, ***ER***, and other traditional and nontraditional strategies. For example, the African American participants categorized some individual responses as follows: **Family** (***parents***), **Hospital** (***hospital***), **Library** (***library***), **Friends** (***other people***, ***friends in recovery***, ***friends***, ***other people in recovery***), **Online** (***Google***, ***online phone***, and ***crisis line***), **Church** (***church***), and **Agency** (***went to where I got anger management help***). The Latino population provided twenty-nine ungrouped responses that included ***grandparents***, ***twelve-step-program***, and ***sponsor***.

See Appendix F for a full list of responses; category labels are in bold, with the corresponding responses below each label.

Nature of Experiences – Participants from every cultural group appeared to have both positive and negative experiences (coded as green and orange, respectively, in Figure 6) when they sought information, treatment, or any type of assistance after opioid or other substance misuse. The researchers grouped the participants' responses into positive and negative categories during data analysis.

Necessary Improvements – Participants were asked to identify at least three areas for improvement with obtaining support/resources, based on their personal experiences. Participants were then asked to group their responses and label each group with a descriptive category name.

Categories such as **Harm Reduction**, **Support**, **Counseling Services**, **Better Person**, and **Comprehension** were some of the areas for improvement suggested by focus group members.

Specifically, students' recommendations included categories such as **Substance Abuse Cultural Resources** (***true anonymity***, ***after care***, ***no shaming***, ***trauma resources***, ***less stigma***, ***Alcoholics Anonymous resources***, ***lack of judgment***, and ***community support***) and **Monetary Funding/Insurance Options** (***insurance***, ***financial help***, ***more money***, ***financial assistance***, ***government funding***, ***scholarship loans***, ***options***, ***opportunity***, ***insurance lasting longer***, and ***options for prices***). Latino interviews included ungrouped responses such as, ***need more peer support***, ***stigma***, ***they treat you like a criminal***, ***training and cultural competency and understanding***, and ***values in this community***.

See Appendix G for a full list of responses; category labels are in bold, with the corresponding responses below each label.

LGBTQ	Positive	Spritual Healing, More Communication, Quit Temporarily, Job, Road to Success, Stabilization, Able to Come Up with Plan, Will Power, Better Help, Treatment, Sobriety, Drug Treatments, Learning Proper Way to Stop
	Negative	Prison/Jail, Didn't do Any Good For Them
Seniors	Positive	Better Life Good Follow Up, Discharged From Treatment Facility, Quit Drinking, Stayed Substance Free,, Treatment Centers Better Educated, More Info In Schools, More Info if Parents, Include Family for Support
	Negative	Hospitalization, Loss of Life, Continue Using, Loss of Job, Probation
Transgenders	Positive	To Continue Come To Recieve Help, Come to Appointments
	Negative	No, Less Requiremtns to Get In, Substance Not Supported in Treatment, No Help, Had To Be HIV Positive, Still Homeless, Still Searching, Became a Struggle, I found it But did not pursue it, The Run Around, Processing, Wasn't willing to comply, Relapse, Back to Jail, Got High
Students	Positive	Referral to Elsewhere, Got Better, Found Freedom, Self Discovery, Compliant, Sober, Got Family Back, Went Back to School,Cathatsis, Went to AA, I Surrendered, Made Friends, Rehab, Recovery
	Negative	Cost, Loss of Money, Couldn't Afford It, Didn't take Insurance, Suicidality, Over It, Loss of Control, Ran Away From Treatment & Got Taco Bell, Avoidance, Started Drinking More, Adopted Behavioral Addiction, Not Getting Better, Relapse, Resistant, Annoyed, Denial, Judgement, Fear, Mad, Stigma Relationship, Loss of Relationship,Psychosis, Resentment, Anger, 13th Step, Childish Games, Geographic Relocation, Got Worse, Threat to Run, Replaced Drug Choice, Isolation, Kept, Hating Treatment
African American	Positive	Got Help, Accepted Help, Accepted for Treatment
	Negative	Emotionally Distraught, Building Depression, Frustration, Not Accepted due to Space, Income Back, No Room, Not Eligible, I Do Not Meet The Requirement, Bad Experience, Wanted to Continue Consuming and Not Seek Help, I Stop Looking Because Want to Continue, Relapse, I Do This Sometimes Other Go Another Time
Latino	Positive	Just wanted my daughter back, Support, Friends/Family, AVITA Counseling, Ideas stayed with me
	Negative	Unsure if it worked, Attempted suicide, Feel better but continued, Far away, Barrier following service, No support, Denial, Had to want it, Just didn't want it, Co-dependant, Like the feeling of getting high, Rehab wasn't a good environment, Staff was unprofessional, Wanted to smoke cigarettes, Wanted to make money

Figure 6 –Nature of Experiences while Seeking Information, Treatment, or Other Assistance

"Magic Wand" / Outside the Box Solutions – In the final guided question, participants were asked to imagine that if they had a magic wand and were able to create a new solution, what that solution that look like. Participants were then asked to group their responses and label each group with a descriptive category name.

This question invited participants to think "outside the box" and provide a response that is not typical or that would not occur to a person who is not embedded in the community. Some of the responses included **Companionship** (***in my husband's arms***, ***someone cares***, ***relaxation therapy***), **God** (***God***, ***spirituality***, ***sage ceremony***, ***liberation within***, ***satay truthfulness***, ***faith***, and ***silence of mediation***), **Housing** (***housing***, ***job/employment***, ***shelter***, help for the homeless, and ***build for the homeless***), and **Recreation** (***social enterprise***, ***food***, ***fairs***, and ***supply of healthy entertainment***). The Latino respondents recommended the following: ***raise awareness***, ***transportation***, ***in churches (peer support)***, ***family education and support***, ***education about childhood trauma***, ***campaign***, ***peer specialist (secret)***.

See Appendix H for a full list of responses; category labels are in bold, with the corresponding responses below each label.

Key Informants

Figure 7 provides the demographics of the six key informants interviewed, and Appendix I summarizes the key findings from this group:

- trends they are seeing with OUD and other substance abuse in their client populations;
- the top three unmet needs for addressing OUD and other substances;
- the top three factors that contribute to opioid and substance use;
- the top three major barriers they encounter in effectively responding to their client populations;
- the top three resources their client populations need that are not being adequately provided;
- their organizations' strengths;
- other issues that were missed/not addressed in the interview guide.

