

8-21-2015

# Developing a Culturally Relevant Version of SBIRT for the Black Community in Hartford, Connecticut

Helena Danielle Green

*University of Connecticut - Storrs*, [helena.green@uconn.edu](mailto:helena.green@uconn.edu)

Follow this and additional works at: <https://opencommons.uconn.edu/dissertations>

---

## Recommended Citation

Green, Helena Danielle, "Developing a Culturally Relevant Version of SBIRT for the Black Community in Hartford, Connecticut" (2015). *Doctoral Dissertations*. 898.

<https://opencommons.uconn.edu/dissertations/898>

Developing a Culturally Relevant Version of SBIRT for the  
Black Community in Hartford, Connecticut

Helena Danielle Green, PhD

University of Connecticut, 2015

This study compares and integrates voices from representative members of three Hartford area stakeholder groups to improve the cultural relevancy of the *Screening, Brief Intervention, and Referral to Treatment* (SBIRT) protocol for the Black community living in the Hartford area, and determines its applicability for other communities in Connecticut with large representations of minority populations. SBIRT is a national demonstration program attempting to provide early identification and intervention for people with substance use disorders. Although SBIRT is currently utilized in community health centers across the state of Connecticut, it is unknown whether the structure and format are supportive of the local implementation environment and of the people who reside there. The current study enlisted representative individuals associated with the Black American community in Hartford, Conn., as participants in three stakeholder groups (community members, community leaders, and service providers) in order to solicit community-based input and feedback regarding the SBIRT protocol. The findings provides further support to the rationale that effective outreach and engagement could be more instrumental to improving treatment outcomes than the actual treatment itself, particularly among communities that are under-resourced. This study also outlines an agenda for incorporating information of this nature into future studies designed to implement and test the use of a culturally adapted version of SBIRT.

Developing a Culturally Relevant Version of SBIRT for the

Black Community in Hartford, Connecticut

by

Helena Danielle Green

B.S., Virginia State University, 2008

M.A., University of Connecticut, 2010

A Dissertation

Submitted in Partial Fulfillment of the Requirements

For the Degree of Doctor of Philosophy at the

University of Connecticut

2015

Copyright by  
Helena Danielle Green

2015

APPROVAL PAGE

Doctor of Philosophy Dissertation

Developing a Culturally Relevant Version of SBIRT for the  
Black Community in Hartford, Connecticut

by

Helena Danielle Green

B.S., Virginia State University, 2008

M.A., University of Connecticut, 2010

Major Advisor

---

Sandra Rigazio-DiGilio, Ph.D.

Associate Advisor

---

Edna Brown, Ph.D

Associate Advisor

---

Idethia S. Harvey, MPH, DrPH.

Associate Advisor

---

Thomas Babor, Ph.D., MPH

University of Connecticut  
2015

## Acknowledgments

I would like to thank all the wonderful individuals who have supported and encouraged me throughout my academic career. My family, committee members, and friends have provided me with the support I needed to not only complete my dissertation, but to also embrace each challenge as I approached each milestone in my doctoral program.

I sincerely would like to thank each member of my committee for their committed time and input. They helped me to see the feasible of my research design, but also pushed me to expand beyond my initial vision. My advisor, Dr. Sandra Rigazio-DiGilio, provided me with guidance and feedback at every stage of my dissertation, and I truly believe that her attention to detail has helped me to reach my full potential.

My family has been a strong source of support throughout my entire academic career, but especially throughout my graduate years. Even from a distance, my family has been my main sources of emotional support. I would like to especially thank my sister, LaShell Green, for helping me on a daily basis to remain motivated. Thank you for providing me with the necessary emotional support and encouragement I needed to complete my dissertation.

This research is community-based, and I truly feel that I became a part of a community as my dissertation developed. I would like to thank each individual that I met within the community of Hartford, Connecticut. Their passion for improving the community kept me motivated, and their willingness to embrace this research study, and contribute to the research process, was very inspiring.

I also strongly believe that my faith is so instrumental, and it shapes me more and more with each year. I want to thank God for giving me the strenght to pursue my doctoral degree to the end. I truly believe in the power of prayer and the influence it has had over my life. God

was with me throughout every challenge and success I experienced as a graduate student, and I could not have achieved so much without Him.

## Dedication

This dissertation is dedicated to my parents, Cynthia and Wendell Green, my sister LaShell,

and

everyone in the Hartford community.



## Table of Contents

Acknowledgements.....	v
Dedication.....	vii
List of Tables.....	ix
Chapter 1: Introduction.....	1
Statement of the Problem.....	9
Purpose of the Study.....	9
Chapter 2: Review of the Literature.....	11
Theoretical Frameworks.....	14
Research Objectives.....	35
Research Questions.....	36
Chapter 3: Methodology.....	38
Research Design.....	39
Participants.....	41
Measures.....	47
Data Collection.....	55
Qualitative Analytic Procedures.....	62
Quantitative Analytic Procedures.....	75
Chapter 4: Results.....	79
Chapter 5: Discussion.....	96
Implications.....	109
Limitations.....	113
Significance.....	114
Future Research.....	115
References.....	117
Tables.....	142
Appendices.....	154

## List of Tables

Table 1: Number of Stakeholder Group Member by Data Collection Method

Table 2: Codebook

Table 3: Phase 1: Identification of Initial Themes

Table 4: Phase 2: Themes supported by low frequency coded text segments

Table 5: Phase 3: One-sentence member check statements

Table 6: Percentages by Stakeholder Groups for Demographic Data

## **Chapter 1: Introduction**

According to the U.S. Department of Health and Human Services (DHHS; 2001), racial and ethnic minority populations in the United States have experienced significant disparities, compared to the majority population, particularly regarding the accessibility, utilization, and quality of physical and mental healthcare services. As the relative size of the minority population in the U.S. continues to increase, healthcare professionals have been called upon to provide relevant and effective services to meet the increasing demand (Substance Abuse and Mental Health Services Administration [SAMHSA], 2011).

Minorities experience more barriers to care, compared to Whites, and are further disadvantaged by their unmet physical and mental healthcare needs (DHHS, 2001). In addition, racial and ethnic minorities are often over-represented among at-risk populations such as the low-income, homeless, and incarcerated. Recognizing these disparities, clinical researchers, scholars, and practitioners have aimed to reduce physical and mental healthcare disparities by advocating for the development of culturally adapted interventions, particularly those interventions with deep structural adaptations that target specific groups by incorporating their beliefs, values, and ideas into treatment (Hwang, 2011).

Within the context of substance-abuse research and service delivery, disparities related to cultural competency, effectiveness, retention, and treatment outcomes for racial and ethnic minorities have remained under-addressed (SAMHSA, 2010). In fact, the research supporting the effectiveness of substance-abuse interventions rarely includes racial and ethnic minorities (Burlew et al., 2011a; Burlew et al., 2011b; La Roche & Christopher, 2008) and lacks comparative investigations that differentiate outcomes across ethnic subgroups (DHHS, 2001; Marsh, Cao, Guerreroa, & Shin, 2009). Further, the literature on substance-abuse research

involving racial and ethnic minorities is limited (Montgomery, Burlew, Kosinski, & Forcehimes, 2011), even though it is well known that the inclusion of racial and ethnic minorities in clinical trials is essential to improve treatment efficacy for all citizens (Carroll et al., 2007). Specific to Black Americans, the substance-abuse literature primarily focuses on barriers to recruitment and retention in treatment, rather than on other components of treatment such as identifying sociocultural influences and appropriate methods of data collection (Mason, 2005; Montgomery et al., 2011; Yancey, Ortega, & Kumanyika, 2006). All of these documented trends indicate racial and ethnic minorities are underserved as substance-abuse treatment recipients.

The evidence of inequalities regarding access to substance-abuse treatment, and to healthcare in general, have been well-documented. Despite statistics indicating White Americans are more likely to abuse substances than are minorities, minorities have a higher mortality rate from abuse-related conditions (e.g., cirrhosis; DHHS, 2008). A partial contributor to this trend is the accessibility to high-quality services that specialize in treating substance abuse. For example, Lo and Cheng (2011) found that White Americans are more likely than all ethnic minorities except Hispanics to receive treatment for substance abuse at specialized addiction treatment facilities and less likely to receive treatment from nonspecialized facilities.

The lack of access to quality physical and mental healthcare services often results in further disparities in health and economic productivity. In general, individuals in distressed communities—defined as communities experiencing multiple crises related to existing disparities in the social environment (Windsor & Murugan, 2012)—exhibit higher risk for physical and mental health disorders when examined in the context of social and environmental determinants of physical and mental health (World Health Organization, 2012). Given that professionals are

often unprepared to meet the multifaceted needs of these populations, health conditions and mental health and substance-abuse disorders often escalate in severity (Roberts et al., 2008).

