CA-CLAS Focus Group Report

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1. Introduction

1.1 Project Background: The Community Alliance for CLAS

The California Department of Alcohol and Drug Programs (ADP) began funding the Community Alliance for Culturally and Linguistically Appropriate Services (CA-CLAS) project in January, 2011. This grant was awarded to ONTRACK Program Resources as a technical assistance and training initiative to support the development and maintenance of cultural and linguistic competence in California's Alcohol and Drug (AOD) service provider network. The CA-CLAS project is led by ONTRACK with additional support from project partners Center for Applied Research Solutions (CARS) and NICOS Chinese Health Coalition**.** The project has previously been supported by project partners LGBT TRISTAR **and** the National Asian Pacific American Families Against Substance Abuse (NAPAFASA). These previous partners contributed their expertise to the development of initial tools and resources, as well as agency based technical assistance and training in the first project year. Currently, ONTRACK, CARS, and NICOS provide high quality technical assistance and training to a minimum of 240 unique AOD providers during each contract year. In addition to agency level trainings, the project also hosts regional trainings on cultural competence related topics across the state. Finally, the project also supports the development of CLAS standards specifically for use by California's AOD community, and a project website which includes CLAS resources for AOD service providers.

1.2 Introduction: Why Focus Groups?

The CA-CLAS project focus groups were conceived as a way to help the project understand whether some cultural groups experience barriers to AOD prevention, treatment, and recovery services. We know that there are cultural disparities in access to healthcare, and one reason for this may be that healthcare organizations are not prepared to meet the specific cultural needs of consumers. By talking to AOD consumers about their experiences with California's AOD field, we hoped to get a more nuanced picture of how well their cultural and linguistic needs were being met. By including a diverse population of participants, we wanted to assess the degree to which AOD service needs and preferences varied across groups. In short, we wanted to understand the difference that culture makes.

Culture is an essential aspect of the human condition. Most broadly, culture can be understood as the totality of our learned experience. This includes beliefs, attitudes, meanings, communications, and material objects. Race, ethnicity, religion, sexuality, gender, economic status, physical ability, and language are all cultural markers, and each of these impacts the way we understand, experience, and interpret the social world. All individuals have a culture, but not all cultures are similarly positioned in terms of access to goods and services. The historical hierarchy that has given some cultures power over other cultures has resulted in disparities in both access and outcomes across market sectors. In terms of healthcare, this means that cultural identities have real consequences for the health of populations. Some cultural and linguistic groups receive, on average, worse services and can expect worse outcomes than other cultural and linguistic groups.

The CA-CLAS focus groups were convened to better understand how well populations that have been historically underserved by AOD services are now being served. The goal of the focus groups is to help AOD providers establish services that respond to the particular ways in which AOD consumers understand, experience, and interpret their needs for substance use prevention, treatment, and

recovery services. The intended outcome is the reduction of disparities between cultural groups in AOD service access and completion.

One of the major tenets of cultural competence is the proposition that communities are the best source of knowledge about their own needs. In the context of AOD services, this means that strategies intended to respond to the needs of consumers should be based on the experiences and understandings of consumers themselves. Culturally competent services are first and foremost culturally responsive services. If we want to know what AOD service providers should do in order to make their services more accessible, relevant, and successful for the spectrum of AOD consumers in California, then we need to ask the consumers of AOD services about their experiences.

Because the cultural groups identified for inclusion in this project have unique cultural histories, we expected that there would be differences in how they experienced AOD services. Do AOD consumers believe that AOD agencies are able to provide culturally and linguistically appropriate services? Are they able to access these services in their own communities? How well equipped are AOD agencies to serve the diverse cultural needs of AOD consumers? What role do cultural norms, preferences, and expectations play in the ability of consumers to complete treatment programs? How can AOD services better support the cultural needs of those in recovery? How can services become more culturally and linguistically competent?

2. Research Methods

2.1 Focus Group Selection

There were a total of 268 people who participated in the focus groups, excluding the facilitators. Of these, about 40% were male, 53% were female, and 7% were transgender. The goal was to involve 12 participants in each focus group, and almost all commenced with 10 to 12 people present. The four ethnic groups targeted by the project were represented in most focus groups, as were LGBT people. Participation in the focus groups was voluntary, and focus group members were provided with $10 Target gift cards as a token of appreciation for their time.

The focus groups were selected through three levels of sampling: the primary cultural identity of AOD consumers, the region in which the AOD services were offered, and the kind of AOD services consumed. In total, 25 focus groups were conducted with specifically targeted groups, in particular locations, with people who had accessed prevention, treatment, or recovery services.

A main goal of the focus groups was to document the experiences of historically underserved populations. The focus groups were therefore comprised of a sample of AOD consumers in which members of undeserved communities were overrepresented; this project was not intended to recruit a representative sample of California AOD consumers as a whole. The CA-CLAS partnership drew on its extensive knowledge of disparities in AOD access and outcomes to develop a population matrix centered on the following historically underserved groups:

- Asian/Pacific Islander (API)
- Lesbian, Gay, Bisexual, Transgender (LGBT)
- Latino
- African American

- Women
- Native American
- Youth

These groups were organized with the recognition that all individuals belong to multiple cultures. Although these categories formed the organizing principle of the groups, each focus group facilitator also collected information about other cultures with which each participant identified. Participants were asked to indicate their racial/ethnic identities, their disability status, their veteran status, and whether they identified as LGBT, homeless, aging, youth, or refugee. This information was collected in acknowledgement that cultural identities are complex, and that identities may be variably salient in terms of AOD services. Please refer to the Focus Group Matrix in Appendix I for detailed information about the composition of the focus groups.

Great care was also taken to ensure that the focus group participants represented the geographic diversity of California. The CA-CLAS partnership identified nine regions in California (see chart below), and ensured that focus groups were held in each of these locations. In many cases, geographical location was deeply connected to whether consumers were able to access culturally and linguistically appropriate AOD services. For consumers who lived in areas where there were few people with whom they shared a cultural identity, accessing services that responded to their cultural needs was generally more difficult. Even within the regions targeted by this project, there were differences between those who lived in communities with large numbers of people who were culturally similar to themselves, and those who lived in communities where they were culturally isolated.

	Nine regions of California, in which CA-CLAS focus groups were held:	
Fresno and the Central Valley	Sacramento	San Diego
Bakersfield	Rural Northern California	Los Angeles
Inland Empire	Northern California Coastal Cities	Bay Area

The CA-CLAS partnership is also committed to ensuring that we serve the range of AOD consumers in the project. Included for participation were youth prevention groups, both school-based and community based; those at-risk for substance use disorders who had never accessed treatment; AOD consumers currently in treatment; AOD consumers who had entered treatment and left before completion; and AOD consumers who had completed treatment and were currently part of an organized recovery group. Many of the people who participated in this project had interacted with the AOD field in multiple capacities. These people, especially, were able to offer valuable insights about the range of programs and experiences they had encountered in California during different phases of their substance use trajectory.   Please see appendix III for detailed information about the facilitators, location, and composition of the focus groups.

2.2 Focus Group Facilitator Training

Every member of the facilitator team attended a mandatory training session to learn how to conduct focus groups with a focus on cultural and linguistic competence. Eyrlene Piper-Mandy, PhD, was retained to develop a facilitator protocol and to train focus group facilitators in its administration. Dr. Piper-Mandy is an instructor in anthropology at California State University Long Beach, and an expert in cultural competence in social service and public welfare contexts.

All of the people who participated as facilitators had extensive experience working with AOD organizations in the state of California. Most of the focus group facilitators have professional resumes that include the provision of training and technical assistance to AOD organizations. Many have direct service experience in the AOD field as well. Some have worked at nonprofit organizations, others for county and state agencies, and some with faith-based organizations. A substantial minority was formally trained in qualitative data collection procedures; many of them had prior experience leading focus groups. Together, they represented a deep and varied knowledge of the context in which AOD services are provided in California.

The project also attempted to recruit facilitators that mirrored the diversity of AOD service consumers. Because we were asking people to relate potentially sensitive information about their experiences as members of marginalized cultural and linguistic groups, a great effort was made to match focus group participants to a facilitator with whom they shared a cultural identity. Although there were a few cases for which this was not possible, the majority of focus groups were facilitated by people who were fluent in the cultural norms and idioms of the participants. This allowed focus group facilitators to use their shared cultural identity as a basis for building both trust and rapport.

The protocol used by the facilitators can be viewed in Appendix II. Although this protocol served as a template for all the focus group facilitators, the training they received emphasized the importance of cultural and linguistic appropriateness rather than strict adherence to the questions as developed by Dr. Piper-Mandy. Facilitators were taught that standards of cultural and linguistic competence are often incongruent with a vision of social science as an objective endeavor. In practice, this meant that facilitators were encouraged to use their own cultural knowledge to guide both the form of the questions and the style of interaction. Dr. Piper-Mandy highlighted the fact that there are cultural differences that structure the norms of social engagement. If facilitators believed that cultural norms were best met by sharing their personal narrative, affirming the speaker's experience, or shifting the conversation beyond the questions provided in the protocol, they were given room to exercise this judgment.

The wisdom of this approach is borne out by the narratives that emerged. All the focus groups covered the same essential questions, making it possible to compare them across groups. But the transcripts also demonstrate how a skilled facilitator can identify additional themes and push through ambiguity and generate lively and respectful debate. Some facilitators shared parts of their personal experiences; others asked insightful follow-up questions that provoked culturally specific insights. Additionally, the transcripts are full of moments where participants seek affirmation from the facilitator, saying "you know how it is" and "you know what it's like." This indicates that focus group participants did feel a cultural affinity with the facilitators, and strongly suggests that this affinity provided a foundation of trust that allowed the facilitators to elicit truthful and nuanced narratives.

Each facilitator also completed a summary report on completion of the group. These summary reports gave facilitators an opportunity to add their contextual knowledge to the recorded data. In these summary reports, facilitators describe the dynamics of the group, report their key findings, and make recommendations for how to better serve this population. The Summary Report Form is attached in Appendix III.

2.3 Data Analysis

All of the focus groups were recorded with the permission of the participants. Participants were informed of their right to confidentiality and signed permission forms indicating that they understood their rights. Every focus group facilitator was required to begin the session with an explanation of the HIPPA laws that included a detailed description of how the focus group data would be used. In order to ensure that confidentiality is kept, no names or locations are used in this report. References to specific programs or people have been removed from the quotations included in this document.

All the focus group recordings were transcribed by Dr. Piper-Mandy and a group of students she recruited to work on behalf of this project. Some of the transcriptions were problematic because frequent cross-talk in the group made distinguishing individual voices difficult or impossible. However, even though the transcripts are imperfect, the excitement and eagerness of people to participate suggests that these groups provided a welcome opportunity for AOD consumers to share their experiences with the field. In general, almost all of the transcripts contained enough usable dialogue to include in the analysis.

The transcripts were provided to Miranda March, PhD, with project partner Center for Applied Research Solutions. Dr. March has been working with the CA-CLAS project since it launched in 2011, and is an expert in qualitative data analysis. Each transcript was reviewed carefully along with the summary report provided by the focus group facilitator. This review followed a structured approach to qualitative data analysis in which responses to individual questions were compared across groups to help identify themes that were common to multiple groups and themes that were unique to specific groups. Attention was also paid to the number of times a respondent used a particular word, and the context within which the word was used. Words that were used often in response to a particular question or set of questions were compared to the responses of other groups. This formed the basis of the analysis below in which broad themes that are common to multiple groups are separated from themes that emerged in relation to specific cultural groups.

The analysis of focus group data is largely an inductive process where reasoning moves from specific examples to support the construction of general propositions. When multiple participants use words of particular intensity to describe their experience with a particular aspect of AOD service, these examples are pulled out of the transcripts and grouped with other examples reflecting similar experiences, beliefs, or criticisms. These ideas are identified as themes, and used to organize the data included in this report. Because some questions provoked more impassioned and engaged responses than others, the decision was made to organize data presentation around the themes that emerged organically rather than to use the protocol questions to structure the report.

3. Broad Focus Group Findings

Although some themes that emerged from the focus groups are specific to particular populations, there were also themes that cut across the particular cultural groups represented in this project. Many of these themes are related to the provision of culturally and linguistically competent AOD services. A few of these finding may be outside the scope of a project primarily oriented towards cultural and linguistic competence. Nonetheless, the frequency with which these issues emerge in the focus group transcripts requires that they be documented.