Title	Program Director	Executive Director, Assistant Dean	CEO and Founder	President, National Project Director	Population Health Director	Executive Director
Years in Position	3.5 years (over 20 years in SUD)	12 years	23 years	20 years	Jan. 2019 (19 years in Aging Services)	19 years
Populations Served	Men (18 yrs. and above) Homeless, HIV/AIDS, Veterans, Deaf, Ex-incarcerated	Students	LGBTQ, African Americans, HIV, Homeless, Mental Health	Hispanic and Latino Immigrant and Refugee Populations with Limited English Proficiency	Seniors 55 and older, adults with disabilities in area of affordable housing 10+ communities in Georgia	Hispanic and Latino

Figure 7 – Key Informant Demographics

Cross-Case Analysis for Focus Groups and Key Informants

This section describes the results of cross-case analysis conducted across the five focus groups, six phone interviews with Latino population members, and six key informants.

Emotional pain was a major factor in participants starting their addiction journeys (substances, opioids, alcohol). Subsequently, participants either sought assistance from inappropriate company, had mental health breakdowns, isolated themselves, or suffered from other triggers (e.g., injury, trauma) that supported their consumption of substances.

The behaviors that were commonly exhibited by most participants involved absence of responsibility, risk taking, and physical changes. After participants were aware of significant changes in behavior, they were either in denial or disassociation, or they internalized the behavior change, conducted self-reflection. and either sought help or provided help to the person experiencing the addiction.

Participants sought help through institutional rehabilitation, searched for information online or from friends, searched for community services, and/or used spiritual methods. They preferred to seek non-judgmental modes of assistance.

Respondents had a mixture of positive and negative experiences when they sought assistance/information; either they couldn't access treatment/information, or they got the needed help and entered the recovery stage.

Participants indicated that their readiness to change influenced their outcome to some extent. Interestingly, the transgendered persons and key informants both identified barriers to accessing housing that stem from prior convictions, non-HIV-positive status, lack of employment, federal policies, and stigma attached to substance misuse.

Themes identified across the key informants' responses indicated that clients from different cultures were not being prescribed opioids at the same rate as the White population; pharmacies were overprescribing during ER visits; different cultural groups were not identified in national studies and statistics: college students were identified as being poly-substance users; and the younger age Latino population was experiencing substance use disorders.

Key informants also indicated that policies needed to be more supportive and responsive to disparate types of needs of the sub-populations. Different types of resources were needed for the sub-populations included in this study, and more training was needed for service providers to be culturally responsive.

The highly engineered drugs being produced by pharmaceutical companies contribute to SUDs. Participants agreed that significant problems exist from the manufacturing and sale of opioids, including stigma associated with substance use and the absence of linguistic and culturally responsive information and support.

Barriers that inhibited service providers from responding appropriately include limited funding; lack of inclusiveness of different cultural voices in research, policy, and funding decisions; society not responding to addiction as an emergency; and responders ill-prepared to deal with the complexities of poly-substance users and cultural factors.

Community resources should include systems that provide easy access to care—in particular, Latino communities need access to direct treatment that is delivered in a cultural and linguistically appropriate manner—and reduce stigmatization, similar to the efforts of the "Me-Too" campaigns designed to reduce stigma related to sexual abuse. Service providers identified what they do best within their communities and

organizations, and several stated that they sincerely care about the people they serve. Providers working with the Latino community are filling a much-needed gap by offering culturally relevant training and organizational assessments throughout the nation.

Program leaders believe that embracing the disease model (versus perceiving individuals who have SUDs as exhibiting a moral failure) and not being judgmental towards these individuals has helped the organization build trust within the mentioned communities.

Three informants concluded the interviews stating that the story of every person is important, that families need to be equipped with resources and information, and advocacy efforts need to continue at the federal, state and county levels.

Recommendations

This section provides three sets of recommendations for future action. These recommendations are drawn from the professional literature, from focus group members, and from key informants.

Recommendations from the Literature

Partnerships of service providers with faith-based communities is particularly relevant for serving African American populations needing mental health and substance abuse treatment (James & Jordan, 2018; Neely-Fairbanks, 2018). Pagano (2014) recommends that in order to reach Latino population, information about services in Spanish should be made available at strategic locations, such as community clinics, county emergency departments, and day laborer hiring zones. Reaching underserved populations through Community Health Workers (CHW) also shows promise, particularly since individuals trained as CHW are "insiders" from within the community they serve and can gain their communities' trust (Weaver & Lapidos, 2018).

Some studies have mentioned that clients from underserved populations found treatment centers and services ineffective. Sometimes, training medical and mental health care practitioners in knowledge transfer (sharing or disseminating knowledge about the condition, resources, services etc.) across cultures and underserved communities, and in processes and skills for actively linking clients to resources and services in the community can be very helpful for practitioners and clients alike. Training that includes knowledge transfer (e.g., practitioners sharing best practices with colleagues), system review (e.g., examining policies and practices that hinder under-served populations), and active listening (e.g., access to available resources and organizations that can assist under-served populations) can be effective. At the very minimum, such training can increase "awareness, recognition, and respect for the needs of patients from under-served communities" (Chew-Graham et al., 2014, p. 15).

Similarly, infusing more unified cultural competency into policies, practices, and education of health care and mental health care providers can also reduce disparities in access to care (Betancourt, et al., 2005). For instance, opening more treatment programs for Latino men and women, in Spanish, in Latino-dominated communities can be particularly helpful. Additionally, improved articulation between 911 services, police, community clinics, emergency departments, and mental/substance abuse treatment centers can improve access to appropriate SUD treatment centers. Also, educating doctors who are frequented by Latino populations about SUD treatment centers can ease referrals to appropriate providers (Pagano, 2014).

Williams and Jackson (2005) recommend that policies and practices need to address disparities through a "cultural lens" and not one-size-fits-all approach. Moreover, level of trust, social and economic disparities in access to mental health care, and stigma attached to substance use are factors that influence African Americans and Latino populations from seeking help. In particular, stigma attached to mental health impacts attitudes towards seeking assistance and ultimately influences the likelihood of using services (Fripp & Carlson, 2017).

Focus Group Recommendations

Focus group members recommended several improvements to existing services, treatments, and information availability. In terms of recommendations for improving the current system of care, they all requested that counselors/therapists be better trained and prepared to deal with their communities from a

cultural perspective, as well as trained in assisting with policy-substance use. Other recommendations included the following:

- Counselors and other professionals should be more empathetic and non-judgmental, and provide culturally relevant care that is responsive to the respondents' specific needs.
- Behavioral health delivery systems need to provide a variety of resources, treatment programs, prevention services, and housing.
- Physicians should be better trained and experienced in making appropriate referrals and diagnosis surrounding mental health and substance/opioid misuse, and access to integrated health care.
- Services should have social, emotional, and spiritual connectedness.
- Information about prevention and treatment should be disseminated through different methods.
- Counselors and support networks need to provide information about alternative methods to cope with emotional stress.
- Peer support should be consistently available across all cultural groups.