### **Can Evidence-Based Interventions (EBIs) Help to Reduce Disparities?**

Over the past few decades, mental health researchers and clinical practitioners have gained recognition for using scientific principles to develop evidence-based interventions (EBIs) for treating specific problems. As a result, effective treatment procedures have been incorporated into manualized treatment protocols (i.e, manuals containing detailed instructions on how to conduct a particular type of therapy) for universal dissemination (Castro, Barrera, & Steiker, 2010). As manualized treatment gains increasing acceptance and support from funding agencies, the dissemination process is challenged by the growing need to adapt manualized approaches to the unique needs of the nation's changing population. Unfortunately, research designed to test the effectiveness of EBIs with underrepresented populations, particularly those living within distressed communities, is not adequate to address the need to provide culturally relevant services for the diversifying U.S. population.

Further, research supported by randomized control trials (RCTs) and efficacy studies examining racial and ethnic minorities is scarce. Although evidence-based research has been recognized as an essential mechanism for the further development of effective physical and mental healthcare services, the significance of outcomes achieved from scientific research will not address the ever-increasing disparities in physical and mental healthcare delivery if the specific service needs of racial and ethnic minorities remain unreported (Bernal & Scharrón-Del-Río, 2001).

For over two decades, national calls have been issued for clinical research and training institutions to develop research-based clinical protocols supporting cultural adaptations for racial

and ethnic minorities (Hall, 2001) and to disseminate these protocols across communities (SAMHSA, 2011). These cultural adaptations need to incorporate input from underserved populations living within distressed communities to ensure that their needs are incorporated into the assessment and treatment process. National agencies have found that such cultural adaptations are necessary to ultimately increase access and quality of care and improve physical and mental health outcomes for underrepresented racial and ethnic minority populations living in underserved and distressed communities (U.S. Department of Health and Human Services Office of Minority Health, 2001).

Compelling evidence from available literature shows that cultural adaptations lead to improved outcomes for manualized intervention protocols (e.g., Calsyn et al., 2012). The President's New Freedom Commission on Mental Health (2003) acknowledged that, although practitioners are challenged with the task of adapting standard services to meet the needs of an increasingly diverse clientele, there remains a lack of culturally responsive practice guidelines to convert knowledge and awareness into appropriate models of service delivery. Practitioners will often attempt to make their own treatment modifications when they encounter culturally diverse clientele (Casalino et al., 2007; Hwang, 2006). However, these modifications tend to be based on individual preconceptions (Gone, 2009), rather than on a systematic framework or model that presents all the layers of a concept (i.e., culturally responsive practice) and displays all the different ways to explore this concept (Hwang, 2006). Additionally, these modifications often fail to account for the historical and societal influences that further reinforce existing barriers (Hwang, 2006). Many clinicians opt to implement an "as-is" approach to treatment, rather than rely on cultural adaptations, partly because they believe adaptations are low in efficacy for treatment acceptability and outcomes (Hwang, 2011). Generalized modifications based on

assumptions about a community may not counteract the higher specific needs and severity of conditions that could be attributed to sociocultural factors, as well as to the poorer quality care available in these communities to treat these conditions (DHHS, 2006; Steinberg, Sullivan, & Loew, 1998).

Many community healthcare practitioners remain divided: They perceive the EBIs as useful tools, even though these protocols have not been validated with populations that match the populations the practitioners serve or the communities they work within (Hall, 2001; Nelson, Steele, & Mize, 2006). Those researchers who recognize this problem and are committed to follow methods for developing cultural adaptations often tend to be guided by theory and recommendations from other researchers and practitioners, rather than by feedback or input from program participants and the community at large (Chen, Reid, Parker, & Pillemer, 2012). The notion that psychotherapy modifications are ineffective if alterations are made without input and feedback from the clients and community is still somewhat new (Hall, 2001).

Gearing et al. (2012), for example, performed a systematic review of 22 studies that identified the need for cultural- and community-adapted mental health services among a non-Westernized population. Nine studies highlighted the community and systemic barriers associated with accessibility and availability of services (Gearing et al., 2012). The reviewers found that adapting service delivery to the local context was effective in overcoming these barriers when (a) local stakeholders were involved in the adaptation process, and (b) key community leaders were instrumental in increasing individual acceptance of mental health services (Gearing et al., 2012). Gearing et al.'s findings indicate that community involvement and additional input of trusted voices from within the community can counteract the stigma that often impedes underrepresented minorities from seeking treatment.

Although incorporating participant feedback is strongly recommended as an essential component in culturally adapting manualized approaches, this recommendation is often underutilized or considered a low priority for program and protocol changes (Chen et al., 2012). To mitigate this perception, Kumpfer, Pinyuchon, Teixeira de Melo, and Whiteside (2008) described a systematic process for developing cultural adaptations in which program recipients and staff participated in focus groups to review program materials and examine the strengths and weakness of the program. Although this approach focused on tailoring the intervention to a particular target group and collaborating through partnerships with program participants, this method is limited if feedback is solicited only from program participants, because it is likely that the feedback is not representative of the community at large (Chen et al., 2012).

Community-based participatory research (CBPR) is an emerging method of clinical research that involves collaborating with patients and community members in each stage of the research (Israel, Schulz, Parker, & Becker, 1998). Emerging from epidemiologic research, CBPR uses various clinical approaches to incorporate the voices of the community as one way to understand more clearly how to treat an issue within that community (Westfall, Van Vorst, Main, & Herbert, 2006). Participatory research evolved from a movement to promote changes in the nation's social and economic conditions by including marginalized groups in the production and disbursement of knowledge (Israel et al., 2006). In traditional research, individuals and communities have historically been viewed as passive subjects, an approach that has significantly contributed to communities'—particularly Black communities'—ongoing distrust of research and the tendency to avoid participation in clinical trials (Hatch, Moss, Saran, & Presley-Cantrell, 1993; Israel et al., 2001). More recently, CBPR researchers have attempted to improve research protocols for specific communities by drawing from the expertise provided



directly by community members (Macaulay et al., 1999). With the combination of community insight and use of empirical approaches, funding agencies and researchers have begun to recognize CBPR as a promising approach to reducing disparities and improving health outcomes (Wallerstein & Duran, 2006).

In the current study, the student researcher used CBPR approaches to incorporate representative voices of three stakeholder groups (community members, community leaders, and service providers) in the local Black community in Hartford, Connecticut, to inform cultural adaptations made to a treatment protocol used for almost a decade among members of this community. According to Hall (2001), cultural adaptations to a treatment protocol need to incorporate input and feedback from the clients in the target community. If the intention is to create a culturally adapted substance-abuse intervention that can be utilized in a target community's healthcare center, the intervention should incorporate individual and community strengths to enhance systematic efforts to alleviate disparities (Williams & Mohammed, 2013).

The next step to decreasing the gap in disparities for underrepresented minority populations living in distressed communities is to increase trust for mental health services within and among all members of each community. Black Americans have experienced a history of exploitation with regard to research and quality of care; thus, it is important to include their input at all levels, from research to treatment (Levine et al., 1994). One such example of a program based on an initiative to improve community health is called *Screening, Brief Intervention, and Referral to Treatment* (SBIRT; (<http://www.ct.gov/dmhas/lib/dmhas/publications/SBIRT-BriefOverview.pdf>)). SBIRT is an assessment and intervention program consisting of evidence-based practices and designed for medical and community settings. The SBIRT assessment is used to identify and provide early intervention for at-risk substance use and referral to

specialized treatment for high-risk substance use. SBIRT is intended for people who have different levels of alcohol, tobacco and drug use, ranging from occasional recreational users to chronic drug addicts. Although there are distinct differences between risky substance use and addiction, the SBIRT screening focuses on the risk factors associated with the use; making it applicable for the larger percentage of the population that can be identified by the risk factors rather than by the criteria for dependence (Babor, et al., 2007). SBIRT has been widely disseminated across 30 sites in the state of Connecticut, and SBIRT program evaluators have acknowledged that SBIRT can be adapted to ensure the functionality of the protocol in specific real-world settings (McRee, n.d).