Many participants initially denied the importance of services developed for specific cultural groups. However, when facilitators dug deeper, some of this initial resistance was belied by the stories that participants told of moments of misunderstanding, hostility, and harassment they had experienced from AOD providers. Perhaps even more insidious, many consumers also expressed dismay at the way providers failed to protect them from the racism, homophobia, and misogyny of other clients. While the analysis provided here respects the integrity of speakers who attach little import to the role of culture in treatment, these voices need to be interpreted within the broad context of our knowledge about the difference that cultural makes in terms of both access and outcomes. One key recommendation of this project is that both providers and consumers be made aware of the data supporting the importance of cultural to successful AOD service provision.

In the below analysis, themes that emerged across populations are considered first. The second section considers the issues of particular salience to population groups of consumers identified as critical for this project.

3.1 Individualism

One of the primary goals of the focus groups was to uncover the degree to which participants felt that a lack of attention to the cultural and linguistic needs of AOD consumers acted as either a barrier to treatment access or treatment completion. Although many focus group participants contributed valuable insight into these questions, these questions also met some resistance in almost every group. In most groups, at least a few participants reacted negatively to the suggestion that program access or success should be understood as a consequence of program factors rather than individual factors. "We're all, like, addicts. We are all drug addicts, so we're alike. It's not necessarily the race that we come from, but, like, the fact that we're all addicts which relates us in a different way. So you could say that, we are all kinda from the culture of being … of addiction," stated one Latino participant.

To understand this resistance, it is necessary to understand the extent to which many programs emphasize the individual nature of recovery. Most approaches to AOD treatment begin with the premise that substance users cannot be compelled to stop using substances until they decide for themselves that they are ready to change. There is a strong belief in the treatment community that each individual must arrive at the decision to stop or modify their substance use of their own volition, and that this process cannot be influenced by factors outside of the individual psyche. Many treatment models are based on the 12-step model; in the parlance of this approach to recovery, an individual must typically hit "rock bottom" before they will be motivated to seek help. Other programs invoke the metaphor of an "individual journey" and encourage clients to understand the road to recovery as a process which should be *supported* by others but must be ultimately faced alone. The theme of individual responsibility, or individual journey, persists across groups. "Right. It is up to you. You know

it's up to you, really. You know what I'm saying; that it could be about money or whatever, but it's really up to you. You know what I'm saying. If you are ready to change or stop using or stop drinking you know it's up to you," remarked one African-American woman.

Culturally and linguistically competent approaches to prevention, treatment, and recovery are in no way antithetical to the emphasis on individualism common to AOD approaches. The trajectory of people towards "rock bottom" may vary across populations, as may the factors that pull them towards treatment and sustain them in recovery. The kinds of support needed along the journey may differ for people who are embedded in different cultural and linguistic contexts. Approaches that align with the spiritual or religious values of some groups may not be appropriate for others, and cultural norms within some populations may require specific treatment modalities that would be meaningless or offensive to other cultures. It is precisely these kinds of differences that the focus groups were convened to identify. And indeed, all of these ideas are supported in the population specific findings detailed below. But the frequency with which people reported that culture is irrelevant to the success of treatment suggests that programs may need to make the importance of culture to treatment an explicit part of their approach, so that the success of a client's individual efforts will not be dampened by culture-based obstacles outside of their awareness and control.

Findings and Recommendations

- AOD service consumers may benefit from knowledge about how culturally informed services can benefit them, and which service options will be most responsive to their specific cultural needs
- AOD service providers should be encouraged to learn about how cultural differences affect substance use trajectories, program utilization and success
- AOD service providers should be encouraged to provide services that are responsive to cultural differences known to impact the success of individual efforts

3.2 Language

Issues around language came up in almost all the focus groups. Because all but one of the focus groups were conducted in English, the participants were generally fluent in English, and overwhelmingly identified English as their language of preference. However, focus group members in most groups expressed concern that other members of their community, particularly older members who were more likely to be first generation immigrants, faced substantial language barriers in treatment access.

Participants in one of the Asian/Pacific Islander (API) groups—all of whom spoke English—were aware of the fact that their own path to treatment was eased by the fact that they could receive services in English. And they worried about those for whom English was not a primary language.

> "One thing I did want to mention is that as an Asian American person it was easier for me to find recovery because I speak English, and there were absolutely no Asian foreigners who have problems [there]. There are no resources for the ones that don't speak English or don't know how to work the systems, so I think that that is a big problem for resources for us that there were no programs that are only Japanese based or Chinese based or whatever."

Asked if services could be accessed in languages other than English, one Latino focus group participant stated very clearly that without a translator on hand to work with clients, there was simply no way for non-English speakers to access the services they needed:

> "See, alcohol and other drug programs here in California are geared to benefit the people that use the program. For individuals that do not speaking English, it is very, very hard to get access to. I'll give you a good example. An individual that has a drug problem, they cannot just walk into a drug facility … it's going to be a language barrier, and the program needs to have an interpreter or a counselor that speaks a dialect in order for those individuals who do not speak English to seek help …. Programs are not set up to distinguish that a non-English speaking person cannot get help."

Another participant in an API group challenged the notion that the use of interpreters could successfully meet the needs of clients. Instead, she called for increasing the number of clinical staff who are fluent in API languages. "My sense is that, for those that do not speak English, and have to have a translator or interpreter, it's not the same as one-on-one. It's kind of lost in translation of the interpreter or the facilitator with a counselor. If you have the individual who speaks their language, basically your directions don't get lost."

No one participating in the focus groups had ever accessed services that were provided in a language other than English. However, many of the participants were fluent in other languages, and had been in programs where they shared a second language with other program clients. Multiple people across different groups reported that programs often have an "English only" rule in place. Some participants explained that this rule was put in place in order to minimize the ability of clients to exclude staff and other residents from the content of their conversations. Feelings about this were mixed, with some focus group participants reporting that they understood the reasoning behind the rule, and others reporting that they felt marginalized in contexts where they were not allowed to express themselves in their family languages.

Language was also sometime a contested space between cultural groups. This was felt especially strongly by Filipino participants. Their second language was often Spanish—Spanish was the official language of the Philippines under Spanish colonial rule for centuries—which caused some friction in programs where this fact was not widely known. Their fluent Spanish sometimes provoked hostility from Latino clients who resented the ability of culturally different people to understand their conversations: "And the Mexicans don't like it when the Asians, when they open a shocker and speak Spanish. They don't," explained one man.

Findings and Recommendations

- AOD service consumers believe that there is little or no availability of non-English AOD programs
- AOD programs should make every effort to recruit clinical staff who speak the primary languages of their service community
- AOD programs that currently employ staff who are fluent in languages other than English should highlight this information in their outreach materials

- AOD programs should review their policies around “English only” communications to determine whether these policies are in the best interests of their clients. These policies should be made transparent to the clients the serve.
- AOD service providers should be encouraged to address individualism within a cultural and familial context.

3.3 Outreach

One of the strongest themes that emerged across groups was the necessity of developing better methods of reaching out to particular populations. Calls for more effective AOD outreach efforts took three forms: first, some participants wanted outreach that included an education component; second, participants reported lacking knowledge about AOD services that were designed to work with people from their particular cultural background; third, many described being unsure about how to find services that worked with their specific cultural group. Each of these was identified in multiple focus groups as a major barrier to seeking, finding, and completing treatment.

For some groups, outreach needed to be part of a broad strategy of education about addiction itself. Members of the API groups, in particular, told facilitators that their communities often viewed addiction as something that should be kept secret. In response to a question about what California can do to better serve their Asian communities, one woman remarked:

> “More outreach to the Asian communities and specific communities. Because Asians—obviously our families are a lot more shameful and they're just not educated on addiction and stuff like that. And out there in Korea, they don't even have rehabs. They believe that if you're an addict, you're pretty much just screwed. So just more education, more outreach to families to learn more about addicts, in the communities.”

Latinos identified fear of deportation as a major barrier to seeking treatment. To overcome this, they explained, outreach needed to be supported by education from trusted leaders. One woman in a group of Latina mothers explained, “We need to find leaders in the community, because they already gained these people’s trust and they can deliver the information.” The group of Latina mothers also believed that there needed to be more efforts to reach the Spanish speaking community in places where they were likely to see them. “It needs to be a place where Spanish gather, so where they cash their checks. Where they go shopping and things like that.”

Many groups also talked extensively about how they had lacked confidence that there were services available where they would be met with cultural understanding and culturally competent staff. A Latino man in a treatment program that was committed to serving the Latino community put it this way:

> “Promote and advertise to lead people, to let the community know, that, ‘*Hey we have drug and alcohol programs available to different cultures—don’t be afraid to seek help.*’ So once people know that, they have the confidence to come and seek help.”

Members of the API focus groups echo this theme, reporting that they had been reluctant to seek treatment because they were unsure that they would find support for their particular cultural needs.

Specifically, respondents indicated that they wanted outreach from services that were prepared to serve API populations in culturally competent ways.

> "A lot of us—you don't seek, you don't look for, we don't seek out the programs because of lack of knowledge. You know you have a problem, you recognize your problem, but you need help and you don't know where to go. There's just no knowledge. Secondly, even though you know it's out there you still have that fear. Your fear of the unknown. You don't, you don't know what kind of program. And you'll be thinking '*Oh, I'm an Asian!' … I don't know if they understand me and my culture'* or things like that."

Some hard to reach populations may require outreach strategies that go beyond normal dissemination channels. In these cases, knowledge of the community is an essential component of successful outreach. A formerly homeless man described how he had seen the effects of detoxification programs without ever knowing the cause, much less knowing how to access these services himself.

> "We have a certain element of a chronic homeless population that are truly missed because they're not gonna go into no office. They actually need people to go out there and canvass for them and try to bring them in. They're chronic homeless. I was one for 12 and a half years and I didn't know nothing about no detox place. I used to wonder why people would disappear and come back looking all fresh, their clothes clean. I said '*Damn! What the fuck?'* I know it couldn't have been jail 'cause they were out too quick."

Finally, there were numerous reports from focus group participants that although they knew that treatment options existed, and that they existed to serve people from their own cultural groups, they had been unable to find appropriate contact information. One of the LGBT groups explained that almost all the LGBT services in Los Angeles are located in West Hollywood. According to this group, it was extremely difficult to identify LGBT services elsewhere in the Los Angeles area. "My difficulty was finding a place, it's like the secret society," commented one male participant. Another participant noted that he had found his current treatment program by accident:

> "I would like them to advertise a little better because to be honest I found (program) by accident and I live four blocks away from them, five blocks away from them. I found it by accident because somebody invited me to their Thanksgiving dinner here and I never refuse a meal but if I had known …. And I had been looking and looking and looking for some place and the moment I stepped in the door of this place it was different, it was professional, it was clean, it was accommodating and it was welcoming. I spent years searching for some place near where I live and I couldn't find any place and I happened to find it by accident."

A man in one of the API groups recounted a remarkably similar story of how he accidently stumbled across an appropriate treatment program:

> "I mean I used to drive around this place all the time. I knew I had a problem, but it's like … I didn't know how to access it. And then I think part of it is based

> on the thing that this is supposed to be confidential; recovery is confidential so we're not supposed to be advertising *'Hey, come get some recovery.'* So that's part of it as far as finding access to it. And then part of our culture is like we're not supposed to even *be* in that kind of trouble."

Findings and Recommendations

- AOD service organizations should ensure that their staff are educated about the culturally specific beliefs around addiction, treatment, and recovery in their primary service communities
- AOD outreach should emphasize the cultural competencies of programs that are able to work effectively with specific populations
- AOD outreach efforts should include the participation of trusted community leaders from within the populations they serve
- AOD outreach strategies should be informed by knowledge of the culture of those who need services, including knowledge of language, gathering places, literacy, and specific concerns of the populations they serve
- ADP may wish to consider supporting the development and distribution of a resource which lists available AOD services and notes their special cultural and linguistic competencies

3.4 Drug Use in Facilities

The majority of people who participated in the focus groups as part of a treatment or recovery program had previous experience with other treatment programs before entering their current program. Many of these participants had left prior programs before completing treatment, either against the advice of clinical staff or in violation of court orders—or both. Many participants recounted stories of drug use in residential treatment programs, and many claimed that these activities had been a factor in their decision to terminate their treatment or had directly contributed to their relapse. Although not directly related to cultural competence, the issue of drug use within facilities emerged with enough frequency that it requires documentation.

A formerly homeless woman remarked, "Yeah, I have been out of the program because there were just too many people in there getting high and I wouldn't take it." Similarly, an African-American woman in treatment described how the staff in her previous treatment program failed to supervise the residence.

