THE OPIOID CRISIS AND THE HISPANIC/LATINO POPULATION: AN URGENT ISSUE

SAMHSA
Substance Abuse and Mental Health Services Administration

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Office of Behavioral Health Equity

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Introduction

The current opioid crisis is one of the most widespread drug epidemics in U.S. history for all racial and ethnic groups. In 2017, it was declared a national public health emergency, with 47,600 reported deaths from opioid-related overdoses, which accounted for the majority of overdose drug deaths.[1] In 2018, overall drug overdose deaths declined in the U.S. by 4.1 percent compared to 2017.[2] However, opioid overdose deaths and misuse continued to occur in significant numbers.[2] In 2018, 10.3 million people misused opioids, including prescription opioids and heroin, and two million had an opioid use disorder (OUD).[3] With approximately 130 people dying each day due to an opioid-related overdose,[4] this epidemic has garnered nation-wide attention, generated significant federal and state funding opportunities for prevention, treatment, and recovery and shaped the priorities of many local communities.

Recently, a demographic shift has been observed in the epidemic with dramatic increases in opioid misuse and overdose deaths among Hispanic/Latino*, African American, and American Indian/Alaska Native populations. As Hispanic/Latinos are one of the fastest growing minority populations—expected to comprise nearly 30 percent of the U.S. population by 2060[5]—it becomes imperative to understand the unique sociocultural factors that influence drug use and access to prevention, treatment and recovery in this population.

***In this issue brief, the term Hispanic/Latino is used as an umbrella term to include those who identify as "Hispanic," "Latino," and/or "Latinx" in the U.S. This typically includes individuals with ancestral origins from Latin America and/or Spain. When data are reported, terminology in the original data source is used.**

As society moves away from criminalizing drug use behavior to understanding it as a preventable, treatable chronic health condition, this public health approach needs to be inclusive of and tailored to diverse and historically underserved communities. Understanding the public health strategies to outreach and engage the Hispanic/Latino population is a critical step in addressing this epidemic.

PURPOSE OF THE ISSUE BRIEF

As Congress, federal agencies, state and county health and behavioral health departments, and community stakeholders mobilize to address the opioid epidemic, what is happening within the Hispanic/Latino communities? This issue brief aims to convey a snapshot of how this population is impacted. Specifically, it will:

a) Provide recent data on the prevalence of opioid misuse and opioid overdose death rates in the Hispanic/Latino population in the U.S.;

b) Discuss contextual factors that impact the opioid epidemic in these communities, including challenges to accessing early intervention and treatment;

c) Highlight innovative outreach and engagement strategies that have the potential to connect individuals with evidence-based prevention, treatment, and recovery, and;

d) Illustrate the importance of ongoing community voice and leadership in the development and implementation of solutions to this public health crisis.

SOURCES OF INFORMATION

This issue brief includes information compiled from a variety of sources, including interviews with key informants, federal data, and the peer-reviewed research and policy literature. Key informants were selected for their expertise and current work to reduce opioid misuse in Hispanic/Latino communities. They represented a range of roles—including community leader, person with lived

experience, peer recovery coach, peer recovery supervisor, executive director and staff of community-based programs, evaluator, researcher, internist, addiction psychiatrist, clinical psychologist, physician, social worker, nurse, and advocate. Key informants were from geographically diverse areas and represented various types of institutions, e.g., university, professional behavioral health association, hospital, health clinic, and community-based organizations (CBOs).

Unique to this brief is the compilation of issues and strategies conveyed by people living or working in Hispanic/Latino communities and addressing opioid misuse and substance use disorder (SUD), and include many who identify as Hispanic/Latino. Their direct statements, indicated by italics and quotation marks, are interspersed throughout the document. The information they shared represents a snapshot of what is happening in selected Hispanic/Latino communities struggling with opioid misuse, and is not a full comprehensive picture of this population across the country.

Contextual Issues Related To Opioid Misuse And OUD In Hispanic/Latino Communities

HIGHLIGHTS OF THE NATIONAL DATA

National and state opioid estimates and rates are from the Substance Abuse and Mental Health Services Administration (SAMHSA) National Survey on Drug Use and Health (NSDUH),[6] the National Institute on Drug Abuse (NIDA) Monitoring the Future Survey (MTF),[7, 8] and the Centers for Disease Control and Prevention (CDC) National Vital Statistics System[9] and Youth Risk Behavior Survey (YRBS).[10] In the figures and tables below, most recently available data are shown.

Opioid misuse.[3] According to the SAMHSA NSDUH, the opioid misuse (heroin use and prescription opioid misuse) rate among Hispanic/Latinos is similar to the national population rate, about 4 percent. In 2018, 1.7 million Hispanic/Latinos and 10.3 million people nationally, aged 12 and older, were estimated to have engaged in opioid misuse in the past year.

Opioid and other substance use and misuse among Hispanic/Latino youth. National data from multiple sources specific to high school aged youth indicate that Hispanic youth are using drugs at rates that are equivalent or higher compared to their racial/ethnic peers. In 2017, the CDC YRBS reported that high school Hispanic youth had the highest prevalence of select illicit drug use (16.1 percent) and prescription opioid misuse (15.1 percent) compared to the total high school youth population (14.0 percent for both) and other race/ethnicities.[11] Similarly, NIDA's 2018 MTF indicates that in general, Hispanic eighth graders had the highest levels of substance misuse across all substances compared to Whites and African Americans.[7, 8] In general, a higher percentage of Hispanic eighth and tenth grade youth reported opioid (heroin and prescription) misuse in the past year than Whites and African Americans (Table 1).[7, 8]

Opioid-related overdose death rates and deaths involving selected drugs by race/ethnicity. The opioid-related overdose death rate for the national population has risen from 2.9 deaths per 100,000 people in 1999[12] to 14.9 per 100,000 in 2017[1]—with a large increase in overdose deaths involving synthetic opioids other than methadone (synthetic opioids, i.e., fentanyl, fentanyl analogs, and tramadol) from 2013 to 2017.[1] In 2017, among Hispanics the opioid-related overdose death rate

Table 1. Annual prevalence of use of various drugs by race/ethnicity for 8th, 10th, and 12th graders—United States, 2018

Race/ Ethnicity	Heroin, Any Use[a]			Heroin with a Needle[a,b]			Heroin without a Needle[a,b]			OxyContin[b,c,d]			Vicodin[b,c,d]		
	8th	10th	12th	8th	10th	12th	8th	10th	12th	8th	10th	12th	8th	10th	12th
Total	0.3	0.2	0.4	0.2	0.1	0.1	0.2	0.1	0.2	0.8	2.2	2.3	0.6	1.1	1.7
White	0.2	0.1	0.2	0.1	0.1	0.1	0.1	0.1	0.1	0.6	1.7	2.5	0.4	1.2	1.9
African American	0.2	0.2	0.6	0.2	0.2	0.2	0.1	0.1	0.4	1.4	1.6	1.7	1.5	0.9	1.1
Hispanic	**0.6**	**0.3**	**0.4**	**0.3**	**0.2**	**0.2**	**0.5**	**0.2**	**0.2**	**0.7**	**4.0**	**2.1**	**0.5**	**1.8**	**1.7**

Source: Monitoring the Future survey, the University of Michigan

[a] 8th and 10th grades only: Data based on three of four forms; N is four sixths of N indicated.

[b] 12th grade only: Data based on three of six forms; N is three sixths of N indicated.

[c] Only drug use not under a doctor's orders is included here.

[d] 8th and 10th grades only: Data based on one of four forms; N is one third of N indicated

Table 2. Number and age-adjusted rates[a] of drug overdose deaths[b] involving selected drugs by race/ethnicity—United States, 2017

Race/Ethnicity	Drug overdose deaths involving:											
	Drug overdose deaths[b], overall		Any opioid[c]		Natural and semi-synthetic opioids[d]		Synthetic opioids other than methadone[e]		Prescription opioids[f]		Heroin[g]	
	Deaths	Rate	Deaths	Rate	Deaths	Rate	Deaths	Rate	Deaths	Rate	Deaths	Rate
Total	70,237	21.7	47,600	14.9	14,495	4.4	28,466	9.0	17,029	5.2	15,482	4.9
White, non-Hispanic	53,516	27.5	37,113	19.4	11,921	5.9	21,956	11.9	13,900	6.9	11,293	6.1
Black, non-Hispanic	8,832	20.6	5,513	12.9	1,247	2.9	3,832	9.0	1,508	3.5	2,140	4.9
Asian/Pacific Islander, non-Hispanic	756	3.5	348	1.6	117	0.5	189	0.8	130	0.6	119	0.5
American Indian/Alaska Native, non-Hispanic	672	25.7	408	15.7	147	5.7	171	6.5	187	7.2	136	5.2
Hispanic	**5,988**	**10.6**	**3,932**	**6.8**	**994**	**1.8**	**2,152**	**3.7**	**1,211**	**2.2**	**1,669**	**2.9**

Source: National Vital Statistics System, Mortality File

[a] Rate per 100,000 population age-adjusted to the 2000 U.S. standard population using the vintage year population of the data year. Rates are suppressed when based on <20 deaths.