Although research supports the efficacy of SBIRT for use in medical settings, particularly for targeting at-risk tobacco and alcohol use, a gap still exists. Practicing medical professionals have been slow to adopt technology from SBIRT clinical trials (McRee, n.d.; Vendetti, Gmyrek, Damon, Singh, McRee, & Del Boca, 2014). Internationally, SBIRT has been evaluated in numerous countries (both high and low income), and researchers have found that for a different culture and language, SBIRT translates effectively, and significantly among countries that have highly accessible and comprehensive health care systems (Cherpitel, Bernstein, Bernstein, Moskalewicz, & Swiatkiewicz, 2009; Cherpitel, Moskalewicz, Swiatkiewicz, Ye, & Bond, 2009). Although SBIRT has been studied among under-resourced, rural communities in the U.S. (Gonzales, 2012), additional research is needed to determine how SBIRT translates among under-represented ethnic minorities within the U.S., who may differ in beliefs about substance use, to further distinguish the adaptability, feasibility, uptake, and outcomes among these subgroup populations (Cherpitel et al., 2009).

For a variety of specified populations, EBI researchers are now beginning to require explicit statements from target population members indicating how well each intervention fits. Keeping in mind the necessity of applying evidence-based criteria to measure the implementation quality of preventive interventions, these statements should highlight limitations, change mechanisms, and other constructs specific to these communities (Steiker et al., 2008). These statements also provide evidence challenging the “fidelity-only” perspective commonly accepted by EBT researchers who suggest that empirically supported intervention should not be altered or adapted. In summary, the statements show that community involvement is a necessary element in the process of developing culturally adaptive EBTs.

### **Statement of the Problem**

Healthcare, specifically substance abuse care, generally has not been appropriately tailored to specific populations; thus, at-risk populations remain underserved (DHHS, 2008; SAMHSA, 2010). The problem is that, although there is a general influx of researchers examining the feasibility for implementing cultural adaptations for target populations (Kumpfer et al., 2008), when cultural adaptations through community-based interventions occur, these adaptations often do not include community members’ voices (Chen et al., 2012). While SBIRT procedures have cross-cultural applicability, the viewpoints and needs of patients themselves have not typically been included in this formative research.

### **Purpose of the Study**

The current study contributes knowledge toward improving access and quality of care by exclusively examining the needs of Black Americans (defined as Americans of African ancestry) living in the Hartford area of Connecticut. The findings further contribute to the literature on substance-abuse research aimed at reducing disparities for ethnic and racial minority populations

living in distressed and underserved communities. Guided by CBPR (Minkler & Wallerstein, 2010; Viswanathan et al., 2004), the aim of this study was to capture the voices of three stakeholder groups (community members, community leaders, and service providers) within one local Black community (consisting of multiple ethnic groups of African ancestry) to inform the development of a culturally adapted version of SBIRT.

According to SAMHSA's National Registry of Effective Prevention Programs (NREPP) (<http://www.nrepp.samhsa.gov/Index.aspx>), no population- or culture-specific adaptations of this evidence-based driven program have been developed. Although SBIRT has been examined in a number of studies involving innovative approaches to adapting SBIRT training curricula for health care professionals and trainees (Gordon & Alford, 2012) and among select subgroups for cultural translations (Korcha, Cherpitel, Moskalewicz, Swiatkiewicz, Bond, & Ye, 2012; Liu & Satterfield, 2015), a need exists for research focused on the cultural and contextual processes associated with administering SBIRT in primary care clinics (Satre et al., 2012). The current study is significant because it was the first study designed to collect information from these three stakeholder groups to inform the development of a culturally relevant version of SBIRT for use in one distressed Connecticut community. Additionally, these findings provide a method for incorporating information of this nature into modifications specific to other underrepresented groups and other distressed communities. Finally, the study adds to the growing body of literature by scholars advocating for research to address changes in the standard of care for underrepresented minority groups living in distressed communities.

## **Chapter 2: Review of the Literature**

This chapter presents a review of the relevant literature . The first section is a description of the current psychiatric definitions for substance use disorder, and the ways in which it coincides with SBIRT and how it informs the theoretical framework. The second section is a detailed account of the study's four theoretical frameworks. Specific emphasis is given to the ways in which these frameworks address the disconnect between healthcare and community systems, and how the voices within distressed communities can be incorporated to advance the development of a treatment protocol that may help improve treatment outcomes.

This discussion is followed by a comprehensive overview of the health and health care disparities related to race and ethnicity. Emphasis is given to the ways in which existing barriers commonly experienced by racial and ethnic minorities contribute to treatment disparities. The third section focuses on the concerns commonly identified in literature that address the effectiveness of evidence-based treatments for under-represented groups and distressed communities. Additionally, the student researcher provides an overview of the ways in which some of these concerns manifest in the form of implementation barriers specific to SBIRT.

In the fourth section, the student researcher presents a review of available research that supports the need for cultural adaptations in currently established assessment and treatment protocols widely used in the United States. Additionally, this section describes early programs of research supporting the need to examine aspects of race and culture in clinical research, as well as the rationale for adapting certain protocols. Finally, the student researcher explains some of the broader programs of research taking form to address treatment barriers through community-based approaches and the ways in which these efforts have informed the design and objectives of the current study. Ultimately, the literature review shows how the extant literature

supports the need for this study. Finally, the student researcher suggests ways in which the findings might contribute to the development of a cultural and community adaptation of SBIRT for the local Black community in Hartford, Connecticut, as well as in similar Black communities in other cities.

### **Defining Substance Use**

With the recent publication of the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), the criteria that previously defined substance use, abuse, and dependence were changed to reflect the ways in which many clinicians observe and understand the etiology and progression of addiction (Grohol, 2013). Some of the changes readily align with the validated criteria (e.g., for validity, reliability, and feasibility) and were cross-culturally examined with each version of the Alcohol, Smoking, and Substance Involvement Screening Test (ASSIST), the screening instrument used in many versions of SBIRT (WHO, 2010a).

For instance, tobacco use is now considered a disorder that follows the same criteria as other substance use disorders (Grohol, 2013). The ASSIST has included tobacco use as a substance alongside the alcohol and drug assessment items since the ASSIST V1.0 was developed in 1997 (WHO, 2010a); thus, an individual's level of risk for tobacco use is determined through the same questions used to identify risk for alcohol and other drugs. Additionally, the DSM-5 now provides criteria for classifying the severity of substance use (e.g., mild, moderate, or severe), each level of which is defined by the number of criteria met by an individual at risk for a substance use disorder (Grohol, 2013). Similarly, the ASSIST uses a previously established scoring system in which each assessment question contributes a number for a total score that determines an individual's level of risk (low, moderate, or high) for each

substance (WHO, 2010a). These two new additions to the DSM-5 have altered the way in which substance use is defined across professions. However, (more relevant to the current study), the additions provide a perspective congruent with the ASSIST, which is an assessment measure readily used in community healthcare settings and which contributes to the overall experiences of each member of each stakeholder group.

Although the focus of the current study was the Black community living in the Hartford area, the aim of the study was to determine the applicability of the findings to other communities with large representations of minority populations. Thus, it was important to consider the cultural factors that influence the ways in which substance use is classified by the diagnostic categories (e.g., intoxication, withdrawal). One existing perspective is that the diagnosis for substance use disorder is universally applicable to all populations; however, many believe in an alternative perspective that diagnosis is culturally influenced and carries different meanings for various populations (e.g., Rehm et al., 2013; Room, 2006).

For instance, in a study of the cross-cultural applicability for substance-use disorder involving the perceptions of local professional and community members from nine sites in different cultures, the researchers found cross-cultural differences with regard to the interpretation of instrument items, the specifications of the criteria for substance-use disorder, and diagnoses (Room, Janca, Bennett, Schmidt, & Sartorius, 1996; Room, 2006). Several other factors, such as diagnosis disparities (e.g., the over-stigmatization of minority patients) and discrepancies in how “normal” is distinguished from dysfunctional behavioral and psychological manifestations indicate a need for further comparative analyses incorporating the perspectives of different stakeholder groups for specific minority populations (Escobar & Vega, 2006).

## **Theoretical Frameworks**

Four theoretical frameworks informed the current study: (a) social constructionism, (b) co-constructive / developmental, (c) biopsychosocial, and (d) ecological and ecosystemic / life-span. Each framework was shaped in part by a common set of core assumptions corresponding with CBPR approaches to clinical research. As such, these frameworks served to guide the methods I used to collect the voices of representative members from the three stakeholder groups as well as the ways each stakeholder group's position in the local community was accounted for as part of the qualitative data analysis.