> "Several people had already went out and used again. And there were no consequences and so on and so forth. And one of them was in my room and I felt like, well, hell I want to take a hit now. You know, because there were other people that did it. So I wanted to go out and take me a hit. And I actually snuck out the program that day in hopes that I will cop me some substance and go back and use in the facility and act as if nothing happened."

A Latino man in another treatment program recounted a similar experience. As he describes it, supervision was so lax that people took turns going out to get high.

> "The first program I left, I left because one of our roommates had brought drugs in the room—everyone brought drugs in the room—and then it was like piggy

> bank: somebody else went out and got high and they allowed them to stay in and so on so forth. So one day I was getting on my top bunk I said '*Hey I might as well go out and get high, too.'*"

Findings and Recommendations

- Consumers who have accessed treatment programs report a high level of drug use in treatment facilities
- AOD treatment programs should ensure that there is sufficient staff supervision to deter substance use in facilities
- ADP may wish to support the development and distribution of a sample policy which provides clients a safe way to report substance use among other clients

3.5 Dual Diagnosis and Criminal Justice Involvement

Asked about barriers to treatment, many respondents reported that they had been denied services because they failed to meet the requirements for a dual diagnosis. According to these participants, many programs require not just a substance use disorder, but also some additional qualification in order to be accepted for treatment. The belief that in order to qualify for programs you needed to have either specific biographical history—e.g. veteran status—or specific diagnoses—such as co-occurring mental health disorders—emerged repeatedly, with some reporting that programs were increasingly restricted to serving so-called special populations.

Members of the transgender focus group stated that along with a funding preference for transgender youth, adult treatment seekers were not considered "bad enough" to qualify for substance abuse services. In their experience, if you were not suicidal, HIV positive, a sex worker, or addicted to "hard" drugs, there were few resources available for help.

> "I had a lot of problems accessing the services I need because I was HIV negative, I did not do hard drugs, and I never was a prostitute. And I find it exceedingly difficult to find services because I'm doing everything right."

In desperation, several respondents in this group admitted that they had falsely claimed to be suicidal in order to get treatment. The belief that it was necessary to "fake it" in order to receive treatment came up in other groups as well. There is widespread belief that many treatment avenues are closed to people who do not have specific symptoms or problems, and that it becomes necessary to lie in order to access treatment. An African American woman conveyed frustration, because, she explained:

> "(People wanted) to come into a program but … because of the rules and protocol and criteria of getting in, they didn't meet all the criteria. But they had to fake it, they had to say that they had this or that or that they *suffer* from this or that in order to get in."

Several people also mentioned that there are no services for people who are not referred by the courts. "This is the biggest issue in California: if you don't commit a crime, nobody's going to help you. If you walk into a drug treatment and say 'I'm a drug addict, I need help' nobody is going to help you. But if you commit a crime they're going to help you."

Findings and Recommendations

- AOD organizations should make clear the requirements for program participation in their outreach materials
- If the AOD services can be accessed by anyone, this information should be highlighted in outreach materials
- ADP may wish to review the extent of dual diagnosis and criminal justice involvement requirements in California
- ADP may wish to support the development and distribution of a resource listing AOD programs that includes information about requirements for service

4. Population Findings

4.1 Asian/Pacific Islander

All three focus groups specifically targeting API populations were conducted with people currently participating in either in-patient or outpatient programs. Asians and/or Pacific Islanders were also represented in most of the youth-focused groups and in all of the LGBT groups. However, it is important to understand that the term “Asian/Pacific Islander” is a category which includes 49 unique ethnicities speaking more than 100 different languages.[i] Caution should be exercised when making generalizations about this diverse community, a fact which was mentioned several times by focus group participants. “I’m the only Filipino in that place. You know like Asian, Korean, we’re not the same, we have different backgrounds, language.” Speaking about his experience in a specifically Asian focused treatment program, one respondent pointed out that there were still divisions among the different Asian groups, and that they tended to group by cultural identity. “I think that naturally, though, in my honest opinion, that you are drawn to your own race naturally. Like, if you look in this room, all of the Koreans are sitting together, all the Filipinos are sitting together.”

Another member of the same Asian-specific treatment program concurred that people did tend to sort themselves by cultural identity, and added that from his perspective this was a positive outcome because it gave him the opportunity to find people with whom he shared a specific cultural identity. “I thought it would be different but it really wasn’t, it’s really easy to make friends with everybody, but I did notice that there are divisions—not divisions, but cliques I guess, of races that, I guess, do naturally come together; I don’t know why. Guess it just happens. Socially, I guess it’s pretty positive for me.”

Perceptions of AOD Cultural Relevance and Accessibility

Out of all the focus groups centered around specific racial or ethnic identities, the API participants expressed the strongest opinions about the benefits of programs designed specifically to meet their cultural needs. Although there were participants who echoed the idea that addiction was a more important unifier than cultural identity, many API participants in this project reported that they had better treatment experiences with programs that were designed to serve Asians. “Coming here I have a Korean therapist that I work with, that I met through (this program). And I find it really helpful that she can understand me culturally because there are a lot of things about my childhood and Korean culture that contributed to my addictive behaviors. So that's good.”

Many of the focus group participants believed that there were culturally specific experiences, norms, and beliefs that affected the ability of Asians to access treatment and to succeed at treatment. One female respondent encapsulated this experience by revealing her belief that there are culturally specific aspects of her personal history that require unraveling as part of her recovery. She noted that being in a program that specifically serves the API community enabled her to feel safe enough to succeed in her treatment program.

> "As an Asian, this place is actually pretty good for me because it gave me an opportunity to look into myself because, as an Asian, I'm the queen of denial and the queen of avoidance. Those are the things that you just don't want to look at that you're doing anything wrong. I absolutely didn't want to tell anybody in my family, absolutely didn't want anybody to know I had a drug problem.… So coming here I was able to understand the core of why I did the things I did. It had a lot to do with childhood and my upbringing and there are just certain things that the Asian culture puts on you that is … it hurts your feelings, and when it does that, you just try to close yourself off from the world. Being in a place where you're able to open up and able to feel safe enough to share how you really feel helps Asians get their recovery."

Many of the API participants reported that their road to recovery was made more difficult because of a pervasive cultural stereotype that Asians, as a "model minority," were not really addicts. Even after entering treatment programs, some participants found that they were met with skepticism.

> "I'm the only Asian there. Yeah, everybody's like, looking like, you're an addict? And I'm like, yeah. I used to go to (a program). I was the only Asian there—mostly whites, Hispanics and a few blacks. And they'd look at me, like, *you* are? And I'm like *'You shouldn't judge a book by its cover, until you read it'* and yeah, we have addictions as well too. We don't come out in the open as much as other nationalities do."

The belief that Asians are not "really addicts" comes not just from outside the Asian culture, but within the Asian culture as well. Cultural norms around alcohol consumption vary across cultures, as do understandings of addiction as a disease that can be treated. Several members of the focus groups identified reluctance among members of their own culture to acknowledge the realities of substance dependence as one factor that delayed them in seeking help. Participants also reported that there are cultural differences in the understanding of addiction that influenced their perception of themselves as people in need of treatment.

> "The problem is that the Asian people, for example, like …. I am an alcoholic. I've seen in my country people drinking. That's normal. That's nothing, and if you drink until you pass out, they say you drink too much. But the word 'alcoholic' never exists. People don't understand what's happening. People don't understand that's a sickness or it's a disease or people really need help."

For some, this denial persisted even within their own families, and even in the face of persistent evidence that substance use was becoming a very real problem. According to the focus group participants, Asian families often don't acknowledge that one of their members is struggling with addiction. This lack of acknowledgement, they reported, has consequences for familial support for

recovery. Talking about his mother, one participant noted "It was really difficult for her to understand. … It's like that culture of how we're brought up is like—she didn't want to know that her son had a drug problem. You know what I mean? It's still hard for me to say it and for us to talk about it."

Staff and Program Issues

There is also frequent mention of the fact that the therapeutic community (TC) model used by many treatment programs is antithetical to what participants identify as a particularly Asian belief in the value of self-containment and reticence. TC models rely heavily on group participation and extensive self-disclosure. In these facilities, it is expected that participants work with each other closely as a method of peer support; a lack of willingness to verbalize feelings in group situations may be interpreted as resistance to treatment. Focus group members who had prior treatment experience in TC settings reported that cultural norms in Asian communities opposed many of the expectations of TC treatment. In order to participate in these programs, there was a need for staff who understood the inherent cultural conflict.

> "To answer the question *'What specifically made it more comfortable for me to get my recovery?'* was that I was always taught that I wasn't able to express my feelings, that I was not supposed to have any. So when I was given the same environment to express how I felt, it actually helped me a whole hell of a lot because I've always … I have this embedded in me that I was not supposed to show any emotion. I was supposed to be tough and have it together, know what I'm doing and feel nothing. To be able to get in touch with what you're feeling and be able to express it helps a lot for recovery."

This notion of privacy as a specifically Asian cultural norm comes up repeatedly, and is often referenced as a specific cultural barrier to treatment. "We're kinda private; as Asians we're kinda like a little bit more private. Like, I know, or at least my family personally, we don't put our business out there. You know what I mean? It's like, make everything look very good on the surface," explained one participant.

Family

Family was a strong theme in each of the API groups. Of particular importance to this group was the ability of programs to work with their families in culturally competent ways. Having a program that acknowledged the centrality of family to the API community was cited as a particular benefit of the Asian specific program. When programs included working with clients' families, clients felt that their needs were being addressed in ways that other programs did not.

> "The family thing was also very important too, the fact that the philosophy of the program knows that culturally we are tied with our families.… So it was important for us to have our families know what we were doing. That was a really, really big step for me to even invite my mom to a Christmas party.… It's important for them to see where I spent my time, and *that* part of the program is very important. Because if the program doesn't know that that's important to have that invite, and we just processed [along], it just wouldn't have that meaning, that milestone marker there. Those are important little notches in my

> recovery like, okay, I finally told my mom what I'm doing, and I finally told my dad, and now I feel like I'm transitioning now, getting it. It's not a secret."

Participants also spoke at length about how important it was for them to be in a place that was welcoming for their families, and where people understood the cultural nuances within which their families operated.

> "For me—I'm half Korean half white. For me family is very important for me to stay strong and be sober on the streets. Without my family—you know what I'm saying—most likely I'm going to go back to using, so I feel that …. Well, I've been to two other programs in the East Bay, and my mom came by. My mom was crying … she was like, *'Oh my God! All these parolees!'*… and it was just unwelcoming for her and just ... she was kind of ashamed to even come by. … She was kind of scared to come the first times to it [here]. It was really welcoming for her to come here."

One of the ways that programs were able to work with families was by ensuring that there was staff who could speak to parents in their native language. According to this respondent, her parents are better able to support her treatment efforts when they could interact with someone on staff who spoke their language.

> "I think it's more of a preference for our parents. Sometimes our parents will come in and ask for a Korean speaking counselor.… They are comfortable speaking to Korean counselor or Korean intake counselor. So they feel the connection. So they're like, *'Okay, I'll send my daughter to come here.'*"

Participants acknowledge that family support is often difficult to obtain, and that being in a program that was designed to work with Asians made it easier to secure the support of their families. Some reported that being in a treatment program responsive to API cultures made it easier for their families to accept the reality of substance addiction.

> "For my parents, I know that they felt a little bit better to see other Asians and to see that, okay, it's not just my daughter. It's not just this Asian girl. It actually happens to other people, and it's okay. My dad actually wanted me to stay here—and he doesn't quite approve of anything that I do. But he told me to stay, and that meant a lot to me because he actually approved of me being here."

This group also talked extensively about the role of family shame in their process of seeking treatment services. Critically, the group concurred that this was a specifically Asian phenomenon, and identified this as a major cultural barrier to treatment. A male respondent said:

> "Like I say, it has something to do with the culture. That's why they keep on denying it. Like, if you're Asian—especially some races like Filipinos, or us or with my family, my culture, my background—I don't want them to know that I was an addict. You know how the culture is based. As an addict you're locked up in all this. You're fuckin' up. It's shameful."

Another respondent agreed: "Yeah it's stuck to your name that you're an addict. So it's hard for us. All on the table like, *'I'm an addict.'* It's hard for us to do that."

For some respondents, this family shame has resulted in being disowned by their families of origin. Several female respondents spoke of being shut out of their families as a result of their addiction, and that even while in treatment for their addiction their families continued to refuse contact. One woman had not spoken to her brothers in 13 years. Many people noted that family shame played a culturally specific role as a barrier to treatment.