Key Informant Recommendations

During the key informant interviews, participants made several recommendations:

- Eliminate stigma so that it does not prevent substance users from seeking treatment. (transformational change)
- Address poly-substance misuse in treatment programs. (structural change)
- Legalize and promote syringe exchange for intravenous drug users. (structural change)
- Address the issue of overprescribing of medications in the older adult population. (structural and transformational change)
- Provide more services that are linguistically and culturally appropriate. (structural and relational change)
- Provide ongoing medical services to the groups included in the study. (structural change)
- Provide easier access to treatment, and streamline intake process for different sub-populations. (structural change)
- Individualize treatment. (relational change)
- Make Narcan more available to all first responders and affordable for other at-risk populations. (structural change)
- Increase the number of providers that can serve non-English speaking immigrants. (structural and relational change)
- Treat clients using a more holistic approach to substance use disorders. (relational and transformational change)
- Approach SUD in media and through different outlets with a non-judgmental tone. (transformational change)
- Increase more harm reduction approaches for dealing with SUDs. (structural and relational change)

There were several similarities in the recommendations provided by focus group members and key informants. For example, both groups provided recommendations about culturally and linguistically appropriate care for clients that are also empathetic and respectful. Both groups were also very vocal in

their recommendation that professionals be properly trained in dealing with their specific needs, especially regarding poly-substance misuse. Both groups also articulated designing solutions for HIV-negative substance misusers, and improving physicians' training to make appropriate referrals for services. Different population segments probably follow different journeys as they relate to theory of change process, which should be taken into account when designing innovative solutions in terms of information and services. These noteworthy recommendations should be incorporated into Georgia's strategic planning efforts.

Limitations

Limitations of this study included the inability to conduct a formal focus group with the Latino community. Because of the recent toxic rhetoric surrounding this population, many are afraid and lack trust in authorities. Also, data cannot be generalized to larger populations of Latino, elderly, homeless, veterans, African American, college students and LGBTQ individuals. Finally, larger samples from these cultural groups would have strengthened our understanding about the topic.

Recommendations for Future Research

- Expand understanding of the different cultural groups using Human Centered Design Thinking.
- Conduct more in-depth interviews with members of the groups to have a deeper understanding of their experiences.
- Expand the key informant interviews with different stakeholders.
- Use systems perspectives and stakeholder theory to further understand the different layers of the issues faced by people in different cultural groups.
- Incorporate theory of change perspective into understanding the journey traveled by different population segments.

Project participants identified several innovative strategies that can be effective in increasing awareness, reducing overdose deaths, and encouraging other behaviors that will reduce chronic disease and promote overall wellness in traditionally underserved communities.

Conclusion

The findings from this study illuminate the voices of several cultural groups (e.g., reasons for substance/opioid misuse; their experiences when they sought help; changes that they would recommend) that were probably not strategically incorporated into the state level opioid and substance misuse strategic plan. Interestingly, identifying and interviewing Latino population members was a challenge, given the current sociopolitical climate. This study exemplifies the use of Design Thinking and Systems Thinking to unravel and understand the journey of participants related to an important complex topic. This understanding is important to develop innovative and responsive solutions for addressing different types of addictions in Georgia. Finally, the study tapped the "magic wand" responses related to enhancing the experiences of individuals from diverse backgrounds as they travelled disparate treatment and recovery journeys.

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Appendix A: Focus Group Guide

Qualifications to participate in the focus group:

- *Demographic:* LGBTQ; Youth/College, seniors; Hispanics; African American; Homeless/Veterans.
- *Screening Question:* Have you ever heard of, seen, or experienced someone abuse (opioids) pain killer drugs or any other substances?

Experience Based Questions:

1. Think of when you've heard of someone abusing pain killers, or any other substances, what led them to using the substance or the (opioids) pain killers? (Get to all of the WHYs). (e.g.). (15 min.)
2. Think of when you've heard of someone abusing (opioids) pain killers, or any other substances, what behavior changes did you notice? (e.g.) (8 min.)
3. What did they/you do when they/you noticed the behavior changes? (e.g.) (8 min)
4. Where did you/they seek treatment/help or information? (10 min.)
    - Probe, online?
    - What did you find?
    - What resources were lacking?
5. What was the outcome/end result for each of the places where you/they sought help? (e.g.) (8 min.)
6. What could have been better in terms of support/resources (at least 3 things) when you or they were seeking assistance? (10 min.)
7. What is being done well in your community, in terms of support/resources where you or they sought help? (8 min.)
8. If you can be part of creating a solution or solutions that would work well for you, what would they look like? In other words, if you had a magic wand that could create a new solution(s) what would it/they be? (15 min.)
9. Is there anything important that you think I/we have missed? (5 min.)

Appendix B: Key Informant Interview Guide

Qualifications to participate in the interview:

- Has worked with the population (LGBTQ; Elderly…) for at least 3 years; level within the organization—managerial or higher; has worked in mental health and substance abuse for at least 3 years.

Questions:

1. Demographic: Position in organization
2. How long have you been in your current position?
3. What are the populations you serve—description?
4. What trends are you seeing with prescription opioid and other substance abuse in this population...? (e.g.)
5. What are the three (3) top unmet needs for addressing opioid and other substance abuse in this population….? (e.g.,)
6. In your opinion, what top three (3) factors that contribute to prescription opioid and other substance use in this population…? (e.g., MAT)
7. In your opinion, what are the three (3) major barriers are you encountering in effectively responding to the needs of this population…?
8. In your opinion, what are top three (3) resources this population needs that are not being adequately provided within the community?
9. What are your organization's strengths as it relates to serving this population?
    - (What do they do well…have you identified best practices for this population?)
10. Is there anything important that you think I/we have missed/not addressed?

Appendix C: Causal Factors

Focus Group Question #1: Think of when you've heard of someone abusing pain killers, or any other substances, what led them to using the substance or the (opioids) pain killers?