[b] Deaths are classified using the International Classification of Diseases, Tenth Revision (ICD–10). Drug overdose deaths are identified using underlying cause-of-death codes X40–X44 (unintentional), X60–X64 (suicide), X85 (homicide), and Y10–Y14 (undetermined). Because deaths might involve more than one drug, some deaths are included in more than one category. On death certificates, the specificity of drugs involved with deaths varies over time. In 2016, approximately 15% of drug overdose deaths did not include information on the specific type of drug(s) involved.

[c] Drug overdose deaths, as defined using ICD-10 codes, that involve opium (T40.0), heroin (T40.1), natural and semi-synthetic opioids (T40.2), methadone (T40.3), synthetic opioids other than methadone (T40.4) and other and unspecified narcotics (T40.6).

[d] Drug overdose deaths, as defined, that involve natural and semi-synthetic opioids (T40.2).

[e] Drug overdose deaths, as defined, that involve synthetic opioids other than methadone (T40.4).

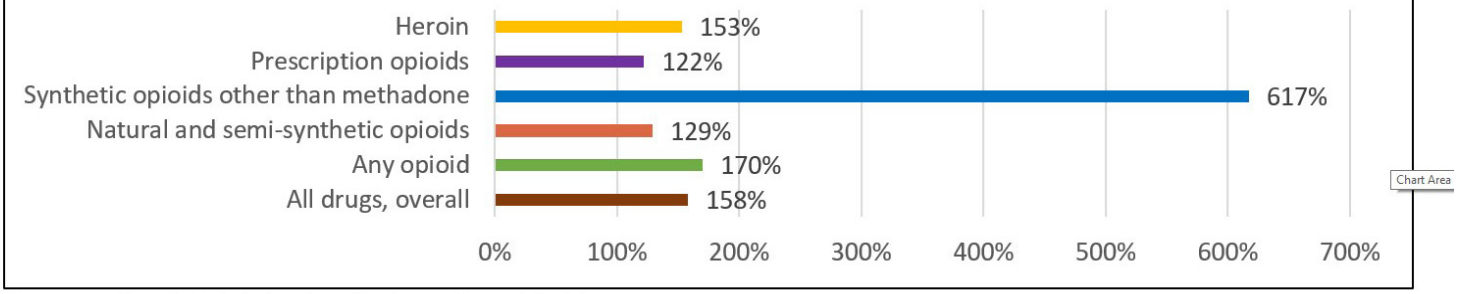
[f] Drug overdose deaths, as defined, that involve natural and semi-synthetic opioids (T40.2) and methadone (T40.3).

[g] Drug overdose deaths, as defined, that involve heroin (T40.1).

was 6.8 deaths per 100,000 people, and was significantly lower compared to non-Hispanic Whites, Blacks, and American Indian/Alaska Natives (Table 2). [13]

Overdose deaths involving synthetic opioids (other than methadone). Data suggest that illicitly manufactured synthetic opioids are heavily contributing to current drug overdose deaths in the U.S.[2] The sharp increase in overdose deaths involving synthetic opioids in recent years is alarming and data show that the mixing of synthetic opioids with other drugs occur across populations.[14] Synthetic opioids are affecting opioid death

Figure 1. Percent increase from 2014 to 2017 in overdose death rates by drug among the Hispanic population in the United States,
data from CDC National Vital Statistics System



See notes from Table 2 for details about drug definitions

rates among Hispanics.[1, 12, 13] In 2017, synthetic opioids accounted for nearly 55 percent of the opioid-related overdose deaths and 36 percent of the total drug overdose deaths for Hispanics, compared to 41-70 percent, and 25-43 percent of deaths, respectively, for all other race/ethnicities (derived from Table 2).[13]

Percent increase in overdose death rates by drug among the Hispanic population. From 2014-2017, among the Hispanic population drug overdose death rates involving all types of opioids increased, with the sharpest rise from synthetic opioids (Figure 1).[13, 15] Death rates involving synthetic opioids increased by 617 percent, and was the second highest for Hispanics compared to all other race/ethnicities (data not shown). [13, 15]

Opioid-related overdose death rates by state.[16] The picture of opioid-related overdose by state population varies depending on whether *death rate, percentage of deaths*, or *absolute number of deaths* by race/ethnicity are being considered. State opioid-related overdose death data specific to Hispanics was available for about half of the states, and of these states the top five states with the highest death rate (Table 3) and number of deaths (Table 4) are shown. In 2018, Massachusetts had the highest opioid-related overdose death rate for Hispanics (30.4 deaths per 100,000). New Mexico had the highest percentage of Hispanic opioid-related overdose deaths by state population; 57 percent of opioid-related overdose deaths in 2018 in New Mexico were among Hispanics (data not shown). A number of Hispanic communities in the Southwest have experienced high rates of heroin dependence and overdose fatalities since the 1960s, which may have set the stage for more recent increases in opioid misuse and overdose rates among Hispanics in the Southwest region.[17]

Table 3. Opioid Overdose Death Rates (age-adjusted per 100,000), Top 5 States and District of Columbia, by Total and Hispanic Population, 2018

	Total			Hispanic	
1.	WV	42.4	1.	MA	30.4
2.	DE	39.3	2.	PA	25.3
3.	MD	33.7	3.	CT	21.0
4.	NH	33.1	4.	OH	19.6
5.	NJ	29.7	5.	NM	19.6

Table 4. Number of Opioid Overdose Deaths, Top 5 States, by Total and Hispanic Population, 2018

	Total			Hispanic	
1.	OH	3237	1.	CA	573
2.	FL	3189	2.	NY	541
3.	NY	2991	3.	FL	405
4.	PA	2866	4.	NJ	341
5.	NJ	2583	5.	TX	329

PAIN MANAGEMENT

In the general population, the increase in prescription opioids for patients with acute and chronic pain[18, 19] contributed significantly to the current crisis and prompted the CDC to issue opioid prescribing guidelines.[20] Nearly 48 percent of the U.S. population 12 and older last misused a

prescription pain reliever for physical pain.[6] For the Hispanic/Latino population, opioid misuse stemming from overuse of pain relievers is also a major pathway to opioid misuse. The key self-reported reasons for misusing a prescription pain reliever among Hispanic/Latinos aged 12 or older was to relieve physical pain (53 percent) followed by a need to increase or decrease the effect of some other drug (11 percent).[6] Among Hispanic/Latino youth, aged 12 to 17, reasons for misusing a pain reliever were to relieve physical pain (67 percent); to help with one's feelings or emotions (12 percent); and to help with one's sleep (8 percent).[6]

Occupational exposures have been associated with the use of opioid pain medications in the Hispanic/Latino population. Military service increases risk for injury and ensuing need for pain medications. Hispanic/Latinos have an increasing presence in the military and have been over-represented among the enlisted recruits.[21] A higher proportion of Mexican Americans have blue-collar manual labor jobs than non-Hispanic Whites, and past research suggests that Mexican Americans with chronic pain may be at greater risk of experiencing widespread pain than non-Hispanic Blacks and Whites making them more susceptible for multiple injuries and higher rates of disability.[22-24] A study of emergency departments in the northeast U.S. found that Hispanic/Latino and Black children, and nonwhites in general were significantly less likely to receive an opioid prescription than Whites for pain, despite reporting similar levels of pain severity.[25] In contrast, other studies have suggested that opioid prescribing and levels of pain at presentation in emergency departments are similar between non-Hispanic Whites and Hispanic/Latinos.[26] Another study using nationally representative data from 2000 to 2015 found that Hispanic/Latino individuals use less prescription opioids than non-Hispanic Whites and Blacks.[27] However, when Hispanics/Latinos do receive opioid prescriptions from a medical provider, pharmacies in neighborhoods where they reside, may not stock these medications.[28, 29] Efforts to address the opioid crisis in these communities, especially in underserved or low socioeconomic status communities, need to consider how pain intersects with opioid use and misuse—*"we need a comprehensive approach to pain management."*

SOCIOCULTURAL FACTORS ASSOCIATED WITH ACCESSING SERVICES

It is now recognized that the social determinants of health are critical contributing factors to major public health issues. Described below are some of the key sociocultural factors associated with opioid misuse within the Hispanic/Latino population. They include facilitators and barriers to accessing appropriate prevention, treatment, and recovery services and supports.

Familismo. *Familismo* is the term used in Hispanic/Latino culture to underscore the importance of the family and family roles.[30] *Familismo* emphasizes the critical role of internal family dynamics, extended social networks, and the distribution of resources through these networks.[31] This concept is critical to prevention, treatment, and recovery approaches for Hispanic/Latino communities. In general, SUD treatment interventions based on family system models and involvement of family members throughout the treatment continuum, from engagement through continuing care have shown success.[32]

Religion, faith, and spirituality. Religion is valued in many Hispanic/Latino communities, with 82 percent of Hispanic/Latinos identifying with a religion.[33] Recognizing the importance of faith and spirituality in many Hispanic/Latino communities is needed when considering effective engagement in prevention, treatment, and recovery interventions.