A few female respondents reported that there was a gender aspect to the ways in which Asian families dealt with addiction issues. "If you're an Asian male, once again you can get away with things. But if you're an Asian female ... you're disowned for a long time from your family." Others, fearing the response of their families if they were to admit to addiction, kept their addiction and subsequent treatment efforts a secret from their families. Others still reported that, although their immediate families were aware of their status as addicts, the families kept this information secret from extended networks of family and friends. The belief of this as a specifically Asian approach to addiction was reiterated several times: "That's one thing about Asian families: they know how to keep it secret," said one man laconically.

Findings and Recommendations

- Programs should be encouraged to develop cultural competencies in working with API populations, and should make these competencies known within the API community
- AOD education curricula should include information about the incidence of substance use and abuse within API communities to help counteract the "model minority" myth
- Outreach efforts to the API community should incorporate the cultural reluctance to acknowledge substance dependency
- AOD programs should be made aware that the therapeutic community (TC) model may require culturally appropriate adaptations for greatest effectiveness with the API community
- AOD programs should be trained to reach out to the families of API clients, and be prepared to work with them in culturally competent ways
- Where possible, AOD programs that work with the API population should have native speakers of API dialects on staff

4.2 Lesbian, Gay, and Bisexual

Three focus groups were conducted specifically for LGBT identified consumers. Members of many other focus groups also self-identified as LGBT, and this section includes some reflections made in these other groups as well. Because of the very specific staff and program concerns raised by members of the transgender group, their responses are analyzed separately.

Perceptions of AOD Cultural Relevance and Accessibility

All the LGBT focus groups generated lively discussions about the benefits of having dedicated LGBT programs or 12-step meetings. Some participants felt that although the places they have sought treatment here in California are not specifically marketed as "gay friendly" they are, in fact, very welcoming. "I find that I go to organizations that are really gay-friendly but they don't really state that,"

remarked one participant. There were some strong feelings that the quality of the service is more important than whether it is marketed specifically for LGBT clients. Some of this is related to the theme of individualism that runs through all the transcripts. The idea appears repeatedly that all self-identified addicts are more alike than different, and that this commonality is more important than variations in sexual orientation. "You know, gay people walk at something that doesn't have a tag on it, thinking *'I'm not welcome.'* Well make yourself welcome goddamn it!"

Other participants drew a distinction between LGBT specific services, and services that were LGBT inclusive. While inclusiveness might be hoped for, and indeed sometimes enacted, some LGBT participants indicated that without LGBT specific services they lacked confidence in their ability to receive culturally competent services. These participants felt that the lack of gay-friendly marketing or outreach efforts meant that they were never quite sure how they would be treated, and identified this as an impediment to seeking help.

> "It's like there's nothing specific towards the gay/lesbian community. It's more, you know …. Hopefully you're accepted in these groups whether it's for everyone or whatever … I actually haven't sought help yet or anything. But I mean I would like to think that if I did seek help it would be available and there wouldn't be discrimination."

Some participants who had experience with treatment reported that when they disclosed their identity as LGBT in non-LGBT specific environments they were met with suspicion and discomfort. This hostility made treatment less effective because it forced LGBT people to balance their need for self-disclosure against a very real fear of being ostracized by others. One lesbian reported that at straight AA meetings there is a perception among other women that "they got this phobia that, because you're gay, you are trying to hit on them."

Other focus group participants felt that treatment should be specified beyond LGBT generally to serve lesbians and gay men separately. "I don't necessarily feel okay saying [out loud] about everything that is going on, even in a mixed meeting with lesbians and women in there. Whereas I know if I am in a gay men's meeting, or a predominately men's meeting … I know they would be able to understand." Participants also drew distinctions between the accessibility of gay, lesbian, bisexual, and transgender services, feeling that there are better services for gay men than for other groups.

> "I also think that G in the LGBT is fairly well addressed but … there's no good services for lesbians even when at women's facilities. As for the bisexuals, I feel sorry for them because none of the literature is aimed towards them specifically, there's no ads for them. Transgenders, they have it rough all the way around, including in drug and alcohol treatment. There's no ads on TV or a huge billboard for us so it still seems like it needs to be secretive. "

Issues of race and ethnicity are salient for the LGBT community as well. People of color who also identify as LGBT report a dual sense of not fitting into treatment programs. There are also specific outreach issues for people of color in the LGBT community. One API participant said that he had seen AOD marketing directed at the LGBT community, but never marketing to Asians within that community.

> "I'd like to see more advocacy towards the API community. Basically in all areas, when people think of the API people, you know they're not listening. You see advertisements: it's always African American, White, Latinos … You never see Asian or API peopled represented. They're totally misrepresented, and I think […] that's something that really needs to be looked at."

In another LGBT focus group, participants formed a near consensus that in Southern California there are more services for Whites and Latinos than for African Americans. "We also think that there's more programs for white people. We feel like it's only for them," said one of the members. An African American man was asked why he had left a previous treatment program before completing it. He explained "I didn't feel welcome. I feel a lot of friction in there, because of my lifestyle." Pressed by the facilitator about whether he attributed this friction to his race or his sexuality, the man responded that it was the combination of both that made him feel unwelcome.

Staff and Program Issues

Members of the LGBT focus groups who had experiences with treatment programs frequently mentioned the need to provide cultural competence trainings for frontline staff as well as the counselors. As members of a sexual minority often bullied in childhood, these participants reported feeling harassed and intimidated by front desk staff they perceived as hostile to their identities.

> "They're under the impression that everybody can stand up for themselves and everybody can walk in and say what they need to say, and if you're scared to death of your own shadow, it's the last thing you're going to do with somebody in your face going, *'What do you want? What do you need?'* That just doesn't work. Having a professional right at that front desk, the first person they speak to is of the utmost importance."

Another man had had a similar experience. He attributed his inability to complete prior treatment to the hostility of the front desk person. "That makes the decision whether or not, you know …. If it's a bad experience then, you know, you're not coming back. That presentation, that introduction with the person at the front counter determines whether you think about coming back or not."

In non-LGBT oriented treatment, some reported concerns about safety and confidentiality. Talking about his experience in a non-LGBT identified program, one respondent told the group that he learned to keep personal information to himself. "… Your sexual identity, your medical condition, because people and programs will take that and use it against you. My experience is, the less they know the better off I am. I'm serious, because everybody's got a counselor and a secretiveness between us. When (this counselor) gets mad at you he's gonna go tell."

Given these experiences, it is unsurprising that there was skepticism among these participants about the degree to which non-LGBT centered programs were prepared to treat LGBT clients. For some, there was a belief that programs which appeared welcoming to LGBT clients did so in order to meet mandates from funders about inclusive treatment practices. They explained that agencies may qualify for additional funds if they can appear to serve gay people or HIV positive people. "It's a numbers game. It's about getting funded, keeping the beds full. *'You get a lesbian and we'll give another hundred thousand.' 'We'll get us a gay person in here.'* So more funding. *'Well let's find somebody who has HIV.'*"

Several of the women in different focus groups were concerned about the lack of HIV services for women while in treatment. Their perception was that AOD services for gay men had successfully integrated HIV management into their programs, but that comparable HIV services for women were still lacking. "I think they need to have more programs for women. On the internet, the research and surveys are talking about tops and bottoms[1] [among] men and they have nothing for us. … I've really been blessed but I noticed they said that the African American women and Latina women are the number one people getting the virus because of the down-low[2] thing. But yet they have no services for women."

Substance Use and Sexual Behaviors: Many of the LGBT participants expressed concern that AOD services for the LGBT population fail to take a holistic approach to well-being. "It's got to be a more holistic type of recovery in order to heal the body, the mind, and the spirit, and they're not addressing that," argued one man. This was particularly true around sexual behaviors, and the link that many in this community identified between sexual behavior and substance use. This connection was drawn almost entirely among men who identified as gay. Many of these men repeatedly insisted that in the gay community sex addiction and substance abuse are entwined. "The gay community, they will use drugs as a way—drugs and alcohol—as a way to have sex with guys who are questioning or at a party, and they relate sex to substance abuse. And so when we're coming down and we're trying to have a healthy sex life, we don't know what it's like." Many men also reported looking for a treatment program that provided treatment for sex addiction and other compulsive behaviors, and not being able to find AOD programs that address the range of their issues. "I feel that none of the facilities have a good gambling program and none of the facilities have a good sex addiction program."

For some, particularly among gay-identified men, there was a deep frustration that services that cater specifically to the needs of gay men can become venues for seeking sexual relationships. This was especially salient for younger gay identified men, who said they were often sexually pursued by older men, particularly at 12-step meetings that attracted a largely gay group of participants.

> "In the beginning of my recovery, when I would be trying to speak, especially in these places that try to be accommodating to gays, to the gay population as well … I find myself editing what I have to say, because I'm already a damaged human being. Going to a straight meeting and then talking about, you know, trying to talk about the fact that I am a sex addict as well as a gay person trying to clean up his life—you know? These straight people don't want to hear that. They cringe … it [makes] for a very toxic environment to try and be clean in. So I would seek out the gay meetings and unfortunately the gay meetings end up usually turning into meat markets. You're damned if you do and you're damned if you don't, you know?"

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[1] "Tops and bottoms" refers to the relative sexual positions of men who have sex with men.
[2] The term "on the down-low" refers to men who have sex with men but either do not identify as gay or do not disclose their sexuality openly, sometimes due to multiple social oppressions. The female partners of men on the down-low may be at greater risk of HIV infection as they are unaware of the elevated risk-factors of their male partners. However, epidemiological analysis of disparities in HIV infection rates between racial and ethnic groups shows they are more related to socioeconomic factors, lack of healthcare access, stigma related to the testing and disclosure of HIV status, prevalence of other STIs, and injection drug use, and that non-disclosure of sexual behavior cuts across all racial and ethnic groups.

Some men also had stories of sexual activity taking place in residential treatment facilities. “When I was in the (program name), we had one client who was prostituting himself over the phone,” reported one man.

Religion

Many treatment programs, especially those based on the 12-step model, include an emphasis on spirituality as part of their clinical approach. In the 12-step model, the spiritual is emphasized as a non-denominational approach in which congregants visualize themselves as subject to a “higher power.” Members of 12-step programs and clients in the treatment facilities in which they are central are encouraged to conceptualize this higher-power in whatever way is consistent with their spiritual or religious practice. Faith-based organizations (FBO) also play a strong supporting role in the provision of AOD treatment. Many of these are Christian, and some programs are affiliated with particular denominations or congregations. The degree to which Christian philosophies inform clinical practices varies; FBO programs may run as largely separate endeavors from the church, or they may reflect the specific religious beliefs of the denomination with which they are associated.

Many LGBT participants report complicated and often uncomfortable experiences with programs that include a spiritual or faith element. For some, the experience has been characterized by hostility towards their sexual orientation. One respondent described church run programs as full of “hateful attitudes.” Another talked about how an FBO run program had simultaneously tried to attribute his substance use to his gender identity and refused to let him explore the role that it played in his addiction and recovery.

> “What they were trying to focus on is religiously trying to convert me, and they were mostly focusing on that rather than the psychological problem with being transgender. [They were] trying to bring me out of that queer lifestyle and integrating me into a religion. [I had] depression, post traumatic disorder from being rejected from the heterosexual community … I’ve been struggling with that. And you know the clinicians want to put a band aid and get a sponsor and go talk spirituality, but it doesn’t allow me to talk about my sexuality. And so I just kinda feel as though my sexuality is very important in my recovery.”

Findings and Recommendations

- AOD programs that have cultural competencies working with LGBT populations may wish to make these competencies visible, perhaps through displaying the rainbow flag or other symbols of LGBT inclusiveness
- AOD programs should explore the possibility of having some separate treatment settings for gay men and lesbians to facilitate more disclosure
- AOD programs with LGBT competencies should be aware of the fact that issues of race and ethnicity are also salient for the service needs of the LGBT community, including outreach strategies
- Competency training in working with LGBT populations should include frontline staff as well as clinical staff
- AOD programs serving LGBT clients should have clear confidentiality policies in place that protect LGBT clients from having their sexual identities and HIV status disclosed

- AOD programs serving LGBT clients should have formal complaint and grievance policies for clients who believe their confidentiality has been violated
- AOD programs providing HIV services should ensure that these programs are available to both women and men
- AOD programs serving LGBT clients may wish to include support for clients seeking help for compulsive sexual behaviors, and to help clients understand the link between substance use and unhealthy sexual activity
- Faith-based organizations should be offered cultural competency training around LGBT service needs, and provided with referral information for LGBT specific programs

4.3 Transgender

Staff and Program Issues

Many transgender participants report that being classed with lesbian, gay, and bisexual people often fails to account for important differences between sexual orientation and gender identity. All transgender people have gender identities that differ from their biological sex, but, like all people, have varying sexual orientations. Transgender people may identify as homosexual, bisexual, or heterosexual. Talking about her experience with 12-step meetings, a transwoman[3] participant noted “I prefer going to heterosexual meetings, because I consider myself a heterosexual woman. And when I’ve gone to these meetings, instantly eyes, here come the eyes, they’re looking judgmental. And then I have a seat, and they are like, you know, the women they grab their husband’s arms,” she continued wryly, “as I come in here to see whose husband I can have.” Because she does not consider herself homosexual, the participant reported that she did not feel comfortable at gay and lesbian meetings either. Ideally, she would like to see more meetings that specifically serve the transgender community.