LGBTQ	Seniors	Transgendered Persons	Students	African Americans	Latinos
Emotional Triggers (7)	**Medical Needs (4)**	**Emotional (5)**	**Emotional Pain (4)**	**Self-Esteem / Hatred**	Used crack cocaine
Death of loved one	Surgery	Down and out	Emptiness	Low self-esteem	Parent was alcoholic
Someone killed your DaDa	Pain	Depression (3)	Emotional pain	Self-esteem	Trauma
Abusive relationship	Pain limited options	Sadness	To numb emotions	Self-stigmatization	Coping with mental health disorder
Traumatic events	**Causation (4)**	Fear of being hurt/killed	Feeling lonely	**Financial Hardship**	Access to treatment was not available
People Places Things (3)	Stress (2)	Grief due to death	Low self-esteem	Not being able to work	Parenting issues: Childhood trauma and neglect
Proximity	Peer pressure	**Seclusion / Vulnerability (4)**	Pain inside	Bad life	Use substances as coping mechanism
Influence	Peers you associate with	Isolation	Loneliness	No job	Became alcoholic after giving birth and receiving pain killers
Pain relief	Depression (2)	Company	Escape	No money	Cool (2)

NOTE: Numbers in parentheses indicate the number of times an answer was provided or a category was named.

Environment	Job	Fear of being different	Avoidance	**Emotional Distress**	Peer pressure
Bad excuses	**Causation (4)**	Company	Anger (2)	Sadness	Surgery 7–14 years of age
Mental Health (2)	**Personal Problems (3)**	Alone	Internal pain	Depression (4)	Surgery pain
Depression (2)	Family	**Access**	Spiritual malady	Stress	Health problems
Anger	Poor family structure	Ease of access	Denial	**Grieving**	Recovery (pills)
Girls	Home problems	Availability	**Spiritual Detachment (1)**	Suicidal	Family
Access	Loneliness	Self-medicating	Fear (3)	Death of my grandma	Pressure (1st gen college)
Anxiety (2)	**Medical Needs (1)**	The high associated	Isolation (2)	Grieving	Bored
Sadness	**Acceptance**	Dosage by doctor	Lust	Close friend's death	Peer pressure
Death of loved ones	Peer pressure	**Triggers**	Self-centered isolation	**Bad Association**	Communication problems
Stress		Childhood trauma	Lack of connection	Relationship issues	Illness/pain/surgery
Loneliness (2)		The pain	**Mental Illness (2)**	Bad Company	Addictions
Escape		Injury	Depression (3)	Sex	
Mental issues		Increase of pain	Anxiety (2)	**Isolation**	
Money		**Social and Environmental**	Sad (2)	Lonely	

NOTE: Numbers in parentheses indicate the number of times an answer was provided or a category was named.

Unwanted Outcomes		Friends	**Physical Pain**	Boredom (2)	
Pain		Peer Pressure	Physical Pain (4)	Isolation (2)	
Stress (4)		Discouragement	Experienced chronic pain	Broken relationship	
The high		Social Tools	Pain	**Broken Marriage**	
Boredom		Family	**Experiment**	**Self-blame**	
The High		Social unacceptance	Fun/party		
Peers		**Escape**	Just wanna chill		
To get high		Boys and more boys	Fun		
To have fun		Seeking fun	To get high		
Material Things		**Ignorance**	Social conditioning		
Cars			It felt good		
Houses			Liked the feeling		
Money			They enjoyed them		
Sex			**Social Conditioning**		
Sex			Peer pressure (3)		
			Experiment		
			Curiosity		

NOTE: Numbers in parentheses indicate the number of times an answer was provided or a category was named.

			Family pressure		
			Not fitting in		
			Lost		
			Loss		
			Wanted to feel lost		
			Wanting		
			Rationalization and Excuses		
			Doctor prescribed		
			Perceived need		
			Availability		
			“Used the best"		
			Misdiagnosis		
			It was legal		
			Misinformation		
			Blame		

NOTE: Numbers in parentheses indicate the number of times an answer was provided or a category was named.

Appendix D: Behavioral Changes

Focus Group question #2: Think of when you've heard of someone abusing (opioids) pain killers, or any other substances, what behavior changes did you notice?

LGBTQ	Seniors	Transgendered Persons	Students	African Americans	Latinos
Financial Management	**Behavior**	**Lack of Energy**	**Physical Consequences**	**Lack of Responsibility and Desire to Work/Lethargic**	Unresponsive
Money Management	Denied	Sleeping	Getting sick	Spending excessive money	Violent
Funds	Out of control	Appearance	Sleepy (2)	Not being concerned w/anything	Sexual and permissive
Spending	Stealing	Tired	Sleep changes	Over sleeping	Physical hygiene, deteriorated
Priorities	Anger	Body language	Toilet	Lazy	High anxiety
Responses	Mad rage	Don't want to move	**Isolation**	Spending excessive money	Isolation
Erectile dysfunction	Hyper	**Mood Alterations**	Not showing up	Not working	Obsession about getting more drugs
Self-interaction	High energy	Isolation	Isolation (5)	Not working	Unable to participate in normal daily activities
Not paying attention	**Withdrawal**	Gained ability to concentrate	Reclusive	Not going to work	Isolation: don't want to be around

NOTE: Numbers in parentheses indicate the number of times an answer was provided or a category was named.

					people that are not using
How they act	Stopped being social	Emotional detachment	Less present	Loss of job	14 years
Perspiration	Hiding (2)	Aggression	Avoidant	**No Boundary/No Limits**	Rebellious
Personality	**Outcomes**	Anxiety	Social distant	False bravado	Ran away
Executive functions	Different		Anti-social (2)	Unguarded	Self-centered
Attitudes	Lost their job	Panic attacks	Emotionally withdrawn	Craving	Fantasy world
Seriousness	Alcohol slurred speech	Mood swings	Emotionally unavailable	Spending excessive money	Young
Worrying more	Home problems	Lack social skills	**Loss of Motivation**	**Lust/Sex**	Not listening
Anxiousness	Left family	Sadness	Loss of ambition	Elevated sexual desire	Sick
Wanting to know what is happening elsewhere	Carelessness	Numb to the pain	Loss of motivation	Companionship	Complaining
Stressed	Alcohol stagger walk	Weight gain	Shift in priorities	**Emotional Instability**	Not happy
Rage	Overdose of meds	**Happy**	Motivation shifts	Extreme Angry	Stopped doing the things you love
Extreme sadness	**Escape**	Happiness	**High Risk Behaviors**	Angry	Aggressive isolation
Fidgety	Lethargic	Fearless	Missing work	Paranoid	Self-image decrease
Mood swings	Fall asleep	Sense of happy	More drinking	**Violent Situations**	Not clean

NOTE: Numbers in parentheses indicate the number of times an answer was provided or a category was named.