### **Social Constructionism**

Social constructionism developed from social constructivism, which emerged from the radical constructivism movement within the field of marriage and family therapy (Hardy, 1993). Although social constructivism is used to describe reality as it exists within the individual, social constructionism theorists posit that reality (a) exists in the individual and (b) is constructed between the individual and the social context (Berger & Luckmann, 1966). The world outside the individual is constructed through acts of interpretive negotiations occurring between individuals (Gergen, 1999). In addition, the individual and his or her relationships determine truth (Gergen, 1999). Thus, truth is constructed, interpreted, and negotiated by interacting individuals, which means that multiple and accepted truths are culturally and contextually created.

The tenets of social constructionism reflect the social processes that describe dominant notions of truth. The process most pertinent to the current study is called reification. Reification is a process by which cultures and institutions are constructed into categories based on taken-for-granted expectations of society, which can promote truth within and about a culture in



progressive and negative ways (Best, 1995; Freedman & Combs, 1996). The prevailing dominant truths tend to discount all other ways of knowing and understanding, which further marginalizes the cultures of under-represented minority groups (Berger & Luckmann, 1966).

For members of the Black community and other minority populations, the reality they construct of their culture can remain central to their core values and beliefs within a Euro-American dominant society when they are able to consider Euro-American beliefs as just one, separately constructed perspective among many others (Jenkins, 2000). When narratives and ideas reach a level of acceptance among a group of people, these narratives and ideas are considered truths. Despite the strength of dominant narratives, which are often instilled by wider structural systems, smaller alternative ideas tend to prevail among minority populations regardless of the existence of these dominant narratives (Hair & O'Donoghue, 2009). For instance, rather than accepting the prevailing viewpoint that American society generally holds about Black Americans' affiliation with the substance-use problems in society, a community with shared perspectives and realities would construct a viewpoint different from the one generally accepted by mainstream society. These realities are important (Gonzalez, Biever, & Gardner, 1994); these ideas (developing out of social constructionism) further justify the rationale for incorporating the voices of representative members from the three stakeholder groups at each step of the research process.

### **Co-constructive / Developmental Framework**

The well-studied co-constructive/developmental framework (Rigazio-DiGilio, 2000, 2001, 2012; Rigazio-DiGilio, Ivey, Kunkler-Peck, & Grady, 2005; Rigazio-DiGilio & Kang, 2015) provides one way to understand the recursive and interdependent factors influencing how individuals, families, and wider systems (e.g., community service agencies, healthcare sectors)

make sense of and participate with one another. These factors affect which participants have more power and influence at any given time. Anchored in the tenets of developmental counseling theory (DCT; Ivey, 1986, 1991, 2000) and systemic cognitive-developmental theory (SCDT; Rigazio-DiGilio, 2000, 2014), this framework provides ways to examine how these interactive processes contribute to definitions of distress and disorder and to the services that have been legitimized to treat these problems. The emphasis on power and influence as factors that shape client–practitioner exchanges is particularly relevant when examining interactions between underrepresented minorities and healthcare systems. In addition, the emphasis on expanding assessment and treatment protocols to include more attention to wider sociocultural and sociopolitical issues is relevant when considering ways to effectively adapt dominant health care protocols to the populations and communities within which these are used. For example, and specific to this study, although substance use and abuse assessment and treatment typically focus on the individual with the disorder, this framework contains guidelines for understanding substance use and abuse as part of a broader developmental process that accounts for influential factors, such as a family’s biology, social history, and cultural and community contexts.

This framework shows how each individual is defined by and develops within the context of his or her family and community systems. The self is defined by the relationships and interactions occurring within the wider social context. Thus, community agencies and healthcare systems are most influential when acting as adaptive systems. According to the co-constructive-developmental framework, adaptive systems utilize available resources in ways that account for the needs of other members, subsystems, and the family unit within wider contexts. Nonadaptive systems are less able to effect change among persons from underrepresented communities

because the resources available are limited to language and constructs that reflect dominant group orientations.

In accordance with the co-constructive-developmental framework, treatment should be a collaborative effort among all involved parties. In the addictions field, some researchers refer to the dominant and resistant narratives as agency (i.e., the awareness of one's own ability to control certain truths within one's environment). Addiction is both an internal concern (addressed in the biopsychosocial model discussion) and an external concern, historically and culturally constructed; addiction differs in interpretation depending on the prevailing viewpoint. Essentially, individuals who use or abuse substances make meaning of their use; clinicians can improve the effectiveness of treatment by understanding these individuals' sense of agency and beliefs about the social contexts they attach to their substance use (McCullough & Anderson, 2013).

### **Biopsychosocial Model**

The biopsychosocial model emerged to provide context for the biomedical perspective, involving a physiological framework and genetic disposition used to explain the etiology of illness; thus, addiction is viewed as a physical disease (Maisto, Galizio, & Connors, 2008). Supporters of the biopsychosocial model believe addiction is a multifactorial disorder based on three contexts: psychological, behavioral, and social forces (i.e., the developmental, social, and cultural contexts; Hatala, 2012); this perspective helps to explain possible predictors of initiation, the spiral into addiction, and the deterrents for cessation (Hatala, 2012). The additional consideration for the cultural component allows researchers to consider a spectrum of factors, ranging from an individual's particular situation and the local environment to societal influences. Thus, drug, alcohol, and tobacco use in any context—but especially within a community of

underrepresented minorities—is understood as a holistic interaction of the biological, psychological, and social domains (each of which is informed by the culture). This conceptualization provides a deeper understanding for the problems generated from substance use, as well as for what needs to be addressed in interventions (Hatala, 2012; Leventhal, Weinman, Leventhal, & Phillips, 2008).

### **Ecological and Ecosystemic / Life-Span Perspectives**

**Ecological perspective.** The current study drew from Bronfenbrenner's ecological perspective to explain how the proximal processes (i.e., reoccurring interactions between an individual and his or her environment) can be just as or more impactful than the environment itself (Bronfenbrenner, 1994). Proponents of this ecological model show that individual, environment, and societal developments are affected by the power, form, and direction of these proximal processes. Understanding the interaction between these systems is particularly relevant to studies of this nature because these interactions help to determine the sources of distress and resources within a community (Roysircar & Pignatiello, 2011).

**Ecosystemic/life-span perspectives.** Theories grounded in ecosystemic life-span perspectives indicate that the transactions among individuals, families, and wider systems are critical influences on their worldview development (i.e., the ways in which individuals make sense of the world around them; Axelson, 1993; Ivey, 1986, 2000; Vygotsky, 1986). An ecosystemic life-span perspective provides a framework for examining the ways in which prevailing, dominant cultural norms (often voiced and managed through professional, state, institutional, and other systems within geopolitical communities) contribute to (a) defining distress and disorder, (b) identifying authorized service providers and methods of treatment, and (c) evaluating treatment outcomes (Rigazio-DiGilio & Kang, in press). The current study drew

from ecosystemic life-span perspectives in order to make sense of the SBIRT protocol as it is currently designed and implemented. The aim was to identify cultural and contextual factors particularly relevant to the Hartford, Connecticut, Black community and similar Black communities in other cities. Identifying these factors may assist the development of more suitable adaptations to the instrument and protocol.

### **Integrating Theoretical Frameworks**

Taken together, these four theoretical frameworks situate the persistent quality gap between underrepresented communities and healthcare systems within a broader, contextual, and interactive territory. This broadened perspective indicates a multiplicity of intersecting factors that contribute to substantial healthcare inequities by race and ethnicity (Smedley, Stith, & Nelson, 2003) and to health disparities and differences in treatment outcomes for Black Americans as compared to other minorities, as consistently reported in over two decades of local and national research (Carpenter-Song, Whitley, Lawson, Quimby, & Drake, 2011). Social constructionism is used to explain the ways dominant and prevailing truths tend to marginalize the truths that develop out of underrepresented groups, which elucidates why voices within these marginalized communities often remain unheard. The co-constructive developmental framework is used to emphasize the importance of considering the larger sociocultural context when trying to address problems, such as substance use and abuse, which are often considered and explored within the context of the individual. The biopsychosocial model is included to emphasize the intersecting areas that contribute to drug, alcohol, and tobacco use and to illuminate the avenues that could inhibit underresourced minorities' access to quality care. The ecological and ecosystemic/life-span perspectives are used to describe how interactions between healthcare practitioners and individuals in a community play a critical role in how services are received by

the community, reinforcing the need to examine the relational components of the SBIRT protocol. With these perspectives in mind, the current study provides a rationale for incorporating the voices of underrepresented community members as an initial step in the process of culturally adapting SBIRT to this community. This study used the CBPR framework to guide this initial step and further developed it as a method that can be replicated for future adaptations best tailored to other underrepresented populations in other geopolitical communities.