Even at a program known for its work with the LGBT community and which runs the only transgender recovery program in the area, there was some feeling that there was insufficient capacity to disaggregate sexual identity and gender identity. One woman reported feeling that her femininity was a liability in the male dominated culture at the program: “There’s a war between male and female, and when I’m in these programs and the males have a strong presence, it doesn’t allow me to express my sexuality and my female gender component. So I just kinda feel that the system is broken.”

There were also issues around housing in residential treatment settings. Transgender participants wish to be housed according to their gender identity rather than biological sex, and are entitled to do so by California law[4]. The practice sometimes caused problems with other residents, who may not be comfortable sharing sleeping space with transgender women. One transwoman reported that the program’s inability to house her with women was a major reason that she left treatment: “They moved me up out of that room and put me in another one. That girl felt uncomfortable with me so ever since then they tried to do whatever they could to get me up out of there. And they did.”

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[3] Transwoman refers to a person who was assigned male at birth and has a female gender identity. The term encompasses people who have used surgical or chemical interventions to align their physical bodies with their gender identity and those who identify as women but have not taken steps to physically alter their bodies.

[4] Gender Nondiscrimination Act – California AB 887

The women in this group also expressed outrage that the program staff seemed concerned only with the sensibilities of the biological women in the unit and not with the sensibilities of the transgender women. “But you know what’s funny is that they don’t care if you’re uncomfortable being with the men. All they care about is the women being comfortable with you being with them.”

Respondents also reported having bad experiences with staff that lacked the understanding and competence to reign in abusive comments from other clients in programs. Explaining that staff needed additional training in transgender competency, one woman recounted how she felt that staff always made her feel like the problem, even in cases where she was clearly being harassed by other residents.

> “If I or another transgender [resident] would start sharing and somebody … said something derogatory, my gender would come up, inevitably. It would happen to the transmen and the transwomen; slang would always come up. And the thing that pisses me off about it is the way these residential treatment [providers] handle it. The way they handle it—they try to get in the middle of it and they immediately tell the transgender person to calm down and they tell you just *‘calm down, let it go.’* They always tell you to let it go. And when you’re sitting trying to explain to them *‘excuse me I’m not a he’* and the person is still going *‘bitch I know what’s between your legs,’* you know? The staff just let all that go on. And the staff go and talk to you and say *‘hey come on, come this way, let’s go, come on’* and they act like you’re the one that deserves to be thrown out.”

Many respondents reported having issues with staff around their medication, telling the group that the staff had insufficient understanding of the necessity of taking hormones for the transgender population.

> “The reason I left is because first they forced me to go back to my doctor and get my hormones changed from injections to pills because they were convinced my injections would trigger me to start using again. Then they tried to deny me. You know where they have the little medication counter where you line up at five p.m. or something, and everyone takes their meds? The pill lady said *‘You don’t really need these, they will just trigger you’* and I told her *‘Yes I do need them’* and then she goes *‘They’re just hormones’* and I was like *‘Yes’* and she goes *‘It’s not like it’s a psychotropic medication or anything—where you have to take it—they’re just hormones if you don’t take them it’s not gonna hurt you.’* So you know they need education around allowing people access to transgender medical treatment.”

There was also a reported lack of knowledge among medical personnel about the interaction effects of hormone therapy with certain psychotropic drugs.

> “You know when I was at (a residential facility) before, I was having an allergic reaction and I couldn’t keep anything down, and they all thought that I was bulimic and got on my case about that. They didn’t even try to check what hormones I was on, what interactions it would have with the psych drugs he put me on. That really spun me out of control and I was in this constant half-awake, half-asleep fog, and I really felt my sanity start to slip at that point because of

> that. Well actually, I was on anti-psychotics; they put me on (drug name) which is an anti-psychotic and immune stabilizer and helps with chronic nightmares. Apparently (drug name), if you're taking estrogen with the anti-psychotics—actually any anti-psychotics—acts like an eight ball and you start tweaking out like you're on speed. I woke up the next morning, my hands were going like this and I couldn't even sleep. I would [lie] in bed at night and feel my heart beat a million times a minute."

Finally, there were also concerns that talking to medical staff about substance abuse problems would lead to revocation of hormone therapy protocols.

> "But I still had that fear in the back of my mind … honestly I haven't wanted to go back to (program) because my thinking in my head right now is that *'Oh I ain't even gonna tell my doctor I used shit, because the minute that my doctor finds out that I used something, she's gonna gang up on me with my therapist and say I'm crazy and take me off my hormones.'* Because you know the medical community looks for ways to take you off your hormones if you're transgender and if you tell them you have a using problem they have one more thing of ammunition to say *'Oh you're just another crazy tranny.'*"

Findings and Recommendations

- AOD programs should be provided with transgender competency training which includes information about the difference between sexual orientation and gender identity
- AOD programs should be provided with best-practices for determining housing and other sex-segregated issues for transgender people
- Policies should be in place to ensure that AOD staff provide a program atmosphere for transgender people that is free of harassment and hate-speech
- AOD programs that serve transgender clients in residential settings should be provided with information about the importance of maintaining hormone therapy for transgender clients

4.4 Latinos

Three focus groups were convened that specifically recruited Latino participants. Two of these groups focused on the experiences of Latino men in treatment, and one worked with Latina women who were part of a regularly meeting mother's group. Both the treatment facilities served primarily Latino clients. The first treatment program was run by a faith-based organization (FBO); the second treatment program was run by a secular organization. Because there were large differences between these two groups, the affiliation of focus group participants is noted in the text below. Latinos were also represented in the LGBT and youth groups, as well as the women and men in treatment groups. The focus groups for men in treatment were conducted in English; the focus group for Latina mothers was conducted in Spanish with the use of an interpreter.

Perceptions of AOD Cultural Relevance and Accessibility

Many Latino men in both groups found broad value in a treatment program that served men with a shared cultural context. "I don't think that it necessarily caters to any one group of people. … Like a lot

of us come from the same backgrounds or whatever, it helps those people and we relate to each other. So it might help out with our recovery, in our transitioning into society." For some Latino men, their shared experiences with incarceration were also salient for their recovery efforts, and many of the participants spoke about the benefits of both a program and a residential culture that understood this history. "I think this house also caters to the person coming from prison trying to transcend into the society. Because we have so many, we have people here that understand, you know, where we are coming from or where they're coming from," explained one participant.

Most of the male participants in both groups declined to endorse the statement that they were better served by a program that catered specifically to Latinos, though the facilitator suggested this idea several times in both focus groups. While they were resistant to the idea that treatment focused specifically on Latino issues was particularly valuable, the second, secular treatment group repeatedly emphasized the importance of shared culture as an important element of successful programs. This was not framed in terms of pro-Latino treatment modalities, but in terms of cultural differences with other groups. This was expressed particularly strongly in terms of perceived differences with African Americans. When queried by a facilitator, one participant explained "Because (we don't) have the same common history with an African American, you know what I mean, for example I wouldn't, I wouldn't be able to relate to crack cocaine. It's the way they're raised. Generally speaking you know, they don't have rules, us being Hispanic, we do." This comment begins a thread in which several speakers weigh in on the cultural differences between Latinos and African Americans, invoking a variety of stereotypes about African Americans as inherently less moral than Caucasians and Latinos. "When shit hits the fan, we have the Mexicans' backs and the Mexicans have our backs but the Blacks are always our enemies," another participant stated boldly.

One speaker links this to the specific racial stratification patterns of southern California. "Here in California you're not gonna see the Whites and the Mexicans getting along with the Blacks like you do in other parts of the country, like in back East." This sense of Latinos and Whites as more similar than Latinos and African Americans is repeated by other speakers, one of whom notes "It's based on the ways that (African Americans) do things, the way that they are. It's different. Whereas Latinos and the Whites they're not so, so different they can intermingle or whatever." Summing it up, a participant says: "We're in recovery. We just don't feel comfortable with certain people."

The racial antipathy expressed in some of the focus groups suggests that there is a need to train providers to better manage group dynamics. Organizations which serve people from multiple cultural groups need support to manage the dynamics of difference in clinical contexts in order to ensure that all clients can access treatment free from cultural harassment. It takes specific skills for clinicians to facilitate discussions in which cultural respect is routinely demonstrated, and these skills are an essential part of providing culturally appropriate services.

Religion

Religion plays an important role in the lives of many Latinos. In general, Latinos say that religion plays a greater role in their lives than non-Hispanic whites.[ii] More than two-thirds of Latinos identify as Catholic. The affiliation of Latinos with the Catholic Church is no longer automatic, however; in recent decades, a growing number of Latinos are making their spiritual home in evangelical churches, making this a fast growing segment of the Latino population.[iii] One of the focus groups recruited participants from a treatment facility run by an evangelical church with a largely Latino congregation. For this group, religious doctrine very much shaped their perspective on appropriate treatment of substance abuse.

Following the religious doctrine under which the program operates, the men saw treatment in highly personal terms, painting it as an individual spiritual journey. For these men, the strong, charismatic leadership provided by the church was a critical element in their ability to succeed in treatment.

For these men, the nondenominational higher power of the 12-step model represented a weak spiritualism that was insufficient for their needs. One resident explained that in his experience, the 12-step models tend to be reductionist, in part because such models focus too little on the spiritual aspects of recovery. Speaking about 12-step models, he said: "It just seemed like they only had little bits and pieces. So I think something with more of a well-rounded, balanced, with all these components: maybe with physical, mental, emotional, the spiritual .... Now coming through this program that I've come through, that spiritual aspect was missing. It has become my foundation."

The importance of strong spiritual leadership was discussed repeatedly by the men in this group. Discussing his experience in previous programs, one participant reported: "I ain't going to lie, there's staff that's crooked and corrupted. They let things go on. If they don't help motivate you, then you're just going to keep on doing bad, you know." In his view, leadership at his current program supports positive outcomes by providing spiritual guidance. "With this program, once you have the leadership to help to motivate you to do good and be obedient and submit yourself … and just help lift you in positive ways."

The men were asked whether the fact that they were all Latinos in the group helped the program be more effective. The men unanimously rejected this precept. "No, I don't think so. I don't think so. I just think that this is, it is a faith based program and we believe in the Bible and we know that we're supposed to love one another and treat each other equal. Not hold another person in a higher esteem than yourselves." Instead, they again pointed to the role of faith in the program's successes, and pointed to the affiliated church's multiracial congregation as a model of unity. The integration of races and cultures mattered to these men because they associated racial segregation with the active drug culture. Critically, they attribute their current program's success at forging racial integration to the unifying power of religion to overcome deep rooted tendencies to segregate along racial lines.

> "A lot of us coming from the background of drugs and addiction, more than likely most of us that have dealt [drugs] have had some run-ins with the law, maybe been to jail—maybe not prison, but been in some type of jail or somewhere. And there's a lot of segregation in those places. You know, La Raza over here, White here, Black here. So, a lot of times that mindset is really drilled into people and even more so for people who have been there years and years at a time. So for some of those people who come back out into [society] and are in some treatment or program, you'll even see it in some secular programs, you know, some different programs where you see Hispanics over here, whites over here and the blacks over here. And that's because of the mindset they have."

What the residents had found in their current program was a model where interracial respect was fostered. Instead of retreating into mono racial groups, the program insisted on cross racial interaction, teaching the men to respect each other as individuals, and holding residents accountable for racial harassment.

> "As (the previous speaker) mentioned, you come out, if you're white, you're going to walk straight to the table with the whites. If you're black, you're going

> to walk straight.… But accountability, it's something that's new. So this individual in the program, if you said a racial offensive comment, he held that person accountable. And you know guys that have been in prison that just never thought about it, they just react. And like you said, he might have caused ripples but it was a healthy kind of ripple. Because he said, you know, *'You're not going to talk to me like that.'* And a guy would be like sweating and perspiring, and *'I'm gonna kill you.'* But it was like, it was a new reinforcement of accountability, I'm going to hold you accountable for what you said to me and you're going to learn respect—not only on your level but a universal level."