Immigration issues. In recent decades, civil wars, economic insecurity, poverty, and natural disasters have contributed to the growing Hispanic/Latino population in the U.S.[34] These circumstances also influence the experience during migration to, as well as living in the U.S. Trauma associated with leaving one's native country and acculturating to a new country can manifest as a mental health condition. For example, research indicates that in general, migrants who are fleeing persecution have high prevalence of mental health conditions such as anxiety, depression, and PTSD.[35] Similarly, research has shown that fears of detention and deportation of immigrants by law enforcement is

associated with mental health issues for the detainee/deportee and their family.[36-38] Immigration, though an opportunity and necessity for some individuals, for many Hispanic/Latinos, is a chronic stressor.

Discrimination and trauma. Discrimination experienced by Hispanic/Latinos and people of color, in general, may trigger flashbacks of past trauma. People who experience a mental illness during their lives may also experience a SUD. According to the 2018 NSDUH, 1.34 million Hispanic or Latino adults, age 18 and over, had a co-occurring SUD and mental illness in the past year.[3] For Hispanic/Latinos, discrimination toward their ethnicity and immigration status, is also linked to SUDs.[39, 40] Data from the National Epidemiologic Survey on Alcohol and Related Conditions suggest that people with mental, personality, and SUDs were at an increased risk for nonmedical use of prescription opioids.[41]

Heterogeneity of the Hispanic/Latino population. Combining all Hispanic/Latinos into one ethnic category is problematic because it overlooks the existing diversity in Hispanic/Latino communities. One Hispanic/Latino treatment provider shared, *"Hispanic/Latino communities are a real spectrum… third generation versus recently immigrated individuals, [those who are] beginning to assimilate, [and] blended families, but [these individuals] don't have access because of language, insurance, and cultural barriers."* These communities include many different cultures, countries of origin, and languages/dialects. For those who immigrated to the U.S., length of residence and levels of acculturation are quite variable. Similarly, many Hispanic/Latino families are of mixed-status—native, naturalized, and undocumented residents—living in one multigenerational household. Differences in health beliefs and terminology regarding substance use may vary widely among the Hispanic/Latino ethnic groups, e.g., Mexican Americans, Puerto Ricans, Cuban Americans, etc.

Intergenerational substance misuse and polysubstance use. For many families in the U.S., substance misuse is passed on from generation to generation and opioids are not the first or only drug being used. In some cases, multigenerational households are misusing opioids and other substances together, both intentionally and unintentionally. In 2016, it was estimated that 27 percent of Hispanics/Latinos in the U.S. lived in multigenerational households.[42] In some cases in states where "pill mills" are more common, older generations within a family may be providing prescription opioids to younger generations without understanding the potential for opioid misuse. One key informant shared that some *"[Hispanic/Latino] grandparents are giving pills to their grandkids."* In these multigenerational households, mental illness may also be co-occurring among multiple family members and generations. In communities with high poverty and economic disinvestment, intergenerational and polysubstance use are not uncommon. For many in these poor and low-income communities, using and/or selling drugs is a means of survival. Opioids are not the only substances of concern and are likely not being misused in isolation.

Risks for youth. Hispanic/Latino youth are unaware of the risk for OUD with prescription opioids. Community members and national data have indicated that Hispanic/Latino youth are using opioids at high rates, and sometimes higher than their racial/ethnic counterparts.[3, 7, 8] Hispanic/Latino youth, like all adolescents, are at risk for negative coping behaviors such as engaging in risky sexual behaviors and drug use. Stress related to acculturation and immigration issues may also manifest negatively and place Hispanic/Latino immigrant youth at risk for anxiety, depressive symptoms, and PTSD.[43-45]

One mental health treatment provider shared that Hispanic/Latino students belonging to mixed status families were being isolated from peers and treatment providers when families take their children out of school for their behavioral health issues; *"[There are a] tremendous [amount of] mixed families. Children are documented, but parents are not. Biggest risk factor of kids with anxiety and depression [is isolation]. They are so isolated and have nowhere to go at 8 or 9 years old."* Among early adolescent Hispanic/Latino youth, the pressure and negative feelings about being the family interpreter or cultural broker has been associated with acculturation stress which is linked to higher risk for engaging in substance use.[46]

Language barriers One of the most commonly cited issues regarding prevention, treatment, and recovery strategies related to the opioid crisis for Hispanic/Latino communities is the need for bilingual providers and materials in one's native language. U.S. Census Bureau data from 2013 show that 63 percent of the total U.S. population who reported limited English proficiency (LEP) were Hispanic/Latino, while Hispanic/Latinos comprised only 12 percent of the U.S. English proficient population.[47] A lack of Spanish-, Portuguese-, and Indigenous-speaking providers, and in-language health-related materials is a major barrier for Hispanic/Latino people with LEP seeking health care in general[48, 49] and especially interferes with accessing care for a highly sensitive and stigmatized condition such as OUD. Research has indicated that mental health clinics that provide culturally and linguistically appropriate mental health services for the Portuguese-speaking population in their community were more likely to provide adequate care to their patients than those providing standard care.[50]

Access to free interpreters for individuals, for whom English is not their primary language, is required by federal law at health care facilities receiving federal financial assistance.[51] However, despite this law, key informants noted that many treatment providers do not adequately provide interpretation and properly inform clients of their right to no cost interpretation services. Instead, key informants commonly reported that Hispanic/Latino youth often serve as informal interpreters for their parents while navigating the primary and behavioral health care system. As one key informant stated, *"Kids are used all of the time to act as interpreters. You see it in the hospital. In the doctor's office or hospital, there is a child serving as interpreter."*

Stigma, misperceptions, and negative narratives about SUD. Similar to the general population, there is a stigma associated with SUD including OUD in Hispanic/Latino communities. Many families and communities in the U.S. stigmatize people who have OUD and see it as a moral failing and not a treatable, chronic disease. As one key informant noted, *"People are hiding addiction, especially Latinos. The message is not getting to them that addiction is a disease."* Because of the stigma, many people will not seek treatment.

In Hispanic/Latino communities, there is a gap in knowledge about treatment options for OUD. A key informant shared about medication-assisted treatment (MAT) and naloxone, *"Most Latinos [are] unaware that these programs exist."* To engage and inform this community, specific Hispanic/Latino-focused educational and social marketing campaigns on opioid prevention, treatment, and recovery are needed. As one key informant noted, *"MAT in the Latino community—I still see families thinking it is drug substitution…Still lots of education that needs to be done…Still lots of stigma around. Don't understand how it works."* In some cases families are the obstacle. Key informants shared that Hispanic/Latino families often do not understand addiction, have seen their family member relapse repeatedly, and do not believe in the possibility of recovery.

In addition to stigma, misperception of need for treatment by Hispanic/Latinos with SUD is also a barrier to care. Only five percent of Hispanic/Latinos with a SUD reported perceiving a need for treatment.[52] One key informant described the Hispanic/Latino participants from an ongoing substance use study in this manner: *"The importance of telling them and identifying for them where in the severity spectrum they are, had a big impact. When given scores to control their condition, so we could refer them – people started reducing their substance use just by being given their severity score."*

Fear of seeking treatment and calling the usual first responders. As noted previously, fears and stress related to immigration status are pervasive in Hispanic/Latino communities. Many documented and undocumented Hispanic/Latinos will not seek treatment for themselves, family members or friends for fear of deportation. *"They won't call law enforcement, we see with domestic violence victims but also true for people with mental illness and substance use disorder. They may be going through everything but they will not call the law enforcement."* Efforts to improve access to treatment or to naloxone through the use of first responders and law enforcement is likely not going to be effective for these communities. For this population, first responders in the opioid crisis are often family members, church leaders, friends, or other people who have used opioids. Efforts to engage Hispanic/Latino people with OUD in treatment or to be trained in naloxone use, should include the first responders that are known and trusted in their community. Additionally, in some places an identification card is a requirement for MAT which raises concerns about immigration status and deportation.