Fighting	Sleep more	**Morals**	Promiscuity	Lot of crime	Don't eat
Nervousness		Promiscuity	More drugs	I saw murder	
Sleepiness		Lack of morals	Lashing out	Violent	
Increased sex drive		Lack of loyalty	Missing school	**Unhealthy Eating Habits**	
Lack of Responsibility		**Attitude**	Acting a fool	Weight loss	
Responsibility feeling			Decreased morality	Weight loss	
Irresponsible			Driving unsafely	Eating habits	
No show			High risk behaviors	Sweating	
Seclusion			**Manipulative Behaviors**	**Guilt /Shame**	
Withdraw			Justification	Not going home for days	
Isolation			Stealing (2)	Poor hygiene	
Relationships			Manipulating	Isolation	
Lack communication			Shady sneaking around	Homeless	
Loneliness			Lying (3)	Stop socializing	
Homeless			Secrecy		
Anxious			Excuses		

NOTE: Numbers in parentheses indicate the number of times an answer was provided or a category was named.

Appendix E: Actions Taken

Focus Group question #3: What did they/you do when they/you noticed the behavior changes?

LGBTQ	Seniors	Transgendered Persons	Students	African Americans	Latinos
Finances	**Denial**	**Feeling Let Down**	**Institutions**	**Spiritual**	Didn't care
Pull money back	Run away	Feel bad for myself	Church	Prayed	Sexual addiction
Ask for help	They dropped out of life	Cried	ER (2)	**Work**	Hostility and violence
Treatment	Ignore it	**Continued Using**	School	Wake up went to work	People shooting up heroin
Laugh	I did nothing	Started selling	Rehab via ER	**Financial Broke**	Sought help with daily activities
Discussion	Withdraw from people	Got more packets	**Peer Support Groups**	Broke	Making people aware of their value
Kept it moving	Accepted as disease	**Self-Aware Self-Help**	AA	**Self-Reflection**	Tell victim that their behavior was counterproductive
Counseling	**Helped**	Self-control	Help groups	Tried to change	Getting the family involved, helping family cope and get balance
Accept treatment	Spoke to them more often	Sought second opinion	Eda group	Questioned myself	Helping family identify when there is a crisis and disease concept
Seek help	Question them	Comfortable in skin	**Disassociation**	Feel guilty	Not having support

NOTE: Numbers in parentheses indicate the number of times an answer was provided or a category was named.

Try to act normal	Stopped call people	Talked to that person	Isolated (3)	Examined my motives	Getting information from unhealthy people
Went with flow with their behavior	Watch for changes	Help that person by talking	Avoidance (2)	Compare myself to others	Stopping using but did not have the support
Try to help them calm down	Angered them	**Detachment Denial**	Run Away	**Guilt Crying Out Frustration Shame**	Did not know how or where to get help from
Walk on	Reported to administration	Nothing	Hide (2)	Lashed out	Guilt and shame associated with addiction getting worse
Talked to others	Shared information	Opinions didn't matter	Avoid people	Angry	Regulating meds
Try to calm them down	You ok?	Quit worrying	Create distance	Blame others	Start using street drugs
Research		Became a savage	Ignored reality	Anger at life	Prayed
Try talking to them		Blame everyone	Nothing	A lot of anger	School change
Distance Self (2)		Ignore	Hopeless	**Seeking Help**	Relocation
Moved to Different Location		Stop worrying about perception	Did not care	Right help	Nothing
Got Something Cold to Drink		Trivialized it	Covered up (2)	**Isolation**	R
		Stop being bashful	Afraid to talk	Isolate	Started using heroin
			Active User Behavior	Broke away from family	Denial
			Denial (3)	**Crime**	Fighting

NOTE: Numbers in parentheses indicate the number of times an answer was provided or a category was named.

			Add other substances	Crime	Help (not sure what to do)
			Not any change	**More Drugs**	Confrontation opens their eyes
			Blame	Used Drugs	Manipulate/control
			Fight (2)		
			Made promises		
			Manipulated to get more		
			Justify		
			Take more/did more drugs (6)		
			Fuck it		
			Stole money		
			Get high also		
			Lied about usage (2)		
			Walked away		
			Hostility		
			High risk behaviors		
			Negative Response of Loved Ones		
			Ignore		
			Walk on eggshells		
			Seeking Help		
			Group therapy		
			Confront		

NOTE: Numbers in parentheses indicate the number of times an answer was provided or a category was named.

			Parents		
			Got help		
			Boyfriend		
			Therapist (2)		
			Processed Emotions		
			Yelled		
			Fear		
			Communicate fear		
			Cry		
			Sad		
			Rationalize		
			Angry		

NOTE: Numbers in parentheses indicate the number of times an answer was provided or a category was named.

Appendix F: Treatment and Resources

Focus Group question #4: Where did you/they seek treatment/help or information?

LGBTQ	Seniors	Transgendered Persons	Students	African Americans	Latinos
Online	**Rehab**	**POS Support**	**Professional**	**Family**	Twelve-step program
Internet	Treatment center (2)	Someone who cares	Therapy (2)	Parents	Grandparents
Drug treatment center	Treatment facility as resident	Friends	Professional	**Hospital**	Sponsor
Google	AA (2)	**Forced Confinement**	Social work	Hospital	Spiritual support
Drug addict groups	NA	Prison	**Spiritual Problems**	**Library**	Rehab
Community Outreach	Treatment not available	To jail	Church (3)	Library	Outpatient
Local church	**Not Motivated**	**Rehab Supportive Confinement**	AA (4)	**Friends**	Mental health
Addict community outreach center	Never did	Drug rehab	12 steps (2)	Other people	Substances use disorder classes
For the street	No help until ready	Doctor	Collegiate recovery program	Friends in recovery	Community mental health information
AA/NA	Not good	Organizations	**Institutions Correctional**	Friends	Very difficult to recruit clients from this demographic
Family	Stayed home	Rehabs	Jail (3)	Other people in recovery	Lack of access to treatment

NOTE: Numbers in parentheses indicate the number of times an answer was provided or a category was named.