### **Health and Healthcare Disparities**

**Health disparities.** Although the overall health status of the nation as a whole continues to improve, this trend does not apply to racial and ethnic minorities, and particularly for minority populations living within distressed communities (DHHS, 2001; Smedley et al., 2003). For example, compared to White Americans, racial and ethnic minorities are disproportionately disadvantaged by mental health disorders (DHHS, 2001). Further, although these health disparities are widely acknowledged among federal and state intuitions (e.g., SAMHSA, 2011), physical and mental healthcare professionals have done little to advance understanding of the conditions perpetuating these disparities (Miller, Simon, & Maleque, 2009). For instance, it is generally acknowledged that the existing gap in health outcomes between White Americans and underrepresented minorities is most likely the result of a complex combination of environmental, biological, and behavioral factors (DHHS, 2011). Despite knowledge of these factors, few researchers have attempted to explain how this complex array of intersecting environmental and behavioral variables continues to perpetuate physical and mental healthcare disparities between racial and ethnic minorities and White Americans (Gee & Payne-Sturges, 2004).

Emerging research shows that a deeper understanding of these multilevel intersecting variables would help guide clinicians and researchers to either select the point of intervention or create carefully targeted interventions (Gehlert et al., 2008); one such example, is a model developed for reducing breast cancer disparities, which calls for identifying each link in a downward chain of causal factors from the sociocultural to the genetic level. This same concept is applicable for substance-abuse researchers, whose observations of social phenomena cannot be explained by any one factor, suggesting that individual characteristics (e.g., genetic and personality), interpersonal characteristics (e.g., use among family and friends), and contextual factors (e.g., availability of substances and community socioeconomics) should each be considered in addition to exploring how the variables interact with each other (Wallace, 1999). These factors, which tend to vary in impact, are more often associated with the level of access to appropriate healthcare and the availability of interventions (Freimuth & Quinn, 2004). This is particularly relevant to this study, given that substance use and abuse are categorized as one of the health disparities most significantly affected by environmental stress (American Psychological Association, 2012).

**Healthcare disparities.** Factors widely considered to perpetuate healthcare disparities include the long-standing and ever-increasing lack of access of racial and ethnic minority populations to quality, relevant, and culturally informed care (Agency for Healthcare Research and Quality [AHRQ], 2009). This lack of availability is even more prevalent for underrepresented minority populations living in distressed communities (AHRQ, 2013). For example, according to the 2012 National Healthcare Disparities Report, Black Americans receive (a) poorer quality of care than White Americans receive on 40% of the quality-of-care measures and (b) poorer access to care than White Americans receive on one third of the access-to-care

measures. Further, fewer than 20% of the disparities for Black Americans show any evidence of narrowing, although the data showed contrasts by age, gender, insurance status, and geographic location (AHRQ, 2013).

The long-standing conditions documented in reports such as the National Healthcare Disparities Report have provided explanations for treatment disparities (e.g., misdiagnoses, inadequate or inappropriate treatment, disproportionately poorer physical and mental health outcomes) for racial and ethnic minorities, compared to White Americans (DHHS, 2001). For example, past research has shown that African Americans were more likely to be misdiagnosed for mental disorders (e.g., schizophrenia) than were Whites in hospital settings (Neighbors et al., 1999). The outlook for racial and ethnic minorities in substance-abuse treatment is similar to that found in other health-related services, given the following trends: (a) higher consequences (e.g., higher rates of alcohol attributed violence and diseases) from drug and alcohol use for racial and ethnic minorities than for majority populations (Mulia, Ye, Greenfield, & Zemore, 2009); and (b) a disproportionate number of prosecutions for drug-related charges for racial and ethnic minorities, particularly Black males (Hartney & Vuong, 2009). These trends actually perpetuate health disparities because misdiagnoses and structural biases tend to deprive racial and ethnic minorities of access to resources and appropriate healthcare services (Iguchi, Bell, Ramchand, & Fain, 2005).

Therefore, although it is generally acknowledged that healthcare disparities continue to exist between minority and majority populations across socioeconomic levels and between distressed and underresourced communities (i.e., groups with insufficient resources), few policymakers have called for a consideration of cultural and contextual variables as foreground factors in any assessment and treatment protocols or practices (Hall, 2001). Considering this



current state of affairs, it is essential for health and mental health professionals to advance their understanding of the complex combination of environmental, biological, and behavioral factors necessary to design and evaluate culturally and contextually informed treatment protocols and practices (Wallace, 1999).

### **Effectiveness Concerns for Evidence-Based Treatments (EBTs)**

National reports have provided consistent evidence of the ongoing health and healthcare inequities in the United States (e.g., James, Thomas, Lillie-Blanton, & Garfield, 2007; Miranda, McGuire, Williams, & Wang, 2008). These reports have led to long-standing national calls for changes that promote (a) the inclusion of underrepresented groups in randomized controlled trials (RCTs) and (b) the re-evaluation of evidence-based practices for racial and ethnic minorities. The calls for change were prompted by reports that racial and ethnic minorities were excluded from most of the instrumental phases of clinical trials and developing interventions; as a result, clinical researchers have a limited understanding of how ethnicity and culture contribute to the effectiveness of treatment outcomes (Carroll et al., 2007).

Although attempts have been made to include racial and ethnic subgroups in controlled clinical trials across medical, mental health, and substance-abuse fields (e.g., Calsyn et al., 2012), little evidence exists to explain why using standard interventions in the treatment of racial and ethnic minorities, particularly African Americans, results in poorer outcomes than those seen for Whites treated with the same standard interventions (Fouad, 2009; Shaya, Gbarayor, Yang, Agyeman-Duah, & Saunders, 2007). Without the empirical data to show how interventions vary for diverse populations, it is difficult to make cultural adaptations to these interventions (Hernandez, 2010; Lau, 2006).

In response to the national calls for improved EBTs, federal agencies have created initiatives to improve health and promote prevention among the entire U.S. population, including among the groups that disproportionately experience disparities. These initiatives drive and support efforts to apply recent scientific evidence to create new interventions and build upon existing interventions and strategies to meet the unmet needs of racial and ethnic minorities (National Prevention Council, 2011). Despite growing awareness of the challenges resulting from a lack of standards supporting data collection among distressed communities, as well as the ongoing inadequacy of existing data on race and ethnicity, these federal agencies acknowledge such challenges as only one of myriad factors leading to health disparities and healthcare inequities (AHRQ, 2013).

**Limitations of universal scales.** These government initiatives represent initial efforts to counteract the existing argument that universal scales are applicable across cultures (Cuijpers, 2013). Some researchers, for example, have argued that the development and use of standardized diagnostic criteria (e.g., the DSM) have led to empirical evidence that shows improved validity for distinguishing cultural differences among mental health disorders (Cooper et al., 1972, as cited in Draguns & Tanaka-Matsumi, 2003). However, other researchers have viewed these standardized measures as problematic because they diminish the cultural nuances providing relevant information about specific cultural groups and communities (Fields, 2010; Redmond, Rooney, & Bishop, 2006).

Neighbors, Trierweiler, Ford, and Muroff (2003), for example, examined the relationship between schizophrenia diagnoses and patient race among clinicians using DSM criteria and a semi-structured instrument and found racial differences in clinician diagnoses. Although there were no racial differences in depressive symptoms, African Americans were more likely to

receive diagnoses for schizophrenia; Whites were more likely to receive diagnoses for bipolar disorder. These outcomes support other researchers who have suggested that standardized diagnostic criteria are based on Euro-American ethnocentrism and result in ethnocentric interpretations (Fields, 2010; Redmond et al., 2006). Researchers intending to resolve these issues with regard to substance-abuse assessments and treatments have proposed that clinicians attend to the sociocultural issues that influence and are influenced by substance use and that subsequently affect acceptance and treatment outcomes among ethnic minorities (Abbott & Chase, 2008). These researchers call for expanding examinations of culture in clinical research to include an assessment of the cultural exchanges between practitioners and patients in clinical settings.

The accounts of underrepresentation of minorities in RCTs and insufficient data collected among distressed communities have contributed to a range of real-world barriers for racial and ethnic minorities in clinical settings. For example, Lundgren and Rieckmann (2011) found through interviewing 172 staff members about their experiences implementing one of four SAMHSA-funded evidence-based practices (EBPs) that barriers differed by EBP and that each EBP had several barriers unique to the treatment. Although these barriers were based on staff perceptions, the findings from the Lundgren and Rieckmann study provide evidence that some barriers are perceived and that there is a current need for research that can accurately account for the barriers that currently exist. To complement this body of research, the current study focuses on a specific EBP (SBIRT) to identify new implementation barriers and validate current implementation barriers associated with SBIRT, as well as to explore a range of additional variables that could contribute to these implementation barriers.