Family

One of the strongest themes in both Latino groups was family. The metaphor of treatment cohort as family was repeated over and over again.

> "… to where we interact as a family, instead of just as individuals. And it actually makes the recovery progress a lot easier, and it's, it's… I think it's a lot more successful too; because, I mean, you don't just look at the next person—you don't look at them by color, you don't look at them by race, you don't look at them like individual; you look at them like your brother."

This theme of program-as-family was often used to explain why the program successfully served a multiracial population. Because they treated one another as family, residents felt, there was little need to introduce culturally specific programming. Indeed, such an approach might create divisions within the "family." Noted one member: "But, I would like to say, like probably other places where—let's say—they're multiracial or whatever. Like, let's say they're coming out of prison like, they might even just like naturally segregate together or whatever, where right here it just doesn't matter; we're all brothers."

One of the ways that the program successfully fostered the feeling of family, the men in the secular program believed, was that it was relatively small—only 30 to 40 people. They felt that this size fostered intimacy, which contributed to the feeling of being a family. Participants also identified the small size a welcome contrast to the prison environment. Several members said that they had tried and failed at programs that were larger, more structured, and more disciplined—more prison like. "I never would've stayed if it wasn't for the way this house was .... It's laid back, but it's structured enough to where we get the help that we need in our treatment, in our environments, in our groups and everything, but it's not forced upon us. But if it was more structured like other programs … then I would've never stayed."

The importance of prevention programs for youth came up in all three of the Latino centered groups. From their perspective, the choices they had made as boys were partially a result of not knowing that there were ways of being men outside of the drug world.

> "Me growing up, people weren't telling me about college, me and my group of friends … nobody really introduced me to that way of thinking. So therefore I fell into the default which was smoking and doing drugs. Because you really have no vision and no aspirations to do anything other than what you're already doing, which is drugs and alcohol and partying."

This man believed that programs that worked with young people to present alternate futures could be effective interventions.

> "If they would incorporate, like, someone to come in and introduce them to a life of, you know, maybe college and getting a better education—something to give them motivation to aspire to. Whether it's college or just something to give them a new mindset in order to reach beyond themselves, and maybe that will take their focus off of using drugs because they now have something to live for and they don't fall into the default. Not only teaching them how to be drug free but what to do after they're drug free .... If they would give people vision and dreams, it'll help them."

As mothers, the women in the Latina group were also very concerned with prevention. They believed that in many Latino homes, where both parents worked during the day, children had too many unsupervised hours. Children in these homes were perceived as high-risk for substance use. The women also worried about drugs in schools, reporting that they had heard that the high schools were rife with drugs and alcohol, and that peer pressure to engage in substance use was pervasive. They worried that school staff were insufficiently interested in rooting out the kids who used substances and who pressured others to do so, especially when their parents were relatively wealthy.

> "One thing that I've noticed in the school is if the kid is very popular or they have good grades, and they find out that they are using or that they have drugs and stuff, they don't want to touch them because they are popular or their parents have a lot of money or they are part of the school district. So they kind of leave them alone, they don't want to mess up their record, so they don't do anything about it. They kind of turn around and don't pay attention."

There was also consensus that it was programs that were needed to counteract the effects of peer pressure. Parents felt that children were more likely to listen to their friends than their parents, and so more was needed than simple parental guidance. Some of the women had had some experience with school-based parents' projects, though their experience of these programs was that they were insufficiently attendant to their cultural needs: "I don't think that it's culturally appropriate. But a lot of the stuff is just translated. And sometimes the translation is not the best… That's the issue."

Findings and Recommendations

- AOD programs who work with previously incarcerated populations should understand the relevance of this experience to the work of recovery
- Where appropriate, AOD programs should acknowledge the importance of religion to the lives of their clients, and may benefit from incorporating the religious or spiritual practices of clients into their clinical approaches
- Religious fellowship may be a model for programs needing to foster cross-cultural understanding between clients from different racial and ethnic backgrounds
- Youth prevention programs should ensure that the Latino community, including parents, is aware of their services and able to access them
- Youth prevention programs should make certain that their materials and curricula are culturally appropriate for Latino youth and their parents

4.5 African Americans

Three focus groups were conducted with specifically African American participants. These included African American men in treatment, formerly incarcerated African American women in treatment, and African American women in recovery. African Americans were also represented in the youth and LGBT groups as well as in the sex segregated men and women in treatment groups.

Perceptions of AOD Cultural Relevance and Accessibility

The overwhelming majority of those who participated in the African American focus groups maintained their insistence that race/ethnicity do not matter for treatment. When asked if they feel that programs are designed to serve African Americans, the majority of women in both women's groups initially insisted that the struggle with addiction is the same, regardless of race: "I don't think drugs discriminate on what color it attacks, you know. Once we're addicted, you know, it doesn't play the race card." However, when pressed further by the facilitator to identify divisions in treatment, there was some agreement that lines tended to be drawn more often between those who shared a common drug of choice.

> "I felt different because I … smoke crack and we have some people that didn't smoke crack—they just smoke weed. Well, it's a difference, because the ones that smoke weed, they think that their habit's not bad as the ones that smoke crack. If you go to a lot of programs and the ones that smoke weed, they put the ones … they put the ones down, the ones that smoke crack. I mean, it's like, you know, they're better than the ones who smoke crack, but then they smoke weed."

Some respondents eventually acknowledged that there tended to be a commitment to serve everyone equally on paper, but felt that this commitment failed to extend to actual practice. "I feel that race will always be an issue, that they will always treat you differently. I mean, lot of times you could tell when, you can feel those vibes when somebody that don't want you there, when they don't want to help you. And it's not what they say but what they do—their actions."

More critically, several members had experienced what they perceived to be discriminatory treatment from institutions that primarily served white, affluent patients.

> "(Program Name) in Santa Monica, is mostly, it's not a mixed group of people like Africans there. And they usually send you to this side of town. If you go there, you have to detox and everything, but they have treatment right in the back. But they're not going to let you go in the back. Because, I believe, of my race. They're gonna send me to this side of town. They give bus tokens, and [I wonder] why did he get to stay here? We both come in at the same time. I'm speaking of another race now. Yeah, I found that incredible."

Another man had had a similar experience in which he tried to get into a particular program and could not. From his perspective, this was a direct consequence of his race.

> "I said *'I'll do anything if you let me in this program. This is the only…'* And it worked with my schedule. But they said, *'Well, we have to send here, we have to send you there.'* I'm like, *'This is more closer to my house.'* It's like they were saying it silently; they're not going to [tell] you exactly what it is. But it's like sign language. That's what I felt … what he was saying, here was another person that came there again of a different race, you know. Came in and they accept him just like that (*snaps finger*). Then when it came to me, they sent me somewhere else."

Staff and Program Issues

Some African American focus group participants reported having positive experiences with staff of all races and ethnicities. Others had had difficulty with staff who they perceived as failing to understand basic elements of their culture. One woman discussed how conflict had emerged over her dreadlocked hair. In this instance, the staff member was also African American, but the client felt that the interaction over her hair demonstrated a lack of cultural competence on the part of staff. Hair has historically been a highly politicized issue in the black community, particularly among African American women. Some African American women commit a great deal of time and money to straightening their hair in order to achieve "good hair," a process which is seen by others in the community as submitting to white standards of beauty.

> "I went into the program and they sent me to this program from prison—most of the counselors were African American—and you see my hair, my hair has been locked since I came around. So that was back in 1994 when locks weren't all that popular. And so this director of this program questioned me about my hair, told me that I couldn't go look for a job with that kind of hair. And if I was on the beach that may be alright. I told her some—*'You know what? You need to get off me about my hair.'* Anyway I am just pointing out cultural competency, she know nothing about this culture where she, I don't know what she thought this was, it is hair or easy clean or whatever but that really bothered me."

Asked about how services could better respond to the needs of their particular community, members of two of the African American focus groups talked about how the food served in residential treatment facilities, describing it as overly starchy and fatty, and particularly ill-suited to the nutritional needs of diabetics.

> "And another thing that I think the programs can change is, like, nutrition. (*laughter*) Really, a lot of times we're in these programs and we come off the street and we're like, binge eating and stuff. And us—as Blacks and Hispanics—we tend to get diabetes and stuff, and overweight and stuff like that. So I think that, they should be like, getting nutritionists or something to do the meals and eat more healthier; more fruits and vegetables should be involved."

There is some skepticism among this group that treatment centers are actually designed to help them achieve sobriety. Instead, several members of this group assert that treatment centers function to make money rather than provide help. "They get rich off us," one participant insisted, and was joined by another who agreed "It's like they just wanted to get your money."

Ethnographic work on residential AOD programs for women has frequently documented the practice of public shaming as part of clinical treatment. In this practice, a woman who has committed an infraction of some kind is generally singled out in some way, and other residents are invited to comment on her actions. Many of the women in this group had experienced this, and perceived it as a detriment to their treatment.

> "I don't like the way they do that little dynamic thing and put the chair in the middle and everybody's like, *'You did it, you was a whore….'*" Another woman concurred: "I was the center of attention, like, I just.... I don't know, '*We need to break her*, *she need to tell the truth.'* I mean, what? I'm telling you the truth, I'm not gonna sit here and make up no story to make you like me. Or to make you write a good letter to my judge, I'm not about to do that."

More broadly, African American women who participated in the focus groups were critical of what they saw as the general negativity that characterized some of the programs they had failed to complete in prior treatment attempts. "The counselors were even a part of it, when they were conducting the meetings; it got so ugly. The stories were ugly. The personalities were ugly. I got sick of it. I couldn't sit in the room; I was very depressed; I was very angry. I wanted to walk off and get out. And they made me sit there. And that's why I left too."

There was also agreement across groups that there was often too little time devoted to one-on-one counseling, and too much reliance on handouts and other literature. "There wasn't a concern about me when I asked the question. You know, they said, *'Just read this.'* I didn't have nobody one-on-one." Participants in both African American women's focus groups report that too many programs rely heavily on language or text that is inaccessible to some program participants, and that African Americans, specifically, may be reluctant to tell people that they don't understand. Participants in this group also expressed frustration that some programs assumed a literacy level not necessarily achieved by all members of the program. One woman described a reluctance among African Americans to admit that they didn't understand the literature distributed in programs, or the discussions that were taking place.

> "We never know what their education level is or how much they can receive and understand the literature that's being passed out or being talked [about]. So therefore a lot of time, especially in our black community, we afraid to raise our hands [and say] '*Well I don't understand*.' And they always said that the dumbest person is who never ask, but I think that's something that should be looked at. Because if you said now with all this literature and you don't understand what you have, how can you understand how to get better? How can you understand that the disease that you are going through is …. So I think that … the way they strategize as far as how they teach what we are needing to really, really know, and hold on to [should be looked at]."

Another woman recounted a similar experience in a different group, echoing the first speaker's fear of calling attention to her lack of understanding.

> "And when you're doing those groups and stuff, a lot of times you run across words and stuff that you may have seen or you may be familiar with but not real familiar with what the meaning and stuff is. So what happens is, you kinda get lost while you're in the group and stuff just kinda fly over your head and a lotta

> times we're probably embarrassed to even say that '*Hey, I don't know what that means. Can you explain that more?'* You know you're just kinda sit there and kinda be like a sponge and try to absorb all you can and get what you can outta it."

Asked what the state of California could do to make programs better, there was consensus that it was the qualifications of staff who make a difference. In particular, participants wanted program staff that had been through recovery themselves. "They got some that go to school for drug counseling, ain't never been where we been. They need somebody who's really been there, who's hit rock bottom, got self-esteem, and then got into that class, that school and got that certificate; that can relate to where we've come from, and have, like she said, a little compassion."

Findings and Recommendations

- AOD program staff should be appropriately trained and supervised to ensure that all clients are treated with respect
- AOD programs should have clear policies detailing their non-discriminatory eligibility requirements for service, and should make sure these policies are enforced
- In the event that AOD service providers are not able to accommodate a person seeking to access their services, appropriate referral services should be provided
- AOD staff should be educated about cultural norms and preferences related to personal grooming
- Residential programs that work with clients at elevated risk for diabetes should provide food that meets their health needs and consider including health and nutrition education in their programs
- Programs that utilize shaming rituals as part of their clinical practice may wish to consider whether these serve the best interests of the clients
- AOD programs should not assume that their clients have the literacy level necessary to make effective use of written handouts and other materials
- AOD staff should foster an environment in which clients feel comfortable asking for clarifications, and are encouraged to do so
- Staff who have personal experience with substance use and treatment may be perceived as more culturally competent

4.6 Women

Two focus groups were convened to discuss AOD issues specific to women. One group was drawn from a residential treatment facility dedicated to serving formerly homeless women, and one with women in a day-treatment program who had previously completed the affiliated residential program. Both groups were racially diverse, and included participants who identified as white, Latina, and African American.