Community	**Unknown**	Grady hospital	Cops (2)	**Online**	Did not have documents rehabs and outpatient would not take them
Institutions	Unknown	**Online**	Police	GoogleOnline	Family is often afraid because of their immigration status
Mercy care		Internet	Court ordered drug court	Online phone	Thought rehab was only for celebrities and did not know where to go
Psych hospitals		Online	**Institutions Medical**	Crisis line	12-step program...gave hope
IDP		To goggle	Hospital	**Court**	Spirituality
Professionals		211	Ridgeview	Court	Mandated to have rehab
Grady			ER	**Church**	Out of darkness (wonderful)
RCA			Rehab	Church	Prison (2 years)
At neighborhood counseling center			Institute	Church	Pregnancy prison, right side up
Prison			Treatment center	**Agency**	Mary hall
			Treatment mental institution	Went to where I got anger management help	Lack of resources
			Mental health services		Good English
			Hospital		No English

NOTE: Numbers in parentheses indicate the number of times an answer was provided or a category was named.

			Personal Relationships		No resources
			Friends (2)		Inpatient centers for English speakers
			Family (2)		Not enough translators (Vietnamese and Chinese)
			Parents (4)		Outpatient: lots of counselors but need more
			Co-worker		LGBT partnerships
			Research/Education		
			Online (4)		
			My mom went online		
			Internet (3)		
			Book		
			Google		

NOTE: Numbers in parentheses indicate the number of times an answer was provided or a category was named.

Appendix G: Desired Improvements

Focus Group question #6: What could have been better in terms of support/resources (at least 3 things) when you or they were seeking assistance?

LGBTQ	Seniors	Transgendered Persons	Students	African Americans	Latinos
Treatment	**Healthy/Edu Public Professionals**	**Types of Support**	**Substance Abuse Cultural Resources**	**Variety of Programs**	Assistance with how to talk to people with addiction
Cheaper treatment	Healthy communications	Outpatient support	True anonymity	Different programs	Stigma and they treat you like a criminal
Better facility	Educated caring psychiatrists	Other resources	After care	Better counseling	Continue of care needs to be better... higher levels of care
Treatment modalities	Better therapist	Housing support	No shaming	More facilities	Training and cultural competency and understanding values in this community
Integrated medicine	Educated professionals	Availability and accessibility of money	Insurance lasting longer	Having more options	Family support
Harm reduction	Less chaotic	Financial support	Trauma resources	**Transport**	To know where resources are available for pregnant women

NOTE: Numbers in parentheses indicate the number of times an answer was provided or a category was named.

Clean needles	Seeing a psychiatrist	No jail	Less stigma	Transportation	Hispanic 12-step groups
Clothes	Education	Better doctors	Alcoholic Anonymous resources	**More Referrals**	Everything had training: Cares
Close	More experienced doctors	More avenues	Lack of judgment	Contact from center	Sympathetic
Financial support	One on one counseling	More assistance for homeless trans	Community support	**Would Have Preferred to Never Have Used the Program**	Counselors need to not be judgmental
Housing (2)	Smarter counselors	Peer support	**Monetary Funding/Insurance Options**	Not used in the program	Emergency room - no support
Support	**Types of Help**	Coming Off methadone can be more painful and intense than opioid withdrawal	Insurance (2)	**Would Have Liked Longer Treatment Plan**	No questions
Admitting to abuse	Parents well informed	**Harm Reduction**	Financial help	Stayed there	Need more peer support
Family (3)	Info from community	Respect of my freedom to make choices	More money	**Getting the Help That Was A+**	Same background
Church	Social support	Sacrifice/don't sacrifice other addictions	Financial assistance		Follow up with med
Environment	Better/more funding	**Goal Accomplishment**	Government funding		10 years prevention
Access	Shared seeking experience	Accomplish	Scholarship loans		Education kids in school

NOTE: Numbers in parentheses indicate the number of times an answer was provided or a category was named.

Friends (2)	Info from schools	Goals met by individuals	Options		Not enough info in school (college, elementary, extra classes)
Healthy company	Doctors help w/stopping use	**More Help for HIV Negative**	Opportunity		Prevention education free
Love	Need more support	**More Help with the Management**	Insurance lasting longer		Colleges, board denial
Support group	Family/friend support		Options for prices		Can't work in Gwinnett County (DBHD)
Counseling Resources	Acknowledgement		**Healthy/Edu Public Professionals**		SAMSA limit
Advice from experiencers	County health clinics		Healthy communications		
More place and options to seek help	**Treatment**		Educated caring psychiatrists		
More determined and dedicated to stopping	Better surveillance		Better therapist		
Likeminded counselors	Background checks		Education professionals		
Educational support	Treatment facilities follow-ups		Less chaotic		
Psychological support	**Result**		Seeing a psychiatrist		
The way they communicate	Relapse x 50%		Education		

NOTE: Numbers in parentheses indicate the number of times an answer was provided or a category was named.

Better Person	**Tough Love**		More experienced doctors		
Comprehension	Tough love		One on one counseling		
			Smarter counselors		
			Health Education for General Public		
			Groups		
			Health insurance education		
			More info		
			Veteran support		
			Naloxone training		
			EDA education		
			Mental health education		
			Veteran education		
			Interpersonal Compassion		
			More caring		
			Gentle treatment		
			Compassion (3)		
			More respectful staff		
			Understanding (2)		
			Primary Support from Family and Friends		

NOTE: Numbers in parentheses indicate the number of times an answer was provided or a category was named.

			Actual support		
			Friend support		
			More support		

NOTE: Numbers in parentheses indicate the number of times an answer was provided or a category was named.

Appendix H: "Magic Wand" / Outside the Box Solutions

Focus Group question #8: If you can be part of creating a solution or solutions that would work well for you, what would they look like? In other words, if you had a magic wand that could create a new solution(s) what would it/they be?

Type of Solution

Support Services	*Financial*	*Treatment*	*Fun / Innovative*	*Emotional*	*Resources / Outreach*

LGBTQ	Seniors	Transgendered Persons	Students	African Americans	Latinos
Housing	**Community Support**	**Companionship**	**Satisfy Instincts and External Influence**	**Changing Surroundings**	Inpatient and outpatient whether documented or not
Housing (2)	Be understanding (take 1 day at a time)	In my husbands	Sex	Different Surroundings	Rich: more prevention and treatment
Job/ employment	Outreach	Someone cares	Laughter (2)	**Alternative Forms of Pleasure**	Dealing with trauma
Shelter	Give support	Relaxation therapy	Jacuzzi	Sick pleasure in enjoying the pain	Education about childhood trauma
Help for the homeless	More support among community	In my husband's arms	Learning a trade	Wish I could use w/o the aftereffects but impossible	Needs assessment for community
Build for the homeless	Community participation	**Safe and Friendly**	Crafts	Life at its best a good life	Support for families and self-healing
Financial Support	**Government Funding**	Church	Animals	**Therapy**	Family education and support
Financial management	More funding	Self-awareness	Food	Psychotherapy and knowledge	Healthy coping mechanism for families
Funds	**Positive Environment**	More trans friendly housing	Rock & Roll	**Alt. Forms of Engagement**	Education for help and resources

NOTE: Numbers in parentheses indicate the number of times an answer was provided or a category was named.