Lack of culturally responsive prevention and treatment. Much like the general behavioral health workforce, there is a significant gap in treatment providers who are bilingual and trained to work with Hispanic/Latino populations. Due to the heterogeneity of this population, a one size fits all approach is not adequate. Hispanic/Latinos living with OUD need access to health, mental health and SUD treatment that is culturally and linguistically appropriate in order to establish engagement in and understanding of preventive and treatment services. Without establishing this rapport, Hispanic/Latinos often terminate treatment prematurely.[53] Guidance to support healthcare providers in implementing culturally and linguistically appropriate services has been developed by the U.S. Department of Health and Human Services and includes 15 standards known as the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS Standards),[54, 55] however adherence to these standards is quite variable. [56]

Less access to Medication-Assisted Treatment (MAT). MAT for OUD, which combines medications and psychosocial therapies, is considered the evidence-based approach to treatment.[57] Research shows that Hispanics/Latinos are less likely to access MAT. A study of 28,000 injection drug users seeking treatment in Massachusetts found that Hispanics/Latinos were more likely to rely on detoxification treatment (non-MAT) only as compared to Whites.[58] Research has also found that methadone treatment is associated with stigma, which can increase dropout and relapse rates.[58, 59] A survey conducted at a New York City methadone clinic serving high rates of Hispanics/Latinos in recovery found negative attitudes related to this treatment in the majority of patients as well as in clinic staff.[60]

Further, Hispanics/Latinos who inject heroin and live in urban areas are more likely to experience barriers to accessing buprenorphine treatment.[61] Studies consistently show that buprenorphine and naltrexone are more readily accessible in White, higher income areas while methadone rates have remained stable over time and cluster in urban low-income areas.[62, 63] Further, Hispanic/Latino adolescents were less likely to receive naltrexone or buprenorphine as treatment for opioid addiction, despite best practice recommendations for using this MAT combination as an early intervention.[64] This disparity in access to buprenorphine by race/ethnicity, geography, and income, is also driven by insurance status/payment method. A study using national data showed that among individuals with OUD, those who self-pay or had private insurance represented nearly 74 percent of those who received buprenorphine from 2012-2015.[65] Despite Medicaid expansion which occurred in most states in 2014,[66] self-pay for Buprenorphine remained relatively stable during the study period.[65]

This disparity in access may be related to barriers for both the patient and clinician. Buprenorphine is generally a less stigmatizing treatment for people with SUD compared to methadone. It is an office-based treatment prescribed by medical practitioners, e.g. physicians, nurses, who have been trained and waivered to prescribe buprenorphine. For the Hispanic/Latino population, many (estimated 30 percent) do not have a usual primary care

provider[67] making access to office-based treatment programs less likely. Incentivizing medical personnel serving this population to get waivered is challenging given the limited or low reimbursement rates and lack of time and resources to pursue the training and acquire the mentorship to properly administer and care for buprenorphine patients.[68, 69] Methadone, while an effective treatment, places more burdens on the patient such as daily clinic visits, regular and random drug testing, employment disruptions, required counseling, etc. Essentially, a two-tiered treatment system exists where buprenorphine is accessed by Whites, higher-income, and privately insured individuals, while methadone is accessed by low-income, and publicly insured people of color.

Strategies To Address Opioid Misuse And OUD In Hispanic/Latino Communities

Effective treatments for OUD have been developed and generally work across all adult populations.[62] However, access to these treatments is uneven,[63, 65, 68, 69, 70] with particular obstacles for Hispanic/Latino and other minority populations. This section begins with a description of standard treatment for OUD and overdose. This is followed by innovative outreach and engagement strategies that have been used in Hispanic/Latino communities. These strategies, illustrated by snapshots from these communities, focus on outreach and engagement efforts that facilitate prevention, treatment and recovery. Supported by community-based participatory research efforts, these strategies are implemented by case managers, partnerships with community leaders and advocates, treatment providers, and peers/people with lived experience of a SUD.

STANDARD TREATMENT

The evidence-based treatment for an individual with OUD is MAT administered by qualified medical personnel. The treatment for an opioid-related overdose is the administration of an opioid overdose reversal drug by a trained individual.

Medication-Assisted Treatment (MAT). MAT is the use of an FDA-approved medication in conjunction with a psychosocial intervention. Currently, three medications are approved for MAT: methadone, buprenorphine, and naltrexone.[57]

Methadone: a medication that reduces withdrawal symptoms and cravings and blocks the euphoric effects of opioids like heroin, morphine, oxycodone, and hydrocodone. For treatment of OUD, it must be prescribed and dispensed from a federally regulated opioid treatment program (OTP). It is taken daily and orally, typically in liquid form but can also be offered as a pill or wafer. It may cause serious side-effects and can be addictive. [71, 72]

Buprenorphine: a medication that treats withdrawal symptoms and cravings and is less likely than methadone to cause intoxication or dangerous side effects such as respiratory suppression. It is commonly administered as a pill or buccal film that must be dissolved sublingually or attached to the cheek. It is also available as a monthly injection or subdermal implant that lasts for approximately 6 months. It may be prescribed and dispensed outside of a licensed OTP by physicians or qualified medical practitioners who have completed requisite training and earned a DATA-2000 waiver.[72, 73]

Naltrexone: a medication that blocks the euphoric and sedative effects of opioids. It is not an opioid and is neither intoxicating nor addictive. It is administered as a daily pill or monthly injection by any licensed medical practitioner or pharmacist. An extended-release injectable form, Vivitrol, is approved for treatment of opioid and alcohol use disorders and its effects last for about 28 days.[72, 74]

For additional information, see SAMHSA's TIP 63: Medications for Opioid Use Disorder.[75]

The second component to MAT is the psychosocial or behavioral intervention. Behavioral interventions target a broad range of problems and concerns not necessarily addressed by the medications (e.g. co-morbid mental health conditions, trauma, lack of social supports, risky behaviors, unstable housing, etc.). A few behavioral interventions such as contingency management, cognitive behavioral, and structured family therapy approaches are widely accepted as effective when used in conjunction with medications.[68] Some research has indicated that motivational interviewing, which has shown to be effective for changing substance use behavior, may also be an effective behavioral intervention for OUD in conjunction with medications.[68]

Opioid overdose reversal drugs. Currently, naloxone is the one FDA-approved medication used to reverse an opioid-related overdose.

Naloxone: a prescription medication to prevent overdose deaths of opioids such as heroin, morphine, and oxycodone by blocking opioid receptor sites to reverse the toxic effects of the overdose; it is given by intranasal spray, intramuscular (into the muscle), subcutaneous (under the skin), or intravenous injection.[76]

Efforts to expand the use and availability of naloxone nationwide through federal, state, and local initiatives is a key strategy to tackling opioid overdose. The effectiveness of naloxone and the critical need for it during this time prompted the U.S. Surgeon General to issue a public health advisory in April 2018.[77] This advisory recommends increased availability of naloxone in communities with high rates of opioid use, including administration by a wide array of health professionals, first responders, overdose survivors, and their family members.[77, 78] Similarly, in December 2018, the U.S. Department of Health and Human Services released new guidance on co-prescribing naloxone for patients at high risk for opioid overdose.[79]

COMMUNITY-INFORMED STRATEGIES TO ADDRESS OPIOID MISUSE AND OUD IN HISPANIC/LATINO COMMUNITIES

Eight key strategies with specific community examples are described below. While not universally representative of all Hispanic/Latino communities, they are strategies that have been used in selected communities with potential for replication.

1. Implement a comprehensive, holistic approach —*"Need for more holistic approaches...so many issues in their communities, housing, employment."*

Strategies to address the opioid crisis in Hispanic/Latino communities, like all communities, require a holistic approach to address the multiple factors associated with SUDs. A holistic approach identifies the key supports like housing, employment, and health care that are needed for an individual to maintain a healthy lifestyle. Collaborations across service sectors are necessary to establish and maintain recovery. This may include housing and employment supports, a consistent primary care provider to coordinate care for co-occurring medical conditions, and a peer specialist network for social support.

Community Snapshot: Creating a holistic addiction practice—Bellevue Hospital. At Bellevue Hospital in New York City, an addiction treatment clinic provides care in a homelike setting that fosters relationships among clients and staff. Activities that are culturally-driven and creative outlets, such as art therapy, yoga, and gardening are provided to support community-building. Clients and staff engage in cooking together in the kitchen at the clinic as a form of healing and therapy. Providing positive and alternative outlets for healing in a community-focused environment allows people of color to envision and believe in their recovery through firsthand participation in a community using mediums that best connect with their culture. The clinic includes linking patients to social services and recovery networks for support, which includes peer mental health workers, to complement their buprenorphine maintenance. The clinic also connects clients with community organizations that assist in housing and food stability issues.

2. Create culturally tailored public awareness campaigns in native languages—*"Don't see commercials talking about addiction in Spanish, none directed to Latino communities."*

A common theme described by key informants is the lack of culturally tailored public awareness campaigns regarding opioid misuse for the Hispanic/Latino population. The need to reach this growing population

is critical to preventing future opioid misuse among young Hispanic/Latino youth and new and recently arrived migrants. Several key informants noted, it is important to convey that long-term recovery is possible—*"they need to believe recovery is possible."* This requires that those who are trying to address the opioid crisis *"Build a narrative of hope, optimism, and availability of treatment options"* and *"identify the cultural brokers and informal leaders and take information to them in Spanish so they are able to recognize opioid use, drug use, and how to safely intervene."*

Community Snapshot: Harnessing media to deliver prevention messages in Spanish and Portuguese —CETPA. In a few counties in Georgia, innovative prevention campaigns that harness the power of media using SAMHSA's Strategic Prevention Framework have reached many underserved and overlooked Hispanic/Latino communities. CETPA, a non-profit based in Georgia has been providing behavioral health services to the Hispanic/Latino community in Georgia for 20 years. CETPA initiated a prescription drug prevention program targeting the Hispanic/Latino communities. Focus groups were held in English and Spanish in various age groups to learn about the community's level of understanding about the opioid crisis. The focus groups included information on opioid use and misuse from national data (NSDUH and YRBS) to educate the community. The focus groups revealed that families with recently arrived Hispanic/Latino family members had the least amount of awareness and knowledge about opioids and potential harmful outcomes. From these focus groups, a media campaign in Spanish was created to educate about OUD as a chronic illness and not a moral failing.