Perceptions of AOD Cultural Relevance and Accessibility

Women also vastly prefer the experience of single sex treatment facilities, reporting that coed facilities provide unnecessary "distraction" from the work of recovery. "My (previous program) was co-ed and that was the most uncomfortable 3 days ever," said one woman. Another agreed "No matter

what, men, you know, anything co-ed—it's going to be a distraction." Still another woman admitted that when in coed treatment she had spent more time worrying about her hair and makeup than her recovery.

This was particularly true for women who had experienced rape or other sexual trauma. "I been raped, molested—you name it you know—and I have quite honestly been uncomfortable talking, you know, with a man about it, you know." Another woman seconded this, explaining that she, too, had been the victim of sexual violence. "I honestly don't think I'll be comfortable talking with any men in the group."

When prompted to answer a question about whether women had treatment needs that were different than men, the women enthusiastically agreed. Part of this was attributed to the greater violence of male drug users, and a consequentially greater need for violence prevention. "Men have issues just like women. They don't say it, the truth of the matter, the reason they have so many programs for me and my baby kids is because men can be far more violent than women. And if we don't take care of these men they are going to kill up a whole bunch of people."

Staff and Program Issues

Like other participants, these women reported that program structure was a key element of success. They described the ideal as a sweet spot between too lenient and too militaristic. Describing her previous experience with treatment facilities, one woman reported that their lack of structure made it too easy to relapse. "Other ones I've been to that were just too lenient … you could just walk out. Like here there's cameras .… You have to be in by a certain time. Compared to this other one I was in and I could just sneak out. It was easy. You know it was easy for me to come in and go. Here there is more security, there is structure. With the open houses it's just a little too easy to relapse, to go out and do your thing. Here is better." Another woman agreed, explaining that she'd been in a previous program that had ended, and, fearing that the lack of structure would lead to relapse, had pursued her current program as an alternative to unstructured aftercare.

> "I've been in this program here for nine months, but I was sentenced to (another program) for a year and I was able to go to sober living afterwards. But I didn't feel that I had enough structure or discipline or enough service networks so I came here and I've been here for nine months. So I've been clean about 18 months now. But I came here because this is more a program for employment and housing, but it also has some structure to it and there's guidelines that I have to follow where I can't slip through the cracks."

Family

Most of the women reported that they were not aware that there were treatment options available to them before being forced to choose treatment as an alternative to losing custody of their children. They report that it would have helped them to know that treatment where they could bring their children was available, and also that they should be told that they will be met with helpful, welcoming, and non-judgmental staff. "I feel like I can share openly with not only another woman but then also a recovering addict, you know, someone that has been where I'm at." Another woman said simply "I had no clue that there were programs out here like this, otherwise I would have been in a program."

Women with older children face special concerns: treatment programs typically limit the age of children who can accompany a parent to pre-teens, and women with older children worry that the children that they left in the care of others are at-risk for behavioral problems. Responding to a question about what was needed to make California AOD programs more usable for people like themselves, one woman explained that being unable to find treatment placement that could accommodate her teenage child has led directly to her homelessness. "But one more thing that I do know tied to this answer is that in the drug and alcohol field there is a window of care missing. In the window of care that I found missing upon my relapse as a single mother… is if you have a child after 12 years old and you're a recovered addict and you're a single mother, you cannot get any housing … I became homeless because of that reason."

Women also expressed concern about the fact that only women's programs allowed parents to get treatment with their children. They wondered why fathers were completely cut out of this equation, and whether there were any programs that worked with custodial fathers with children. The women in this group were adamant that recovery needed to be seen as an ongoing process, not something that was ever fully achieved. "You never recover, because you're in recovery," summed up one woman at the conclusion of a lively discussion.

Findings and Recommendations

- Many women, especially those with a history of sexual trauma, strongly prefer a single-sex treatment environment
- AOD programs should solicit feedback from their clients about the degree to which they feel that the level of program structure is appropriate for their treatment needs
- AOD programs that accommodate children should engage in more aggressive outreach efforts
- AOD programs that accommodate children may wish to evaluate their child age limits
- AOD programs should consider the possibility of developing programs where fathers can be treated in programs that accommodate children

4.7 Native-American/American Indian

Two focus groups were conducted with Native American participants, one with adults in recovery who regularly attend a recovery group held at a Northern California Native American Health Center, and one with Native American youth who had experience with prevention programming. The youth group spoke entirely about their experiences as youth, and not at all about the relevance of their Native American heritage. Because of this, the youth group is included in the analysis of youth rather than with the Native American adults.

Perceptions of AOD Cultural Relevance and Accessibility

The men and women who participated in the Native American adult focus group felt strongly that they were better served by programs that worked specifically with Native Americans. It was very important to the participants in this group that the programs with which they worked acknowledge the

effects of historical trauma on their relationship with substance use[5]. Many of the speakers in this group referred specifically to the excellent services they have received through [program], an organization which offers prevention, treatment, and recovery resources to Native Americans nationwide.

> "This historical trauma has been passed down from generations from what I understand, in fact the strength level of natives actually. And so I think that from what I've heard [program] is unique and that it covers this historical trauma. So it's easier for us to understand like how we are dealing with these problems right now. And I think that that emphasis is part of what makes me understand myself as a person."

Most people in the group had had experiences with non-Native programs because of the difficulty of finding services with specific cultural expertise in Native American service provision. This was true for participants who lived off reservation and those who lived on reservation. One woman's experience was that the culture of substance use on her reservation, coupled with a small population's ability to police the actions of all, made seeking AOD treatment nearly unimaginable.

> "But like on the reservation where I'm from, I mean it's like there's enough. I mean it's just, we were just … I mean treatment is like a joke, like people would make fun of you. It's like everyone parties. Everyone has drugs. There is no such thing as like a treatment facility really."

It was seen to be especially difficult to find appropriate services for children; most of the people in the group had sought services for their children, and expressed frustration that there were so few services available. One group member, who had spent many years in recovery, now worked with Native Americans to connect them to AOD services. He explained that he was often forced to refer Native American youth to services out of state.

> "I think California does not have enough resources for Native American use in our own state ... I refer all of our kids out of state. To Oregon, to Utah, to Nevada, to Arizona. And it's not an easy process to do that. To make a referral out of state takes so much signatures and documents that need to be done before it can even get there."

The situation is not much better for Native American adults, according to this source. In his experience, Native Americans seeking AOD services are often forced to endure lengthy waits, and even then cannot be assured of receiving services that meet their specific cultural needs.

> "I think to specifically access native programs or even county programs, there's a huge barrier. There's a huge barrier … I try to eliminate as much as I can and make it as easy as possible to get somewhere where they need to go

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[5] Historical trauma refers to the shared history of genocide, forced migration, forcible assimilation, child removal, and language suppression shared by many Native-American and Native Alaskan people. This trauma is often multigenerational, and contributes to high rates of alcoholism and substance abuse among Native-American communities.

> instead of having to wait a month or two months. Like if I had to refer them to county AOD. It's a month long process, it's a two month waiting list. And so I think that California is falling short on that, on Native Americans."

Particularly in California, some explained, services for Native Americans tended to be subsumed under services for Latinos. Although several members of the group had Mexican heritage, their language and cultural affinities lay with Native American culture. They reported that they were often assumed to be Latino and Spanish speaking when they attended 12-step meetings that were not part of Native American Health Services.

> "Every AA we got into, every NA we go in, if you don't speak Spanish, they will forget about you. Even the church I was in, they forgot that I was there. So I quit going to a church to start back into the native way, native traditions. And it's a lot more comfortable for me and my kids."

Staff and Program Issues

Although the men and women in this focus group had a great deal of praise for the work of [program], they also had concerns about the ability of their programs to be an effective resource for their children. Because programs for youth were not conducted separately from those for adults, youth tended to be reluctant to access programs where their families and other elders would be present to hear their intimate feelings.

> "(My kids) tried to come in to [program] and to do anger management here and they're not comfortable because there's none of their peers here to share their stories. And they feel like … in a sense like he felt like he was being in … kind of looked down on because a lot of the people that were in the program are my friends, his uncles and stuff and his aunt. And he can't say nothing in front of them because they would all tell me."

Some members of this group had also accessed programs other than [program] in an effort to secure family support services around substance use and its consequences. These experiences had been widely negative, with participants reporting that AOD service providers either ignored the relevance of their culture entirely, or condemned the traditional spiritual practices in which they engaged. Reflecting on her experience seeking AOD services through a major healthcare provider, one woman said "But I was never asked at (hospital) if I was Native or if I needed any special care. If anything related to my culture, it just wasn't addressed at all." Another woman had sought family counseling because she and all of her children had been abused by her alcoholic husband, and two of her children had started to abuse alcohol themselves. She hadn't lasted long in that program, however, because the counselor to whom they were assigned was dismissive of the traditional healing ceremonies she was also using to help her family recover.

> "So we went to counseling, the whole family was in counseling, but it's hard because the counselor didn't understand … we were in the Powwows and our family gatherings, or getting our traditions. They didn't understand and they were trying to figure it out. And ... they say '*oh that's witchcraft or voodoo or whatever, it's not right*.'

Family

Many of the women in this focus group had histories with Child Protective Services (CPS). The relationship between these women and CPS was complicated, and needs to be understood in the context of the specific Native American history with government intervention into the lives of Native families. For nearly a century, the federal government pursued a policy of removing Native American children from their homes and sending them to boarding schools where, separated from their families and culture, it was hoped they would assimilate into the dominant culture. Subsequent to this program, a 1960's policy initiative enabled Native American children to be removed from their homes and placed with white families.[iv] This history of government sponsored family fracturing is an important context for Native-Families who are under supervision by social services.

Despite this traumatic context, some women reported that they had had positive experiences with CPS. One woman successfully used CPS resources in conjunction with Native American specific resources to access AOD services.

> "For me when I first gone onto recovery, I had the resources for being Native American plus the resources from being involved with CPS. So either way there was a resource available to me, it's just speaking up and asking for help. I think that's where some people have a problem with. And there are resources available, you just got to speak different as for it. So it was really easy for me to do that on both sides, being Native American and have a CPS base."

Other women, however, report that they refused to access services through CPS, out of fear that any admission of substance use problems would lead to their child being removed from their care.

> "But for me like I'm scared of CPS so I wouldn't want that now. But she was comfortable doing that so that was good for her. I don't—I am just scared of CPS, I don't want to have anything to—I don't want them to—what can I do with me, my baby or me. Because I'm scared they'll take him away or something, I don't know."

The male participant who works with the Native American community to connect them to AOD services helps put this woman's fear in context, explaining how the particular history of Native Americans in the United States has fostered a pervasive fear of government involvement.

> "We're talking about many different reasons why natives don't access a lot of the services. And it does go back to historical trauma, it does go back to that time when again everything was taken from the native people. Their identity and their way of life, the children. And there's been a lot of studies that go back to that time when even the kids were taken and placed in boarding schools. So you have two generations that were brought up in boarding schools. Which created that line between it's almost like natives and the rest of the world and everybody else in the United States."

The women's fear of CPS was not unfounded. Several of the women in the focus group had had their children removed by CPS at various points, and some had entered treatment as a final attempt to avoid

losing their children to foster care. At least two women acknowledged that fear of losing custody of their children had been an important barrier to treatment. Because of their unique history, it may be especially important for Native American women to be able to access services which allow children to remain with their mothers while in treatment.

> “For the past like two years, for about two and a half years, I've been in residential programs. I've been into outpatient programs. I've been in transitional living. And during that whole time, there are programs, outpatient programs, residential, transitional, that do offer help to mothers with kids. Every one of my kids were doing the whole thing with me the whole time. And they're still doing it.”