Money	**Comprehensive Treatment**	With mom	Soft bed	Social activeness (positive)	Meetings that provide childcare
Power	Treatment	Be less trusting of others	Skill building	Alternative things to do	Afterschool program
Respectful	Long-term treatment away from family and friends	Cav's	Travel (2)	Nothing else to do	Transportation
Resources	Half-way house for support	**Help for HIV Negative Trans**	**Consequences**	Alternative high	Free
Recreation	**Education**	If HIV Negative, No Help There No Housing	Peer Groups	**Method of Info. Delivery**	Community give more money
Social enterprise	Provide information/resources (2)	In My Husbands Arms	DBT	Peer testimonies	Paid training
Food	Communication between generations	Looking into My Husbands Eyes	EMDR	Better education about addiction	Peer specialist (secret)
Fairs	Research info for help	**Outreach**	12 Step Program	Better info.	In churches (peer support)
Supply of healthy entertainment	Information	Networking and Promotion	Peer Support	More education	Promoted more
Emotional Support	Prevention	Increase Awareness	Process Groups	Better marketing	Campaign
To stop clown the people and help them	Provide info and resources		**GOD**	More forums	Events
Chanting	Acceptance person and disease		God (4)	**Being Able to Understand Why You Did It in the First Place**	Raise awareness
Intensive counseling	**Abstinence**		Spirituality		Alcohol or drugs (caught 2 times)
Start a mentorship/focus group	Don't buy or drink alcohol		Sage ceremony		
Working more on personal situations	**Willing to get help**		Liberation from within		

NOTE: Numbers in parentheses indicate the number of times an answer was provided or a category was named.

Meditation group trip			Satay truthfulness		
Med Research			Faith		
Clinical Trials			Silence of mediation		

NOTE: Numbers in parentheses indicate the number of times an answer was provided or a category was named.

Appendix I: Key Respondent Interview Results

Question 1: What is your position in the organization?	Program Director	Executive Director, Assistant Dean	CEO and Founder	President, National Project Director	Population Health Director	Executive Director
Question 2: How long have you been in your current position?	3.5 years (18 years in service)	12 years	23 years	20 years	Jan. 2019 (19 years in Aging Services)	19 years
Question 3: What are the populations you serve?	Men (18 years and above); homeless; HIV/AIDS; veterans; deaf and hard of hearing; released from jail/prison	Students	LGBTQ; African Americans; HIV; homeless; substance use; mental health 5–99 years old	Immigrant and refugee populations, specifically those with limited English proficiency and specific to Hispanic and Latino communities	Seniors 55 and older along w/ adults with disabilities in area of affordable housing with 340 communities nationwide and 13 communities in Georgia (1600-plus residences)	Latinos; children and their families; 90% of clients meet federal poverty guidelines

NOTE: Numbers in parentheses indicate the number of times an answer was provided or a category was named.

Question 4: What trends are you seeing with prescription opioid and other substance abuse in this population?	Spike in number of opioid-addicted referrals	On campus students are not seeking help for prescription opioids in any significant numbers but are seeking help for alcohol and cannabis misuse and dependence. A great number are polysubstance users. See more in recovery from prescription opioid misuse not in active use.	African American women and men on the lower level because the system was already set up not to prescribe them medication change the name to opioid because of the stigma that comes with individuals that's doing heroin. So now it's called the opioid epidemic because it's affecting the socioeconomic people that can make change.	Hispanic and Latino populations are not showing up in the number of overdoses or overdose deaths, but numbers now show that this population are full participants in this epidemic. Latinos were not being giving prescriptions for pain, and if given prescriptions, in communities that pharmacies did not carry these drugs for fear of break-ins and violence. Now seeing a shift from prescription drugs to street drugs. H&L role is more toward street drugs. Shift in the age of the opioid user 25–34 decrease and 15–24 increase. High rate of oxycodone and other prescription drugs and street drugs increase among youth. 52% increase amongst Hispanics, 81% amongst Blacks.	Across the spectrum of aging, we're seeing older adults and over-prescribing of opioids. For example, the ER and those who do not have primary medical services are at risk of addiction because they can be prescribed additional meds. Older adults over 65 are taking between 6 and 14 medications daily.	Not many services are offered in the area of substance abuse because we don't have a psychiatrist on staff, but we are seeing an increase of substance abuse in the community, (marijuana and opioids) especially in young people.

NOTE: Numbers in parentheses indicate the number of times an answer was provided or a category was named.

Question 5: **What are the three (3) top unmet needs for addressing opioid and other substance abuse in this population?**	Not equipped to deal with or treat opioid addicted clients.	Easy, immediate, and fluid referral to treatment.	Legalize and fund clean syringe exchange.	Linguistic access from all levels: prevention, promotion, intervention, education, treatment, and recovery.	Statewide awareness campaign around older adults with testimonies.	Providing more wrap-around services or coordinated family services.
	Not enough space for current demand: 70 bed facility.	Medication-assisted treatment that promotes abstinence-based recovery as an outcome.	Educational base about harm reduction in relation to clean syringes, and get rid of stigma about holistic approach to harm reduction.	Workforce: Shortage of providers who are bilingual, interpreters, and need for bilingual workforce.	Population health management solutions; community health education (stigma), counseling/ therapy.	Providing education about opioids when children are younger and to the families.
	Training to provide adequate services to those addicted to opioids.	An easy academic withdrawal policy and procedure for students who withdraw to attend treatment.	Government examine system of how it became an epidemic from a socioeconomic level and how the faces of epidemics change. (Racism?)	Access: Barriers for immigrants, paperwork, proper workforce, medical assistant treatment, two bilingual physicians in the state that can distribute.	Public policy transformation; alternative solutions to pain management (medical cannabis). Government seeing it as a disease, not punitive down to the criminal path.	More services in general...that are linguistically and culturally appropriate.

NOTE: Numbers in parentheses indicate the number of times an answer was provided or a category was named.