Media is a critical form of information-sharing among Hispanic/Latino community members and many in their community regularly attend the movie theater. CETPA capitalized on this vehicle. They collaborated with Spanish language TV stations to create and air high quality PSAs. CETPA then partnered with Fandango, a movie ticket company, to incentivize viewers to earn Fandango credit by watching a PSA aired as part of previews in local movie theaters. At the end of a movie trailer an opioid PSA in Spanish would air followed by a code for viewers to text to a phone number. The viewer would then receive a five-dollar Fandango credit for their next movie. CETPA partnered with movie theaters, including dollar theaters, in heavily Hispanic/Latino communities.

Additionally, CETPA provided thirty minute to one-hour Spanish radio interviews to educate the public about the dangers of opioids in the Hispanic/Latino community. They also used popular Spanish and Portuguese newspapers, writing articles and including full or half page advertisements regarding the opioid epidemic. They also put up billboards within the community to educate about opioids.

Community Snapshot: Partnering with local pharmacies to distribute pharmacy bags with opioid facts and information —CETPA. CETPA implemented another innovative prevention campaign using pharmacy bags. Partnering with 22 pharmacies in four cities in Georgia, CETPA had the pharmacies replace their pharmacy-branded medication bags with bags printed in Spanish and English with information about safe disposal and use of opioids. Each bag with opioid information also included a QR code to the state's website on safe drug disposal for the state. Each county in Georgia has at least one safe disposal site. They printed over 200,000 bags with the opioid information. Pharmacies and customers responded favorably to this campaign and the information conveyed.

3. Form diverse partnerships—*"Successful practitioners tap into partnerships with CBOs."*

Key informants underscored the importance of involving community residents, leadership and

organizations in addressing the opioid crisis. Multi-sector partnership and collaborations between community experts and health care practitioners are essential.

Building trust is critical to developing partnerships. For mixed-status Hispanic/Latino families, fears about separation and deportation make it challenging to trust government entities and healthcare institutions. These families seek trusted allies—many who are Hispanic/Latino focused CBOs, with a large number of Hispanic/Latino staff and where Spanish is widely spoken—that are willing to provide education, legal, health, and other services.

Hispanic/Latinos connect to substance use treatment through different pathways, including primary care, emergency departments (EDs), schools, faith-based communities and ethnic-specific services. As one key informant noted, *"People are calling CBOs; relying on informal networks, such as home day cares, hair salons, afterschool programs, YMCAs, Parks and Recreation staff, especially for homeless youth."*

Community Snapshot: Linking and educating small CBOs aboutopioids—Ser Familia. Key informants noted that many Hispanic/Latino families are working class families whose work schedules are not compatible with available hours at behavioral health clinics. As a result, individuals who may want to seek services are unable to do so because of the lack of flexibility in hours of service. As one key informant indicated, *"Clinic hours don't work for clients, we changed our hours to 8am to 8pm and Saturdays 8am to 3pm."* Additionally, many CBOs that do not provide behavioral health services have noted that they do not know where to refer clients for opioid use treatment or other behavioral health services—*"the workforce treating Latino communities needs information, the community needs the information, the community is still in the dark about the opioid epidemic."* To address these issues, Ser Familia, a behavioral health services CBO in Georgia, is coordinating meetings between small Hispanic/Latino-serving agencies to create informal networks of CBOs. These networks are being trained and educated in Spanish by Ser Familia staff at meetings on behavioral health. Many of these CBOs expressed interest in getting information and assistance regarding opioid use. Ser Familia is helping these smaller CBOs by teaching them how to identify the issue, intervene, and connect clients with treatment.

Community Snapshot: Training community members to administer naloxone—National Latino Behavioral Health Association (NLBHA). There is uneven knowledge in the Hispanic/Latino community about naloxone and its use in reversing an opioid overdose. Working in communities in New Mexico with a high proportion of Hispanic/Latino and American Indian populations, the NLBHA partners with local behavioral health providers to provide trainings in Spanish and English to teach community members and families how to administer naloxone.

4. Utilize schools—*"Family liaison, in schools with large Latino populations, is an employee that is Latino, serves as an interpreter, organizes the services, becomes 'everything' for the families."*

The social and community context is critical to many Hispanic/Latino families, especially due to the acculturation and language barriers associated with immigration. Recently arrived immigrants often have a difficult time adjusting to a new culture, and language is commonly cited as a barrier to seeking and accessing services. Social and community ties created through schools provide safe spaces for Hispanic/Latino families to get information and seek services. Key informants noted that the fear of deportation or incarceration inhibits Hispanic/Latino families from reaching out to law enforcement, social services or the health care system for opioid related services. One key informant noted, *"[There is] tremendous fear that families experience and [an] unwillingness to look for help now. A sense of fear is an understatement; [it is] absolute panic. [There are] parents with concerns regarding substance use and depression issues. In [the] last couple of years, the fear has increased, [and has] shown in unhealthy ways. It's dangerous to the community. If a child is using, they will not go for help. It will isolate the the family from community and [their] support system. If authorities intervene, they will be in danger because of [their] immigration situation."* Thus, social and community

institutions that are trusted become the navigators to assist Hispanic/Latino families in the opioid epidemic.

Community Snapshot: Leveraging "family liaisons" to engage parents and youth in opioid education—CETPA. Youth-based prevention programs in schools are being implemented in Georgia through partnerships between Hispanic/Latino-focused CBOs and schools, both which rely on the schools' "family liaison"—a bilingual school employee responsible for connecting Hispanic/Latino families with information and services from the school—to engage parents to attend. The family liaisons often become the trusted person that parents go to for advice and support regarding family and educational issues related to their children. These family liaisons are recruited from the community which they serve, similar to promotoras and community health workers.

CETPA partnered with schools to provide education to families about opioids, the dangers of misuse, and other relevant topics. The successful engagement of parents was the result of several factors such as flexibility in time, provision of food and childcare, and, most importantly, the persistent outreach of family liaisons. Repeated outreach, reminders and personal contact in Spanish by the family liaisons and active and visible support of the schools' principals contributed to the active participation of the Hispanic/Latino families. Sixty to eighty parents on average attended each of these meetings.

5. Leverage faith-based organizations—*"Church is the last institution standing to provide supports [and has a] historically important role in dire circumstances."*

Faith-based organizations can be key partners in addressing the opioid crisis for many Hispanic/Latinos, where faith is a core component to their culture.[33] For some communities, faith institutions act as the primary place for help for a variety of social and health concerns. The degree to which faith institutions collaborate with behavioral health and medical professionals to address healthcare needs varies widely. Some faith communities may not yet accept that OUD is a chronic disease, perceiving it still as a moral failing, while others may partner with behavioral health and medical clinicians to administer MAT. While some are actively engaged in recovery support, the full potential of faith communities in motivating individuals to seek help for OUD remains untapped. In particular, connecting with the faith leaders in Hispanic/Latino communities to act as "trusted messengers" to help link individuals with SUDs to treatment may be a key pathway to care for some Hispanic/Latinos.

Community Snapshot: Partnering with the church to provide treatment and health services—Project Hospitality. In Staten Island, New York, an interfaith CBO, Project Hospitality has a decades-long history serving vulnerable and immigrant populations in its community. Project Hospitality's behavioral health clinic partners with a local church to provide treatment for OUD for a significant population of Hispanic/Latinos. Project Hospitality contracts with a physician to offer MAT, in particular suboxone, at the church facility. While this has been an important partnership and critical step in treatment, numerous challenges remain, including lack of funding for coordination of care between behavioral health care and primary health care teams, lack of staff to manage billing and reimbursement issues, and lack of funding for relapse prevention. *"There is no funding for relapse prevention. After treatment, the patient shows up in the hospital with an overdose, a relapse. Many patients are dying in this process."* Despite these challenges, Project Hospitality continues to ensure patients are given the tools and resources to continue their recovery and maintain their health by linking them to additional health, legal, and social services and supports in the community.

6. Build a bilingual, culturally aware and respectful workforce—*"Being culturally aware...takes more than didactic."*

Communities know that when people feel welcomed, understood and comfortable, they are more likely to continue treatment. In many situations, it is important that staffing of treatment centers reflect the community being served. When Hispanic/Latinos make the difficult decision to enter treatment, often they will not see any staff at the

treatment facility that share a similar cultural background with them. Addressing the shortage of Hispanic/Latino medical personnel who are waivered to prescribe buprenorphine may reduce the inequity in access to evidence-based medications. Additionally, recruiting and training a diverse and bilingual workforce and creating billable funding structures to pay for this workforce is critically needed.

To persuade someone to enter treatment for SUD is not simple. It is important to consider the context in which a person with SUD is living. It is equally important to consider the challenges that may prevent an individual with SUD from entering treatment. People are often unfamiliar with or untrusting of existing resources for SUD. They do not know who to ask for help nor what to ask for. Often they have the belief that no one actually cares about them. Physically going to where people are, connecting with them, bringing authentic care and hope—particularly in their own language—facilitates linking them with trusted treatment and recovery providers. Leveraging the experience, expertise and familiarity of community health workers and those with lived experience of having an OUD such as peer recovery coaches may be critical to engaging a person in treatment.