**Barriers for SBIRT.** In 2005, SAMHSA funded the transition from Screening and Brief Intervention (SBI) to SBIRT as a response to the underutilization of SBI by medical practitioners. Some of the barriers to implementing SBI related to the medical setting (Babor et al., 2007); however, among studies spanning different countries and healthcare settings, many of these and other barriers were challenges specific to the medical professionals (e.g., negative provider attitudes, desire to prioritize urgent medical care over substance abuse, concerns for dishonesty among patients reporting their use; Vendetti et al., 2014).

Vendetti et al. (2014), for example, examined the factors that support and challenge implementation by surveying and interviewing 139 SBIRT staff and stakeholders from seven program sites. Themes of factors that facilitated implementation were revealed through inductive content analysis and included (a) committed leaders (i.e., persons who encouraged and supported implementation from within and outside organizations) and (b) intra- and interorganizational communication and collaboration (i.e., cooperation between departments and across agencies). While these outcomes aligned with the outcomes of other SBIRT studies (e.g., Greenhalgh, Robert, Macfarlane, Bate, & Kyriakidou, 2004), most studies lacked the input of consumers (clients) to verify whether these outcomes transcended across systems, different ethnic groups, and unique geopolitical communities. The current study followed a methodological approach similar to that used by Vendetti et al. (2014) and additionally included the perspectives of the community to compare responses across stakeholder groups for one specific racial group, the Black community (comprising multiple ethnic groups of African ancestry) living within one particular underresourced and distressed inner city.

**EBT concerns specific to substance abuse.** In addition to the general concerns that have inhibited racial and ethnic minorities from participating in clinical trials designed to inform

the generalizability of evidence-based measures, additional barriers hinder substance-abuse researchers (e.g., potential consequences for patients who disclose substance use; Burlew et al., 2011). A stigma associated with substance abuse deters underrepresented minorities, as well as White Americans, from seeking treatment. These are just two of the overlapping concerns that limit the number of research studies focused on designing and validating EBTs for treating substance abuse among racial and ethnic minority target populations (Burlew, Copeland, Ahuama-Jonas, & Calsyn, 2013; Steiker et al., 2008).

Among the research validating evidence-based treatments and practices, few researchers have acknowledged the existence of cultural barriers (e.g., Castro & Alarcon, 2002), as well as the ways in which these barriers deter therapists from implementing EBPs to treat substance-related disorders. Rather, more researchers show that racial and ethnic minorities differ in retention and outcomes in comparison to Whites, without explaining or describing how cultural and community factors contribute to these trends. For example, in one study, researchers attended to the previously mentioned concerns by examining data from a multisite, longitudinal study evaluating substance-abuse treatment programs designed to determine whether the needs-service ratio matched across ethnic groups. The needs-service ratio was determined by gathering information on the services that clients reported receiving, compared to the services they actually needed (i.e., physical and mental health services, family support, and a variety of life skills trainings). Results showed that in comparison to African Americans and Latinos, Whites more often reported receiving the benefits of the range of needed services. In addition, African Americans and Latinos more often presented for treatment with higher risk substance-abuse problems and fewer economic resources and received fewer services, lower quality treatment, and fewer of the services they said they needed (Marsh et al., 2009). According to these

findings, treatment facilities advocating for comprehensive care most often fail to meet the needs of racial and ethnic minorities and neglect to provide the services that are important to them.

In response to the Marsh et al. (2009) analysis and other similar studies, experts in the area of substance-abuse prevention and treatment have called for research specifically focused on examining how culture affects program efficacy and effectiveness for racial and ethnic minorities. Researchers have determined two core questions to explore to appropriately address minority substance use: (a) “How does the experience of being a racial/ethnic minority person influence the etiology and onset of substance abuse and dependence?”; and given this status, (b) “How is this ethnic experience related to specific health service needs?” (Castro & Alarcon, 2002, p. 790). Answers to these questions would provide the basis and rationale for cultural adaptations; however, a need still exists for evidence-based strategies and guidelines on how to create and evaluate culturally relevant prevention and intervention programs.

**Substance abuse research among Black Americans.** Specific to substance abuse and Black Americans, some researchers have suggested that the first step to producing empirically supported substance-abuse research is to specify the subgroups that are often grouped together and categorized as African Americans in the literature (Sharma & Atri, 2006). Ethnic subgroups differ by historical impact of substance use within their communities, leading to a wide range of substance-related beliefs and behaviors that are further differentiated by gender and sociopolitical context (Burlew et al., 2013; Fields, 2010; Redmond et al., 2006). For instance, cultural differences in depression levels have led some researchers and theorists to believe that depression is culture-specific and best understood within an identified context (Redmond et al., 2006). These historical developments indicate that cultural factors mediate outcomes, a notion often misunderstood or misinterpreted when researchers examine treatment outcomes (Mountain,

2013). Ultimately, researchers need to replicate with Black American subgroups the substance-abuse studies conducted among White populations. These replicated studies will help advance understanding of the precursors for substance abuse among Black American populations (Sharma & Atri, 2006).

The prior and current understandings about health and substance-abuse treatment does not fully align with the current and growing number of researchers who recommend culture-specific examinations and community-based approaches for substance-abuse treatment targeting racial and ethnic minorities, especially Black Americans (e.g., Windsor & Murugan, 2012). The literature reviewed in the next section provides a brief synopsis of the concerns associated with EBTs for racial and ethnic minorities. I offer a rationale for culturally adapting assessment and treatment protocols, even though there is limited guidance for employing this type of research by means of evidence-based strategies. This study aligns with calls for cultural adaptations for evidence-based interventions and practices and with calls for involving consumers and community members in this process. The study represents a first step toward validating, modifying, and evaluating a culturally sensitive and community-supported adaptation of the SBIRT for the Black community in Hartford. In addition, the study provides detailed guidelines and procedures for implementing a community-based participatory research protocol and a mixed methods research design that can be used to conduct clinical research to advance modifications tailored to racial and ethnic minority populations living in distressed and underresourced communities in Connecticut and beyond.

### **The Rationale for Cultural Adaptations**

Some researchers have suggested that treatment barriers have been sufficiently documented, and it is now time to move away from documenting barriers toward creating

comprehensive plans to address these barriers (e.g., Fouad, 2009). Across the board, from local community treatment settings to federally funded government initiatives, researchers and clinicians are becoming increasingly aware of these challenges and of the socioeconomic and community factors that contribute to health outcomes. Although pathways linking sociocultural factors and access to resources are well known, these trends are often only referenced conceptually because there are challenges to validating these trends through empirically supported measures and instruments (Horowitz & Lawlor, 2008).

Early attempts to develop culturally sensitive assessments and interventions have resulted in measures that include cultural components but lack attention to community and sociocultural factors that differ by and within each racial and ethnic group. For example, the Hofstede model for measuring cultural values (Hofstede, 2001, 2011) is one of the most widely used cultural measures across mental health fields. It includes six dimensions (power distance index, individualism/collectivism, masculinity/femininity, uncertainty avoidance index, long/short term orientation, and indulgence/restraint), which provide a way for researchers to categorize culture into distinct variables. More recently, however, the model has been criticized for being redundant and for being used inappropriately in past cross-cultural research studies (e.g., Redmond et al., 2006). More importantly, the Hofstede model diminishes the significance and variations among communities and the ways in which communities influence culture (Jones, 2007).

Cultural differences in treatment outcomes, particularly lower outcomes for minorities, have led to empirical investigations to understand how culture contributes to the variations in incidence rates and prevalence for a span of disorders. Notable differences in research designs and measurement accuracy have contributed to methodological problems in culture research



(Redmond et al., 2006). EBTs were known to alleviate this issue by closing the gap between research and practice (Kilbourne, Neumann, Pincus, Bauer, & Stall, 2007); however, a more recent belief of scholars is that the strict adherence characteristics of EBTs actually increase the gap between practitioners and subcultural groups that benefit from services tailored to their individualized needs (Castro, Barrera, & Steiker, 2010).