Findings and Recommendations

- More programs for Native American people are needed
- AOD programs working with Native Americans should understand the effects of historical trauma on this population, and its relevance for substance use
- [Program] should be a resource for programs seeking to increase their cultural competence with Native American clients
- There is a particular need for more programs that serve Native American youth
- Programs for Native American youth should understand the reluctance of youth to share in front of their families and elders, and should be held separately
- Information about the cultural identity and cultural needs of clients should be collected as part of regular intake assessment in all healthcare contexts
- AOD providers should be educated about Native American spiritual practices
- AOD providers need to be informed about the history of removing Native American children from their homes
- There may be a special need to have programs for Native Americans that accommodate children because of the specific history of government child removal

4.8 Youth

Five focus groups were conducted with youth who were variously engaged with AOD services, including prevention, treatment, and recovery. Prevention focused groups included a Native American youth group and a racially diverse group of students at a high school who participated in prevention activities on campus. A treatment oriented focus group was conducted with a racially and sexually diverse group of female high school students who had been referred to an on-campus anger management program. An additional treatment oriented group was conducted with a group of young African Americans and Latinos in residential treatment for AOD abuse. These young men had varying time in treatment. Nine of them were currently part of a residential treatment program, and 2 of them were enrolled in outpatient recovery services. Finally, a youth-based group was conducted with high school students who were currently enrolled in a health class engaged in a unit on AOD prevention. The majority of these youth were African American and Latino, and most were current substance users.

A key difference should be noted between the prevention based and treatment based youth: participation in prevention programs was voluntary; participation in treatment was not. This difference shaped their primary concerns—prevention based youth were most worried about making their

programs appealing to substance users who were not part of the program, while treatment based youth were most concerned about making the programs more suitable for themselves. While these differences are not inconsequential, the youth also shared some of the same concerns, most notably how to abstain from AOD use in an adult environment where substance use was normalized and glamorized.

Perceptions of AOD Cultural Relevance and Accessibility

Prevention-based youth were most concerned about the inability of their programs to reach the people who needed them the most. “They don’t want to do it—they do it just because they are making bad choices and they do not want to admit it at all. You know that they might be the ones who need a little help because they don’t want to listen,” lamented one participant. Students at both groups knew that they needed to appeal to the kids who were at high risk for substance dependency. When asked who was missing from the prevention group, one student responded “… kids [who are] emotionally depressed and emotionally messed up and at home and stuff, and pretty much all of them do drugs and drink because of that.”

Young people in both prevention groups expressed concern that LGBT youth were underrepresented in their prevention programs. The Native American youth worried that these students might be in particular need of prevention support because of homophobia in the community. “I think the majority of the town, the people grew up there, we all know each other that most of the people will accept you but there are some people you know, who still [judge],” explained one participant. A student in the school-based program worried that LGBT students didn’t participate because of the harassment they suffered on campus. “[LGBT students] don’t feel … comfortable. Cause they’re being put down a lot.”

The group conducted with male youth in treatment expressed more direct homophobia, with participants pronouncing that they believed that LGBT kids should be separated from the facility and treated elsewhere. Interestingly, the female youth in treatment were very vocal in their support of their LGBT members. Some members of this group identified themselves as lesbian or bisexual during the course of the conversation, and others affirmed that everyone was made welcome.

> “I feel really comfortable in my group personally because everyone knows a lot about me and I mean, my background and my sexual orientation and what I am to this school, and they respect that and they respect that I am in here .… We’re all pretty accepting of each other because there are guys in our group that are gay .… We’ve all become really close over the years, I mean, some of us have had group for more than a year and we, I feel like ours is really … close. Close and diverse and nobody’s judging for what we are or what we’ve done and what we share.”

The girls in treatment were very outspoken about not wanting to make race and ethnicity an issue, and said it was a non-issue with the program, counselor selection, or group composition. They seemed offended that the group leader’s questions continued to turn to this issue, as if the leader was not getting the message. “I feel like you’re asking the same question every time like we’ll talk about a different subject and then … you’ll bring the race thing back up,” complained one of the girls.

Staff and Program Issues

Youth in prevention programs generally praised the allure of their programs. One of the things that programs do well, these students felt, is to host activities that appeal to young people. Drug-free activities are very important in prevention programs, youth reported, because they have a positive impact with regards to learning how to respect and interact with other people. Successful prevention programs should offer drug alternative activities like “basketball tournaments, baseball tournaments, leagues.” They also thought that programs which sponsored trips and outings were more likely to draw in youth that would otherwise ignore prevention programs. The high school students in the AOD curriculum expressed wanting an AOD treatment center in their community, ideally one that is comfortable and “like home.” One suggested “group activities [like] swimming or something that would help [you] breathe. Because like the more exercise you get [the] better—the better brain health you have…. And a library or stuff like that too, people could read because it was like a sanctuary.” And all the youth were in agreement that prevention activities should be accompanied by food.

Youth across the spectrum of AOD services believed that staff was critical to program success. Youth in both prevention and treatment programs reported that it was necessary to have staff to whom they could relate. Prevention based youth thought that it was important to have role models that they could imagine having once been like themselves. “It’s better if they were raised how we were so we can see that we can be successful too,” explained one member of the school-based prevention program. This was also very important to Native American youth, who were in absolute consensus about the importance of having program staff that understood their particular perspective. “It matters when our selves match,” said one young woman, “I mean it helps out thinking you guys are from the same thing.”

Youth in treatment wanted to know that staff had had similar experiences to themselves and had lived to tell the tale. “I think that for people to talk to another person, you have to relate to that person. For me like I won’t be able to talk to somebody I don’t know and I don’t [know] what they’ve been through. I don’t know if they’ve been through the same as I had,” explained one young man. For the girls in treatment, having a woman lead the group was essential. Most felt they would not be able to open up to a male counselor. “It’s just if there was a guy counselor, that would be awkward because yeah I don’t want to tell a guy all my business, like he’s grown he can listen to someone else.”

Both prevention and treatment based youth shared some derision for program materials that were culturally inappropriate for young people. There were complaints that the program materials did not use experiences and vernacular relevant to teenagers (e.g., references to spouse, raising kids), and that there wasn’t enough acceptance about normal teen AOD use. One expressed, “They should make it more [relevant] for teenagers so we all understand instead of trying to take wild guesses …. They should be, like, ‘*Mary went to a party and she was fucked up …*’” Another similarly said, “It should be more … like ‘*the security guard found out you have a fake ID or you got caught drinking at school or you’re walking down the street and you got in a fight*.’” A third pointed out that the materials did not address things that could actually happen to teens, “like people getting raped at parties, trains run on people, people getting stuff laced in their drinks and their weed … these are things that have really happened!” Another said, “I think it needs to be more accepting in the fact that teenagers are gonna do stuff because we’re still young and we’re gonna experience stuff.”

Whether because the groups are in place or because there is more structured, supervised time, the girls indicate there is far less AOD use during the school year than in the summer. One said, “I think that it only works for the school year though, because then summer comes and you meet new people and

then you're always, like, never at school." Another corroborated, "Summer changes everything that you learned…."

Community Context

Youth in both prevention and treatment worried that AOD use was normalized or glamorized in their communities. Some expressed this in terms of their younger siblings. One of the young women explained "like in my personal opinion, because I have a little brother … just turning three, and so I would want like this community just to be better so he does not have to grow up and see or hear the things I have had to, you know?" One participant shared their experience with a very young child they care for wanting to smoke marijuana because all of the adults in their family do it. "All I know if they stop smoking like that around the baby and stop smoking around the baby, the baby won't try to hit the weed probably," he explained.

This group believed that changing their immediate environments to be more neutral about AOD use would help alleviate some of the dysfunction in their lives, specifically by asking adults to take their AOD use outside and away from any environments where there are children and other youth. A student from the health class explained:

> "I think it's … your own environment, but when you have kids and you smoke and then you drink and I think you should just like take that away from your kids. Even if you're going to do what you got to do, just set an environment for your kids that is good."

Several of the youth groups commented on the ways in which smoke shops or medical marijuana dispensaries impacted the community context for AOD use. The teens in the Native American prevention group saw and heard of adults in their community buying items for underage people. This has a significant impact on their community, and because it is so small, problems are amplified. "Yeah I have a cousin my age and their mom would come up to [the headroom], '*Oh I'm going to buy her a bong for her birthday,*'" said one girl. Another commented that "because we are so small, it's like if someone were people on drugs that it makes it seem more like people on drugs, because it's so small." Medical marijuana dispensaries also provided a direct venue of access to marijuana to some. One said, "I'm smoking so much because like me going to the Cannabis Club, I had to resell my stuff. Like you just want to buy like a candy store."

However, some youth felt that these facilities also potentially offered perceived harm reduction strategies. For example, participants expressed preference for eating rather than smoking, citing health reasons, and said that dispensaries provided edible forms of marijuana. One said "I heard it's better to eat the product than smoke it. I heard it was better for you … because you inhale the smoke when you smoke it." Another added, "they tell you that when you go in to get your medical marijuana card and tell you all the risks and dangers to make sure you understand them."

The young men in out-patient recovery services discussed how difficult it was to maintain sobriety in the face of significant environmental obstacles. Said one "when I go out it gets harder" because of "gangs and other factors in the environment". His fellow outpatient client agreed, saying "I'm kind of scared, but at the same time I know I can do this so I'm actually going to stay sober." One of the students from the health class said wistfully "I would like to see my kids in an environment where it's

peaceful and quiet. I will walk down the street and I ain't going to worry about my kids getting robbed or getting shot at or kidnapped or nothing."

Findings and Recommendations

- Prevention programs for youth need to develop outreach strategies that appeal to youth at risk for substance abuse
- Prevention programs should support activities and events that appeal to young people's particular interests
- Prevention programs need to engage in outreach to LGBT youth
- Some prevention and treatment programs may benefit from LGBT cultural competence training that helps staff foster an inclusive, harassment free environment
- Most youth report a strong preference for staff who have had similar experiences to themselves, though they are divided on the question of whether race or ethnicity are important
- Programs for youth prevention need to extend into the summer months, when youth may be at higher risk for substance use
- Both treatment and prevention programs should engage parents and caregivers around the importance of modelling appropriate substance use behaviours
- Caregivers, community members, and policymakers should be educated about how to limit the access of young people to smoke shops and medical marijuana dispensaries

5. Conclusions

The purpose of the focus groups was to investigate the degree to which cultural and linguistic differences affect the ways that consumers utilize AOD services. The results of the analysis presented in this report strongly support the need for continuing training and technical assistance (TTA) around cultural and linguistic competence. Of particular note is the fact that too many consumers are unaware of the relevance of cultural appropriateness to the equality of treatment access and outcomes. The CLAS project will continue to work with both providers and consumers to help facilitate knowledge about the importance of culturally informed services.

AOD consumers who have accessed prevention, treatment, and recovery services in California report a litany of unmet or partially met cultural and linguistic needs. As indicated in the "findings and recommendations" section following each of the identified themes, many of these needs can be supported through the CA-CLAS project.

As the CA-CLAS project continues its mission to decrease disparities in AOD services access and outcomes, its efforts will be guided by the findings from these focus groups. Some of the general themes that emerged in these groups, including a lack of knowledge about the relevance of culture and issues around outreach and language access, fall squarely within the aegis of the CA-CLAS project. Several others—the perception that services are available only to the dual-diagnosed and reports of frequent substance use within treatment programs—represent systemic concerns best addressed by coordinated leadership from the field as a whole.

The population specific findings offer a wealth of insights about the needs and preferences of California's diverse population of AOD consumers. As the CA-CLAS project moves into its next phase, these findings will be incorporated into its TTA mission. These findings will shape both proactive and

reactive strategies. As a proactive measure, the project will actively pursue consultants who have the expertise to provide training in the areas highlighted by focus group participants. Additionally, the project will incorporate the findings from this analysis into its outreach to the field. By deepening our understanding of the needs of consumers, this data will enable the CA-CLAS project to better match providers with the resources that best serve the communities they engage. A continuing challenge of the CA-CLAS project has been the succinct articulation of the benefits of CLAS training to organizations that are pressed for time to commit to training activities. These results will enable us to provide organizations with much wanted examples of the CLAS needs articulated by consumers themselves. The ability to share with organizations the specific concerns raised by particular cultural groups enhances the capacity of the CA-CLAS project to bring TTA services to the field.

There is also a reactive duty inherent in the possession of this data. The nearly 300 people who participated in this project took the time to share their deeply personal experiences with AOD services. We have followed the cultural competence mandate to include consumers as key stakeholders in the planning of TTA service delivery and content. We now have an additional duty to ensure that these consumers are heard by the community of AOD service providers and the leadership under which these services operate. We will ensure that these findings are widely distributed to the field by making them accessible on the project website, creating tip-sheets for providers, and presenting these findings at meetings and conferences. By incorporating these findings into the public education mission of the CA-CLAS project, we can support the expanding knowledge of the field about the cultural and linguistic competence needs of those who access AOD services.