Additionally, key informants continually mentioned the extreme gap in the bilingual capacity of the behavioral health workforce and the urgent need for more Spanish and Portuguese speaking behavioral health providers in the U.S. As stated by one key informant, *"With Latinos, first thing that comes to mind is the language. There are a lot of Spanish speakers, it is unbelievable that we have only one inpatient program for Latino population, with 29 beds."* While another behavioral health treatment provider shared, *"Most recent count: 700,000 Latinos in Atlanta metro area. We have 70 licensed bilingual therapists; 4 psychologists, 5 psychiatrists that speak Spanish. Tremendous disparity. Criminal negligence, no desire to create the capacity; advocating in every forum…no one responding."*

Community Snapshot: Working with peer recovery coaches —Project RECOVER. In Boston, peer recovery coaches with ongoing supervision from a recovery coach supervisor are being used to link, engage and retain people with an OUD in outpatient medication-based treatment for at least six months after completion of detoxification. Recent literature shows that the transition after completion of detoxification to be a critical touchpoint with elevated risk for opioid-related mortality.[80] Through a series of interventions including motivational interviewing, peer recovery supports, strengths-based case management and development of recovery wellness plans, coaches work with individuals to address perceived barriers to one's recovery. The peer recovery coaches help link individuals to SUD focused primary care services where they can get comprehensive care, e.g., screening, treatment, and referral for mental health disorders and injection related chronic diseases such as HIV and hepatitis B and C. Most importantly the peer recovery coaches provide overdose prevention education and naloxone distribution and training to all clients and close members of their social network.

In this model, the peer recovery coaches are from the Hispanic/Latino or Black/African American community and are people with a lived experience of a SUD who are in longer-term recovery. Eligibility to be a peer recovery coach requires being in recovery for at least two years and completing an intensive five-day training that includes courses on motivational interviewing; ethical considerations; SUD 101; cultural awareness and responsiveness—knowing the "street" language used; wellness recovery plans; and linkages with community resources, such as housing and primary care to address related infectious diseases. The peer recovery coaches are required to complete 500 hours of recovery coach work with 35 hours under supervision from a peer recovery coach supervisor. Once eligibility is met, they are certified by the State of Massachusetts and their services are billable.

The peer recovery coaches are critical in outreach and engagement; they know the community, know the resources, and are able to communicate effectively, and are able to draw upon their own

experiences of SUD and recovery. They develop a unique connection with the client. As one key informant noted, *"The key strength is that we [recovery coaches] understand addiction, we went through the same stuff…Recovery coach is there to support and give guidance. We connect them with MAT, help with job seeking, housing applications; if relapse, recovery coach is there to help you pick up there all the time; sometimes can spend four hours in a day with getting them to appointments and assisting with transportation…we can sit with you 3 hours in a courtroom. How many professionals can do that?"*

The peer recovery coaches acknowledge that the Latino community encompasses different groups which require different cultural approaches. One key informant described engaging a person in recovery, stating, *"I try to dig into their background culturally. Sometimes they use words that are different for me. I asked them what that word means because in my country that word means this. You need to speak the same language, people are responsive when you are trying to learn their culture and see you are trying. We're all Latinos, but speak differently. Do the homework…Must be very aware."*

Community Snapshot: Building capacity through community health workers—Disparities Research Unit in Boston. Another promising strategy for opioid prevention among Hispanic/Latino communities is the use of community health workers (CHWs) to lead psychosocial interventions. CHWs can help people to learn and practice skills that are useful for addiction recovery, such as cognitive restructuring, mindfulness, behavioral activation, coping with cravings, and shifting negative thinking. In Boston, the Disparities Research Unit at Massachusetts General Hospital is piloting a manualized intervention for people with mental health and substance use disorders which is delivered by CHWs and available in English, Spanish, Mandarin, and Cantonese. The CHWs in this program are people from the community who have an associate's or bachelor's degree, are bilingual, and demonstrate good engagement skills. Their training includes an initial 20 hours of theory and roleplaying with clinical supervisors, and ongoing weekly clinical supervision. The intervention at the Disparities Research Unit is based in cognitive-behavioral therapy and mindfulness techniques, and involves ten to twelve hour-long individual sessions with CHWs. The CHWs also help clients navigate different systems to receive other services as necessary. The benefits of CHW-led interventions extend far beyond affordability and accessibility. As one client noted, *"CHWs are seen as equals, so trust and engagement is better than with health professionals. There's a feeling of 'she's like me, she understands me, comes from same place, same language. I'm getting skills from person I really trust.'"*

Community Snapshot: Developing a pipeline to a bilingual workforce—CETPA. CETPA has implemented an innovative approach to building bilingual behavioral health workforce capacity. Recognizing the dearth of Spanish- and Portuguese-speaking individuals in the behavioral health workforce pipeline in the U.S., it has been actively recruiting behavioral health practitioners from Latin American countries and identifying newly immigrated practitioners and supporting them through the licensure process in the U.S. CETPA has grown its capacity from two bilingual clinicians to 40 in two decades.

7. Develop culturally and linguistically appropriate prevention and treatment—*"We need to have the treatment available for Latinos and tailored for Latinos."*

To reduce opioid misuse and overdose deaths in Hispanic/Latino communities will require improving access to quality prevention and treatment services that can be provided in-language, that are culturally meaningful and that are provided in a culturally responsive environment.

The treatment environment can influence whether the person remains in treatment or terminates treatment prematurely. Building trust and comfort is needed for optimal engagement into treatment. Seeing individuals who share a similar culture is a necessary first step, but building a trusting relationship is paramount.[81] Food, staff and décor of the facilities that are welcoming and convey a sense of cultural familiarity all facilitate treatment engagement. As one key informant shared about the

recovery process, *"I found somebody who inspired, who told me their story… he took me under his wing and showed me it is possible. I tried two other programs that were for non-Spanish speakers. I wasn't understanding part of the program at all because I did not speak English. The food was totally different of what I am used to eating. Latino program they were speaking my language and had the food I was raised with."* The staff of a treatment facility that value and respect culture, convey empathy, compassion, and cultural respect in their approach are more likely to build trust with the client. Without this, some Hispanic/Latino individuals seeking treatment may quickly become offended, ashamed, or uncomfortable and may choose to disengage from treatment.

Community Snapshot: Implementing Familia Adelante—Amistades, Inc. In communities across the country, culturally-specific organizations are leading the way in providing ethnic-specific interventions for Hispanic/Latino individuals. One such example is Amistades, Inc. in Tucson, Arizona which is a Latino-led and Latino-serving CBO focused on providing culturally responsive prevention services. Amistades, Inc. promotes evidence-based practices and, since 2015, has been implementing Familia Adelante, an emerging evidence-based program designed to reduce multi-risk behaviors in Hispanic/Latino adolescents and their parents.[82] Amistades, Inc.'s advocacy for culturally tailored youth prevention programs enabled them to secure funding for Familia Adelante through the Arizona Governor's Office of Youth, Faith, and Family Parent's Commission. Familia Adelante focuses on developing coping and life skills in both youth and parents, improving youth and family communication, preventing/reducing substance misuse, and increasing knowledge of high-risk behaviors. It includes focus areas relevant to Hispanic/Latino populations such as coping with acculturative stress and immigration issues. The program is offered in both Spanish and English. Past evaluations have shown improved outcomes in youths' self-esteem, school performance, overall conduct, enhanced communication and perception of substance misuse harm, and reductions in past 30 day drug use and other risky behaviors. Amistades, Inc. has implemented Familia Adelante with 300 families resulting in the youths' increased perception of risk and harm associated with substance misuse, and decreased favorable attitudes towards substance misuse. Parent satisfaction with the Familia Adelante program has consistently been rated very high (>90%).

Community Snapshot: Tailoring to the community's needs—CETPA. As one key informant noted, *"Environment has to be appealing."* CETPA regularly assesses their community's needs and considers the feedback from clients. Many families communicated with CETPA that they were unable to seek care during the available business hours due to work schedule conflicts and lack of paid time off to see the doctor during work hours. As a result, CETPA altered their business hours to add more flexible timeframes, including earlier and weekend hours that would allow Hispanic/Latino working families to come outside of traditional hours. Hispanic/Latinos often live in multigenerational families[41] and bring multiple family members to appointments. Accordingly, CETPA expanded the square footage of the lobby to accommodate an increased volume of people. Additionally they noticed that children were often coming into their clinic with trauma issues, so they created a separate children's area play space in the lobby away from the adults waiting to be seen. These changes created a more welcoming environment.