Attempts to end the conflict between fidelity and adaptation have led to the emergence of culturally adapted clinical interventions, also known as hybrid interventions. These new generational approaches to health, mental health, and substance-abuse treatment employ evidence-based strategies; however, emphasis is first placed on mobilizing resources within the community (Horowitz & Lawlor, 2008) and identifying sources of program irrelevancy for the specified population. Once a culturally sound protocol is established, attention can shift toward achieving the highest fidelity among the target population (Steiker et al., 2008). Despite the increasing literature supporting the development of community-focused and culturally based interventions, research is still scarce. However, the limited amount of existing rigorous empirical evidence indicates that these community interventions can improve health outcomes (Horowitz & Lawlor, 2008; Lurie & Fremont, 2006). Considering the limited evidence in this area, I conducted the current study in a manner that fulfilled the first step in a multistep process designed to obtain empirical evidence for validating, modifying, and evaluating a culturally adapted substance use and abuse intervention protocol.

**Challenges in developing culturally adaptive interventions.** Even when studies show that cultural adaptations are more effective than standard interventions for racial and ethnic minorities (Steiker et al., 2008), certain assumptions and barriers at institutional and community levels deter collaborative efforts to implement culturally adapted interventions and protocols.

For example, in reference to institutional level assumptions, Kumpfer, Alvarado, Smith, and Bellamy (2002) claim that some culturally specific programs that proceed to implementation are based on practitioners' interpretations of a community's need and therefore lack a theoretical basis. In contrast to this notion, the current study supports the perspective that cultural adaptations based on institutional assumptions and theoretical underpinnings do not correct the existing disconnect between the community and healthcare service professionals.

Evidence of community-level barriers has often been reported as attitudinal barriers that exist because of community distrust for healthcare systems, which also is known to deter individuals from seeking help (Hall, 2001). Attitudinal barriers (i.e., the attitudes representative of societal viewpoints) are often excluded from reports examining access to care (Whetten et al., 2006). Among various ethnic minorities, attitudinal barriers contribute to the stigma associated with seeking physical and mental healthcare services (DHHS, 2006; Lau, 2006); in contrast, however, these barriers also serve a purpose for sustaining some of the protective factors within the affected communities (Alderete, Vega, Kolody, & Aguilar-Gaxiola, 2000). For instance, tight-knit communities common among underrepresented minority groups often reinforce negative attitudes toward research and treatment, while also providing an environment supportive of cultural beliefs and traditions (Branson, Davis, & Butler, 2007). Substance-abuse researchers examining the relationship between the level of trust in healthcare providers and service utilization have recommended examining level of trust and other relational factors to determine how these attitudinal barriers affect the ways in which racially diverse clients report patterns of use (Whetten et al., 2006). Beyond the scope of existing literature, there is a need for research that focuses on attitudinal barriers encountered during the process of applying cultural

adaptations to assessment and intervention protocols. Exploring these barriers was an objective of the current study.

The next section of the literature review provides a brief synopsis of the challenges that have delayed the development and dissemination of culturally adaptive interventions. This section also provides examples of some of the institutional assumptions and community barriers that impede the movement to address the call for the reevaluation of evidence-based practices for racial and ethnic minorities and the inclusion of underrepresented groups in RCTs. With these challenges in mind, in the current study I intended to bring attention to the need for the inclusion of community voices in the process of culturally adapting assessment and intervention protocols.

### **The Emergence of Community-Based Approaches**

Researchers who aim to reduce community barriers by decreasing the gap between consumers and healthcare professionals have often been drawn to community-based approaches that emphasize strengthening the relationship between community and healthcare systems (e.g., Israel, Schulz, Parker, & Becker, 1998). Hall (2001) recognized that any collaboration between EBT researchers and culturally focused researchers is a promising approach to improve the efficacy of psychotherapies for racial and ethnic minorities and recommended that researchers and clinicians continue to join in such efforts as a means to facilitate further developments. In this section of the review, I focus on a specific approach, community-based participatory research (CBPR), to explain the ways in which this approach utilizes evidence from within the community, in addition to evidence based on research literature, to continue efforts to bridge the gap between research and practice.

**Community-Based Participatory Research (CBPR).** Researchers have begun to recognize the importance of including community leaders in the process of developing and

adapting treatment interventions (Hernandez, 2010). CBPR is grounded in the belief that there are strengths and resources within each community and mutual benefits to engaging community representatives in each aspect of the research process (Israel et al., 2006). This belief facilitates the development of interventions relevant to the community's concerns, effectively utilized over time (Weiner & McDonald, 2013). Rather than conducting research with specific ethnic groups after an intervention has reached fidelity with dominant populations, researchers select measures and methodologies that include relevant community members in the process of creating and adapting interventions. Not only does the treatment salience improve as community members review treatment materials and provide input on the content and relevance (Hernandez, 2010), some researchers have been able to determine the aspects of participation that further facilitate community involvement (e.g., recognition as experts and different options for participation). These community involvement aspects allow community participants to feel they are making meaningful contributions to research as it develops (Breen & O'Connor, 2014). Thus, this approach offers promising guidelines that have been used to alleviate some of the deficits found in other cultural measures and to inform other studies.

Although studies using CBPR are increasing as a reputable approach for community-based initiatives, these studies have been known to vary in scope, level of community involvement, and outcomes (Weiner & McDonald, 2013). For example, a study was conducted in 2010 in which four CBPR investigators and three community leaders were interviewed to understand some of the challenges that developed from working within partnerships in accordance with community-based initiatives. The findings showed competing versions of CBPR, and despite the intention to involve community members throughout the entire research process, many community members did not feel the need to be involved in each phase of the

research process, especially if there were phases that did not directly align with their initial decision to participate (Weiner & McDonald, 2013).

Despite these challenges and the variances in outcomes, researchers committed to applying CBPR principles can learn from past community-based studies. For instance, researchers for the Philadelphia Area Research Community Coalition (PARCC) learned from previous experience that one of the traditional standards of CBPR (to involve the community in each aspect of the research process) presented further challenges. They reduced the definition of CBPR to indicate that community involvement is achieved even if community members only participate in (a) defining the problem, (b) interpreting the results, and (c) sharing the results with the community (Johnson et al., 2009). In the current study, I followed the example of PARCC, basing community involvement on the preferences of representative members of the Black community (consisting of multiple ethnic groups of African ancestry) in Hartford, Conn., so that the developing partnerships could be sustained beyond the scope of this current study. Thus, the core elements of CBPR have significantly informed the study's research design and objectives.

The current study is significant because it incorporated a range of representative community voices (an approach that has not always been included in past CBPR studies) to inform cultural adaptations for SBIRT for the Black community in Hartford and for similar Black communities in other cities.

### **Research Objectives**

The current study addressed three primary research objectives:

1. To advance our understanding of the ways in which representative members of three stakeholder groups (e.g., community members, community leaders, service providers)

perceive the severity of the substance use / abuse issues within the local Black community in Hartford, CT.

2. To advance our understanding of the ways in which these same representative members perceive the accessibility and quality of current services and resources available to members of the local Black community to address substance use / abuse issues.
3. To enlist the assistance of representative members from these same three stakeholder groups in assessing the effectiveness and relevancy of a protocol and associated instruments (currently used in 30 community health center sites throughout CT) for members of Hartford's local Black community, and in providing suggestions regarding cultural and community adaptations that may increase the effectiveness of this protocol.

In addition, the following secondary objective was addressed:

1. To explore the degree to which and the ways in which representative members from these same three stakeholder groups might be willing to inform those committed to culturally and contextually adapting the protocol to increase its utility and relevance for use in Hartford's local Black community.

### **Research Questions**

To meet these objectives, the study explored seven primary research questions:

1. What are the ways in which the three stakeholder groups perceive the severity of substance use and abuse issues in the local Black community in Hartford?
2. What are the ways in which the three stakeholder groups perceive the effectiveness and relevancy of the substance use and abuse services and resources currently available to the local Black community in Hartford?

3. How does each stakeholder group perceive the comfort and relevancy of the patient–provider exchange of the SBIRT protocol?
4. What are the ways in which the three stakeholder groups assess the relevancy of the current questions of the ASSIST and report card, and what suggestions do they have for improving it, specifically for members of the local Black community?
5. What are the ways in which the three stakeholder groups perceive the effectiveness of the brief intervention in helping members of the local Black community understand the nature of (or reflect on) their substance use and abuse issues and in encouraging individuals to seek services that would best address these issues?
6. What are the similarities and differences in perceptions across and within each stakeholders group for the other research questions listed above?
7. Would members of the three stakeholder groups be willing to participate in any additional steps toward creating a culturally relevant version of SBIRT, and do they believe that their participation would make a difference?