Question 6: **In your opinion, what top three (3) factors that contribute to prescription opioid and other substance use in this population?**	Age: Addicted are younger	The way the substances have immediate effect–feeling good very quickly.	Greed (Pharmaceutical)	Health disparities	Lack of coordinated care for one medical home, that is inclusive of mental and behavioral health.	Availability of opioids for young people (ex. 10-year-old is the one asking for opioids on behalf of mom).
	Ethnicity: More white clients than before.	Highly engineered products/substances that target the reward system of the brain in a profit-driven, capitalistic society where profit drives decisions rather than human needs, safety, and health.	Stigma	Access to street drugs.	Lack of addressing social determinants of health.	No preventive education in the community about the dangers and all the ways in which our young people are having access to opioids.
	N/A	High stress and performance anxiety.	Secrecy	Lack of linguistically appropriate information and treatment.	Elders receive less patient-physician time, and they have very complex healthcare situations.	Little support that is culturally/linguistically appropriate.
		Lack of addiction prevention education				

NOTE: Numbers in parentheses indicate the number of times an answer was provided or a category was named.

Question 7: **In your opinion, what are the three (3) major barriers you are encountering in effectively responding to the needs of this population?**	Housing: Affordability and Housing First program clients do not qualify for.	The brain itself is the barrier. It's the only organ in the body that prevents itself from getting help.	Funding for ADDICTION	Political will to implement change for those with limited linguistic ability.	A large majority of older adults live in poverty: treating this disease as a disease and not just an addiction.	Lack of enough support.
	Employment	Uneducated faculty, staff, and students.	Availability and cost of Narcan in one area versus another.	Lack of providers who can serve immigrants, limited English proficiencies, lack of insurance, high cost.	Affordable housing; that's a barrier.	Accessing those supports that are available, like families might be afraid to go ask for help. (Fear that family member having drug issues will jeopardize permanent residency.)
	Legal services	A lack of an emergency care system that doesn't see addiction as an emergency. The catch, detox, and release model is ineffective.	We need to talk about all ADDICTION...denial that there is an epidemic in our community is gonna kill us.	Funding and inclusiveness for this population.... the will.	Lack of a registry to monitor and curtail over-prescription of opioids; a re-education of our healthcare and aging services professionals.	Fear of deportation.

NOTE: Numbers in parentheses indicate the number of times an answer was provided or a category was named.

Question 8: In your opinion, what are top three (3) resources this population needs that are not being adequately provided within the community?	Housing: Agency is backlogged/ bottlenecked because clients can't qualify for housing.	Easy access to care.	Clean syringes	Prevention and information: No bilingual prevention programing and education for community, especially for kids.	Me-Too campaign that is inclusive of older adults and all ethnicities and cultures impacted by opioid epidemic.	Behavioral health
	Clearing up current and past legal and credit (budgeting) issues.	Streamlined assessment process.	Education	Direct treatment access in a culturally and linguistically appropriate manner, and can start with peers (bilingual/ bicultural workforce).	Federal, state, and county funding for behavioral and mental health for communities regardless of income (elderly committing suicide and homicide due to great pain).	Parent education/parenting in general.
	Ongoing medical services.	One point of entry for emergency care.	Stigma (resource that empowers so that stigma does not prevent substance users from seeking help).			Support in their language (culturally and linguistically appropriate).

NOTE: Numbers in parentheses indicate the number of times an answer was provided or a category was named.

Question 9: What are your organization's strengths as it relates to serving this population?	We care (empathy) and work with them to better themselves… culture of caring. Services provided gets client from homeless/addicted to sober state of mind.	We understand addiction and how to get people into recovery through non-judgement, open access to professionals, peers, and staff. We provide hope to struggling students. We connect students to the community of recovery and provide mutual aid supports, sober events, academic supports, and a recovery-oriented system of support. We get it, students can see that.	What we do well is use the holistic harm reduction approach. We do that very well. The human rights is about human beings have a right to do what they want with their body. The public health is to give them the information on how to do what they want with their body and be healthy. Human rights and public health are the two principles that need to be focused on.	Very successful with other states by training them on how to establish conduct a culturally and linguistically appropriate agency assessment on a national class standard and then how to implement those for their organizations to become more open to those who speak other languages. Speaker, trainer delivering opioid prevention work in English, and we need to now shift and make it available in Spanish and other languages. Also providing training and assistance to those who want to be able to open their doors to those from other cultures.	Home for Life is an enhanced service coordination program, NCQA-accredited, evidence-based model to address social determinants of health that gives the opportunity for medical and support service professionals to go into their homes.	All personnel are bilingual and bicultural, Latino and Spanish dominant. We identify barriers and try to address those barriers, provide transportation (Uber/Lyft). We provide a combination of extensive services based on family assessments of each member over the age of 10 for 18 months or more.

NOTE: Numbers in parentheses indicate the number of times an answer was provided or a category was named.

Question 10: Is there anything important that you think I/we have missed/not addressed?	One of the populations we work with is the deaf and hard of hearing individuals. So they come with their own special needs in addition to being addicted to a substance, having a mental health diagnosis, so being deaf is a communication barrier. We have staff who are fluent in sign language, but establishing a diagnosis is a tremendous barrier for us.	Although this population may experience many of the same characteristics of the disease of addiction, they are each unique, their story is important and it matters.	Holistically, let's stop chopping up humans. Let's include social determinants to health that would take care of the public health, and then we can talk about human rights. We can look at the whole individual, then we can really stop what we are dealing with for the next generation.	There is a huge, gigantic barrier that we need to overcome, and that is that it takes 3 to 7 years to become fluent or master a language, and until that person reaches that level of fluency, they need services in their own language. Spanish community is not homogeneous with people coming from 22 countries including the U.S., with different levels of acculturation and dissemination and levels of English proficiency. When this is brought up, many want to make it a political issue about immigration, and it has nothing to do with it. Many have no immigration problem whatsoever, and they still have no access to services in the state of Georgia. Barriers to having to bring documentation and interpreter. Not an immigration issue, but a civil rights issue.	Strongly need to advocate for federal, state, and county funding for mental and behavioral health, education expansion, permanent affordable housing expansion, and research along a really broad spectrum concerning the topic of opioids and its use and abuse.	It is important to know the sheer numbers of the Latino community and the expected growth. There is a need to make a serious commitment to serve this population in a manner that is culturally and linguistically appropriate in order to revert the trends that we see in the community that is very concerning.

NOTE: Numbers in parentheses indicate the number of times an answer was provided or a category was named.