8. Link to primary care—*"Getting them back to primary care physician services to address other chronic medical conditions impacted by OUD."*

The shortage of behavioral health workforce professionals is a major barrier to providing adequate and quality treatment for people living with OUD. Healthcare providers are implementing creative models that leverage the expertise of primary care, emergency medicine professionals, and addiction specialists. The integration of behavioral health and primary care is increasingly occurring in many federally qualified health centers. The linkage from emergency medicine to primary care or OUD treatment providers for people who have an OUD is similarly increasing with recognition that an emergency department visit is a "hot moment" or opportunity to link to behavioral health treatment. However, SUD treatment practitioners that are Spanish speaking are in limited supply. For example, bilingual practitioners that can provide MAT or who are waivered to provide buprenorphine are in high demand due to a severe shortage. One key informant noted that, *"There is a lot of suboxone, and prescriptions, and other stuff. I don't see a lot of doctors with the waivers who can prescribe, and then for the Latino population, there are some who know some English but not fluently. You understand these issues better in their language. Have not seen any movement targeting the Latino population."*

Community Snapshot: Adaptation of Screening, Brief Intervention, and Referral to Treatment (SBIRT) in New Mexico. SBIRT is an evidence-based approach used widely in primary care settings to screen individuals for risky alcohol and drug use or an existing SUD. The State of New Mexico was funded by SAMHSA to implement SBIRT in community health centers in rural and border counties. In order to make the SBIRT screening more culturally and linguistically responsive to Hispanic/Latino patients, screening instruments were translated into Spanish; the program hired bilingual practitioners and provided health center staff with cultural competency training. The New Mexico SBIRT Program screened over 50,000 adults in a variety of health care settings including those that serve primarily Hispanic/Latino and American Indian populations, and is currently used in six sites across the state.

Community Snapshot: Providing treatment to culturally diverse communities through federally qualified health centers—El Centro Family Health. El Centro Family Health, a network of federally qualified health centers, provide culturally and linguistically responsive, integrated primary and behavioral health services to predominantly Hispanic/Latino communities in rural northern New Mexico. El Centro provides a number of services to address opioid misuse and overdose in the populations it serves, including MAT for opioid-dependent individuals, and a promotores de salud program, that provides training in the administration of naloxone to reduce opioid fatalities in Hispanic/Latino communities. In addition, their Semillas de Esperanza project uses peer recovery support specialists to support individuals in recovery from OUD.

Community Snapshot: Increasing provider competencies—Project Extension for Community Healthcare Outcomes (ECHO). Project ECHO developed at the University of New Mexico School of Medicine, delivers specialty medical care training using a novel educational model of team-based interdisciplinary networks designed to support health care professionals in treating patients with complex conditions in their home communities. Applying a hub and spoke model, health professionals—nurses, physician assistants, primary care physicians, promotores de salud, and counselors—are "spokes" and are paired with specialty clinicians—the hubs—who have expert knowledge in a variety of complex conditions including OUD. The hub, in this case SUD specialists, mentors the "spokes" who often have a shortage of specialty clinicians in their geographic areas. The ECHO Project provides an innovative model for training health professionals that primarily serve hard to reach underserved populations. A spin-off of Project ECHO, TeleECHO programs are being developed to address the opioid crisis. TeleECHO programs are designed for health practitioners seeking information and consultation on chronic pain and opioid management and MAT. Some of these programs are also geared for CHWs/peer support workers, and first responders working with underserved populations with OUD.

Moving Forward

Hispanic/Latino communities in the U.S. are facing unique challenges related to the opioid crisis. Navigating bicultural and multicultural identities, facing intergenerational and intercultural differences within households, coping with language barriers, managing trauma and stress related to migration and discrimination, and protecting youth from engaging in risky behaviors are some of the issues that Hispanic/Latino communities encounter. Acknowledging these contextual issues and recognizing the heterogeneity within the Hispanic/Latino population is essential for developing culturally-responsive prevention, treatment and recovery services.

The opioid crisis, similar to other public health issues, requires partnerships and collaborations across organizations and service sectors and across cultures. While this is a national crisis, it is also a community by community crisis whose solutions depend not only on national policy and resources, but on the voices, experiences and cultural practices of residents and leaders of the Hispanic/Latino communities. Evidence-based prevention and treatment practices in conjunction with culturally-driven engagement and outreach practices represent a partnership poised to address the opioid crisis in Hispanic/Latino populations and reestablish healthy communities.

Glossary

Fentanyl: a synthetic opioid, approved for treating severe pain, typically advanced cancer pain. It is 50 to 100 times more potent than morphine. However, illegally made fentanyl is sold through illicit drug markets for its heroin-like effect, and it is often mixed with heroin or other drugs, such as cocaine, or pressed in to counterfeit prescription pills.

Heroin: an illegal, highly addictive opioid drug processed from morphine and extracted from certain poppy plants.

Methadone: a synthetic opioid that can be prescribed for pain reduction or for use in MAT for opioid use disorder (OUD). For MAT, methadone is used under direct supervision of a healthcare provider.

Natural opioids: a group of opioids that include such drugs as morphine and codeine.

Opioid misuse: any misuse of prescription opioids (also called prescription pain relievers) or the use of heroin (and synthetic opioids depending on the data source). Misuse of prescription opioids is the use of a prescription opioid in any way not directed by a doctor, including without a prescription of one's own; use in greater amounts, more often, or longer than told; or use in any other way not directed by a doctor. It is sometimes also called "nonmedical prescription opioid use" or "misuse of prescription pain relievers" dependent on the data source, and refers only to misuse of prescription opioids.

Opioid use disorder (OUD): having either a heroin use disorder (i.e., dependence or abuse) or pain reliever use disorder related to their misuse of prescription pain relievers in the past year, or if they had both disorders.

Opioid use: any use of prescription opioids, heroin, or synthetic opioids (e.g., fentanyl). Opioid-related overdose death: death resulting from unintentional or intentional overdose involving an opioid.

Prescription opioids: Opioids are a group of chemically similar drugs that include prescription pain relievers such as hydrocodone (e.g., Vicodin®), oxycodone (e.g., OxyContin®), morphine, and others. They are sometimes called "prescription opioid analgesics" or "prescription pain relievers" depending on the source.

Semi-synthetic opioids: a group of opioids that include such drugs as oxycodone, hydrocodone, hyrdromorphone, and oxymorphone.

Synthetic opioids other than methadone: a group of opioids that include such drugs as fentanyl, fentanyl analogs, and tramadol.

Resources

Centers for Disease Control and Prevention (CDC) Reducing Harms from Injection Drug Use and Opioid Use Disorder with Syringe Services Programs (Info Sheet) | https://www.cdc.gov/hiv/pdf/risk/cdchiv-fs-syringe-services.pdf

SAMHSA Opioid Prevention Toolkit (Toolkit) | https://store.samhsa.gov/product/Opioid-Overdose-Prevention-Toolkit/SMA18-4742

SAMHSA TIP 63: Medications for Opioid Use Disorder (Treatment Improvement Protocol) | https://store.samhsa.gov/product/TIP-63-Medications-for-Opioid-Use-Disorder-Full-Document/PEP20-02-01-006

SAMHSA Clinical Guidance for Treating Pregnant and Parenting Women with Opioid Use Disorder and Their Infants (Clinical Guidance) | https://store.samhsa.gov/product/Clinical-Guidance-for-Treating-Pregnant-and-Parenting-Women-With-Opioid-Use-Disorder-and-Their-Infants/SMA18-5054

SAMHSA Use of Medication-Assisted Treatment for Opioid Use Disorder in Criminal Justice Settings (Resource Guide) | https://store.samhsa.gov/product/Use-of-Medication-Assisted-Treatment-for-Opioid-Use-Disorder-in-Criminal-Justice-Settings/PEP19-MATUSECJS

SAMHSA Behavioral Health Barometer, Volume 5 (National Data Report) | https://store.samhsa.gov/product/Behavioral-Health-Barometer-Volume-5/sma19-Baro-17-US

SAMHSA National Hispanic and Latino Prevention Technology Transfer Center Network (Website) | https://pttcnetwork.org/centers/national-hispanic-latino-pttc/home

SAMHSA National Hispanic and Latino Addiction Technology Transfer Center Network (Website) | https://attcnetwork.org/centers/national-hispanic-and-latino-attc/home

SAMHSA National Hispanic and Latino Mental Health Technology Transfer Center Network (Website) | https://mhttcnetwork.org/centers/national-hispanic-and-latino-mhttc/home

SAMHSA TIP 59: Improving Cultural Competence (Treatment Improvement Protocol) | https://store.samhsa.gov/product/TIP-59-Improving-Cultural-Competence/SMA15-4849

National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS) (Webpage) | https://thinkculturalhealth.hhs.gov/clas

Limited English Proficiency (LEP) Resources for Effective Communication (Website) | https://www.hhs.gov/civil-rights/for-individuals/special-topics/hospitals-effective-communication/limited-english-proficiency/index.html

U.S. Department of Health and Human Services Office of Minority Health Improving Cultural Competency for Behavioral Health Professionals (Continuing Education e-Learning Program) | https://thinkculturalhealth.hhs.gov/education/behavioral-health

National Council on Interpreting in Health Care (Website) | https://www.ncihc.org/certification

The National Board of Certification for Medical Interpreters (Website) | https://www.certifiedmedicalinterpreters.org/

Certification Commission for Healthcare Interpreters (Website) | https://cchicertification.org/

American Psychological Association The Opioid Guide: A Resource Guide for Practicing Psychologists (Resource Guide) | https://www.div12.org/wp-content/uploads/2019/03/ORG-Fnal-2019_0205.pdf

National Council for Behavioral Health Improving Adolescent Health: Facilitating Change for Excellence in SBIRT (Resource Guide Package) | https://www.ysbirt.org/

National Council for Behavioral Health Implementing Care for Alcohol and Other Drug Use in Medical Settings: An Extension of SBIRT (Resource Guide) | https://www.thenationalcouncil.org/wp-content/uploads/2018/03/021518_NCBH_ASPTReport-FINAL.pdf?daf=375ateTbd56

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Substance Abuse and Mental Health Services Administration

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Table 1. Annual prevalence of use of various drugs by race/ethnicity for 8th, 10th, and 12th graders—United States, 2018

Race/ Ethnicity	Heroin, Any Use[a]			Heroin with a Needle[a,b]			Heroin without a Needle[a,b]			OxyContin[b,c,d]			Vicodin[b,c,d]		
	8th	10th	12th	8th	10th	12th	8th	10th	12th	8th	10th	12th	8th	10th	12th
Total	0.3	0.2	0.4	0.2	0.1	0.1	0.2	0.1	0.2	0.8	2.2	2.3	0.6	1.1	1.7
White	0.2	0.1	0.2	0.1	0.1	0.1	0.1	0.1	0.1	0.6	1.7	2.5	0.4	1.2	1.9
African American	0.2	0.2	0.6	0.2	0.2	0.2	0.1	0.1	0.4	1.4	1.6	1.7	1.5	0.9	1.1
Hispanic	**0.6**	**0.3**	**0.4**	**0.3**	**0.2**	**0.2**	**0.5**	**0.2**	**0.2**	**0.7**	**4.0**	**2.1**	**0.5**	**1.8**	**1.7**

Source: Monitoring the Future survey, the University of Michigan

[a] 8th and 10th grades only: Data based on three of four forms; N is four sixths of N indicated.

[b] 12th grade only: Data based on three of six forms; N is three sixths of N indicated.

[c] Only drug use not under a doctor's orders is included here.

[d] 8th and 10th grades only: Data based on one of four forms; N is one third of N indicated

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Table 2. Number and age-adjusted rates[a] of drug overdose deaths[b] involving selected drugs by race/ethnicity—United States, 2017

Race/Ethnicity	Drug overdose deaths involving: Drug overdose deaths[b], overall		Any opioid[c]		Natural and semi-synthetic opioids[d]		Synthetic opioids other than methadone[e]		Prescription opioids[f]		Heroin[g]	
	Deaths	Rate	Deaths	Rate	Deaths	Rate	Deaths	Rate	Deaths	Rate	Deaths	Rate
Total	70,237	21.7	47,600	14.9	14,495	4.4	28,466	9.0	17,029	5.2	15,482	4.9
White, non-Hispanic	53,516	27.5	37,113	19.4	11,921	5.9	21,956	11.9	13,900	6.9	11,293	6.1
Black, non-Hispanic	8,832	20.6	5,513	12.9	1,247	2.9	3,832	9.0	1,508	3.5	2,140	4.9
Asian/Pacific Islander, non-Hispanic	756	3.5	348	1.6	117	0.5	189	0.8	130	0.6	119	0.5
American Indian/Alaska Native, non-Hispanic	672	25.7	408	15.7	147	5.7	171	6.5	187	7.2	136	5.2
Hispanic	**5,988**	**10.6**	**3,932**	**6.8**	**994**	**1.8**	**2,152**	**3.7**	**1,211**	**2.2**	**1,669**	**2.9**

Source: National Vital Statistics System, Mortality File

[a] Rate per 100,000 population age-adjusted to the 2000 U.S. standard population using the vintage year population of the data year. Rates are suppressed when based on <20 deaths.

[b] Deaths are classified using the International Classification of Diseases, Tenth Revision (ICD–10). Drug overdose deaths are identified using underlying cause-of-death codes X40–X44 (unintentional), X60–X64 (suicide), X85 (homicide), and Y10–Y14 (undetermined). Because deaths might involve more than one drug, some deaths are included in more than one category. On death certificates, the specificity of drugs involved with deaths varies over time. In 2016, approximately 15% of drug overdose deaths did not include information on the specific type of drug(s) involved.

[c] Drug overdose deaths, as defined using ICD-10 codes, that involve opium (T40.0), heroin (T40.1), natural and semi-synthetic opioids (T40.2), methadone (T40.3), synthetic opioids other than methadone (T40.4) and other and unspecified narcotics (T40.6).

[d] Drug overdose deaths, as defined, that involve natural and semi-synthetic opioids (T40.2).

[e] Drug overdose deaths, as defined, that involve synthetic opioids other than methadone (T40.4).

[f] Drug overdose deaths, as defined, that involve natural and semi-synthetic opioids (T40.2) and methadone (T40.3).

[g] Drug overdose deaths, as defined, that involve heroin (T40.1).

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MEDICATIONS FOR OPIOID OVERDOSE, WITHDRAWAL, & ADDICTION

Medications for opioid overdose, withdrawal, and addiction are safe, effective and save lives.

The National Institute on Drug Abuse supports research to develop new medicines and delivery systems to treat opioid use disorder and other substance use disorders, as well as other complications of substance use (including withdrawal and overdose), to help people choose treatments that are right for them.

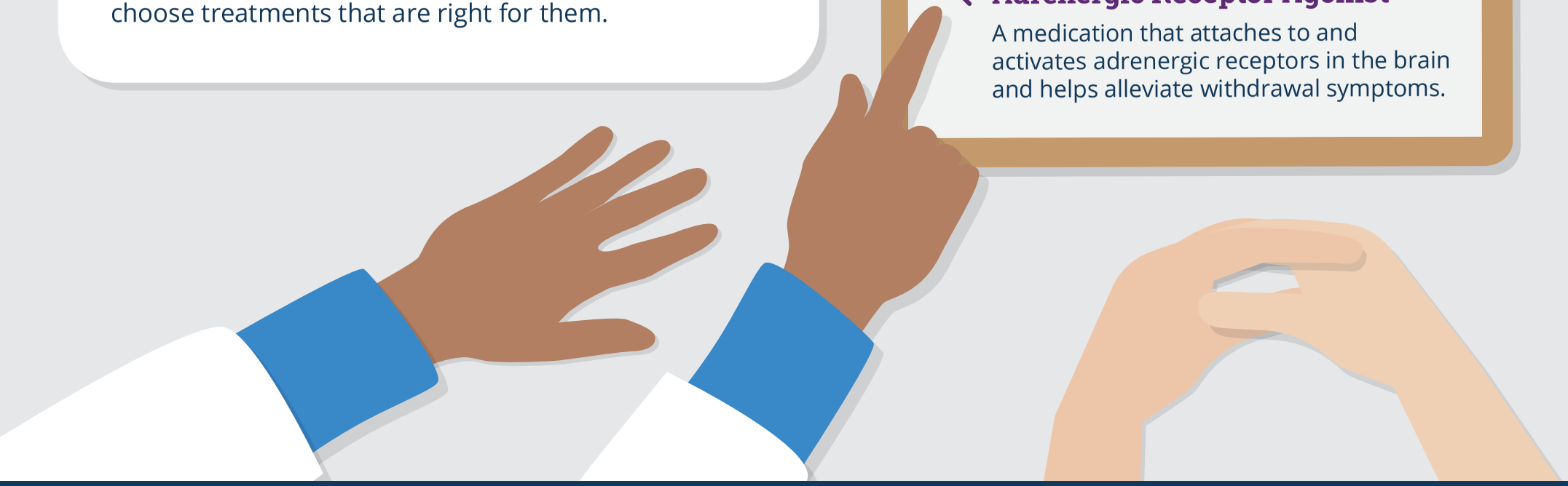
FDA-approved medications for opioid addiction, overdose, and withdrawal work in various ways.

Opioid Receptor Agonist
Medications attach to opioid receptors in the brain to block withdrawal symptoms and cravings.

Opioid Receptor Partial Agonist
Medications attach to and partially activate opioid receptors in the brain to ease withdrawal symptoms and cravings.

Opioid Receptor Antagonist
Medications block activity of opioid receptors in the brain to prevent euphoric effects (the high) of opioids and alcohol and help reduce cravings.

Adrenergic Receptor Agonist
A medication that attaches to and activates adrenergic receptors in the brain and helps alleviate withdrawal symptoms.



REDUCES OPIOID USE AND CRAVINGS

Methadone
Daily liquid or tablet
Dolophine®, Methadose®
Generics available

Naltrexone
Monthly Injection
Vivitrol®

Buprenorphine
Daily tablet
Monthly injection
Sublocade®
Generic tablets available

Buprenorphine/ Naloxone
Daily film under the tongue or tablet
Zubsolv®, Suboxone®
Generics available

TREATS WITHDRAWAL SYMPTOMS

Lofexidine
As-needed tablet
Lucemyra®

REVERSES OVERDOSE

Naloxone
Emergency nasal spray or injection
Kloxxodo®, Narcan®, Zimhi™
Generics available