### **Chapter 3: Methodology**

Clinical researchers note that psychotherapy modifications in health and mental health care protocols are inaccurate if these are created without input and feedback from the local community to account for individual client variability, predominant help seeking behaviors, and relevant community institutions and other networks (Hall, 2001). Recognizing this limitation, the current study followed the Community-Based Participatory Research (CBPR) framework (Blumenthal & Braithwaite, 2013; Minkler & Wallerstein, 2010) to include the input of three stakeholder groups to inform the modification of the Screening, Brief Intervention, and Referral to Treatment (SBIRT) (Babor et al., 2007) protocol for use with members of Hartford's local Black American community. The SBIRT protocol consists of the Alcohol, Smoking, and Substance Involvement Screening Test (ASSIST) and the Ten-step ASSIST-linked Brief Intervention; both of which are typically administered in community health centers to every patient. The ASSIST and the Ten-step ASSIST-linked Brief Intervention are currently used to assist practitioners to identify clients' current substance use patterns and to encourage those at risk to change behaviors associated with these patterns.

In this chapter, the student researcher presents the research methods and describes the processes by which CBPR and mixed method approaches were applied. The rationale for both approaches are detailed below. The Participants section is separated into subsections to describe each stakeholder group, and the research team. In the Measures section, the student researcher describes how the research instruments were designed and provides a description of the SBIRT materials reviewed by the participants. Under Data Collection, the student researcher provides the procedures followed in phases one and two of the research study. Finally, each step of the



qualitative and quantitative analytic procedures are described, along with the associated validity and reliability strategies.

### **Research Design**

This study was a mixed methods design that incorporated data from focus groups and surveys designed to elicit responses from representative members of three Hartford area stakeholder groups (i.e., members of the local Black community, leaders in the local Black community, and health care providers serving the Black community). The study also was categorized as a non-experimental research design because there was no manipulation of the independent variables, and because the student researcher incorporated naturally occurring participant responses into the overall interpretation of the findings (Creswell, 2005). Finally, this study was classified as a comparative research design because information gathered from each stakeholder group was cross-examined and compared as one way to widen the lens for understanding various issues and concerns about substance use and abuse as well as various perspectives about the SBIRT protocol held both within and across the three stakeholder groups.

**The rationale for applying CBPR.** A primary rationale for using CBPR approaches aligns with the ultimate goal for CBPR in general, which is to build meaningful collaborative relationships between an underrepresented community and the research community that results in “a deeper understanding of a community’s unique circumstances, and a more accurate framework for testing and adapting best practices to the community’s needs” (Viswanathan et al., 2004, p. 1). This deeper understanding enhances the quality of data that can directly inform cultural and contextual adaptations in mainstream instruments and protocols so that these modifications are best suited to the populations and communities served. Likewise, the process for conducting research for one community can inform the process for facilitating adaptations

among other groups. With CBPR, higher emphasis is placed on ways researchers share the power of the methodological decisions with the community, rather than the actual research methods used (Minkler & Wallerstein, 2003 as cited in Community Anti-Drug Coalitions of America [CADCA] National Coalition Institute, 2011). The intention is to involve different representations of the community in defining the problem, implementing the research procedures, and generating and sharing possible solutions (CADCA National Coalition Institute, 2011).

Any research design can be used to employ CBPR as long as the community is in agreement with the design and research approach (Bordeaux et al., 2007). This study utilized CBPR within a mixed methods design to capture the voices of three representative stakeholder groups associated with the Black community in Hartford, CT, which will be used to inform culturally relevant / community specific adaptations to the SBIRT protocol. This study was appropriately considered a mixed methods design because it used a combination of qualitative and quantitative approaches to provide comprehensive information about complex research questions. More specifically, this study was categorized as a concurrent triangulation design because qualitative and quantitative data collection and analysis occurred separately, but at the same time (Creswell & Plano Clark, 2006). According to Lingard, Albert, and Levinson (2008), the rationale for using mixed methods must be justified in regards to the sequence of methods. Although both methods occurred concurrently, the quantitative data provided the breadth (i.e., a larger representation of each stakeholder group) while the qualitative responses, which were more reflective of voices across the three stakeholder groups, provided the depth. In those instances in which both the student researcher and the secondary coder recognizes that there was divergence between a qualitative theme and the associated quantitative outcome, the student

researcher provided an additional interpretation that brought two findings together, as advised in Creswell & Plano Clark (2006); this phase of the research is further detailed under Qualitative Analytic Procedures. The specifics of this design are described below and follow the CBPR model.

In accordance with CBPR, the student researcher interacted with representative members of the three stakeholder groups as collaborative partners, rather than as passive participants throughout the research process. Specifically, the student researcher encouraged all members of each stakeholder group to remain engaged throughout the data collection, data analysis, and interpretation phases of the research. Participants who chose to remain involved in multiple phases of the research (assuming roles of co-researchers) provided local knowledge and community insight, which increased the likelihood for the research to be more accessible, relevant, and effective for the target populations (Israel et al., 1998).

## **Participants**

**Defining the three stakeholder groups.** After reviewing the literature in support of CBPR principles (Chen et al., 2012; Hall, 2001; Kumpfer et al., 2008), the student researcher initially identified three stakeholder groups that would serve to provide perspectives about substance use, available substance use/abuse services, and the SBIRT protocol as these pertain to the Black American community in Hartford, CT. These three stakeholder groups were originally identified as (1) community members, (2) community leaders, and (3) clinicians. The student researcher was able to confirm practicality of the established criteria for each stakeholder group with individuals who were present during the formal and informal presentations she conducted describing the study – further detailed in the Recruitment section. In order to confirm that participants self-identified with a particular designated stakeholder group, the student researcher

explained the criteria for each stakeholder group, and asked participants to identify themselves in their own words. Asking participants to identify themselves in their own words is a procedure recommended for CBPR to ensure that designated groups are consistent with how the community views itself (Bordeaux et al., 2007). As a result of this process, the titles and criteria used to define the community member and community leader stakeholder groups were retained as originally identified, while the title and criteria used to describe the clinician stakeholder group changed from clinicians to service providers once the researcher was informed that most of the health educators involved with SBIRT are not licensed or certified clinicians.

The participant sample included representative members of three stakeholder groups within the local Black community in Hartford, CT: (1) community members, (2) community leaders, and (3) service providers. A total of 85 individuals participated in the study and comprised the general sample, further detailed under the Chapter 4 heading Demographic outcomes of the sample. According to Teddlie & Tashakkori (2009), there is a mixed methods sample size trade-off, which means that the sample size either needs to meet the standard for saturation in qualitative studies or representativeness in quantitative studies. The student researcher focused on meeting the standard for qualitative studies. For focus groups, Grueger and Kasey (2000) indicated that researchers should assess for saturation after three to four focus groups, and considering this parameter, the current study ended with four focus groups. Regarding quantitative data, given (1) the unique nature of this study containing three community-specific stakeholder group populations and (2) the standard for determining sample size for quantitative studies is calculated based on sample size, there were no clearly established parameters for achieving representativeness for this study. In congruence with the representativeness/saturation trade off (Teddlie & Tashakkori, 2009), this study placed more

emphasis on saturation for the qualitative, so less emphasis was placed on representativeness for the quantitative.

**Community member stakeholder group.** The first stakeholder group, community members, consisted of individuals who identified with the Black community and lived in or utilized institutions in the Hartford area for health and mental health services. According to the 2010 U.S. Census, approximately 38.7 percent of the Hartford population identify as Black or African American (U.S. Census Bureau, 2010). For this study, the community member stakeholder group was comprised of males and females who identified with the Black or African Americans residing in the Hartford area and met all other criteria. All participants of this stakeholder group also met at least one of the following criteria: (1) personally use or used tobacco, alcohol, or an illicit drug on a consistent basis, (2) has or had a close friend or family member who abuses or abused tobacco, alcohol, or an illicit drug, or (3) witness or have witnessed substance use in their neighborhood and surrounding community.

**Community leader stakeholder group.** The second stakeholder group, community leaders, consisted of persons who were identified as leaders by others in the community, or as affiliated with an agency or organization that is actively addressing disparities for under-represented minorities in the Hartford area. When asked by the student researcher, each community leader self-identified as a community leader. Most of them were referred to the student researcher by others who also self-identified as community leaders. Additionally, the student researcher requested that members of the agencies and organizations who agreed to participate as representative community leaders did so because they had some awareness of the substance use patterns for the Black community in Hartford.

**Service provider stakeholder group.** The third stakeholder group, service providers, consisted of health educators and other healthcare providers who work with the Black community in a community health setting. There was a deviation to the criteria originally described in the dissertation proposal for the service provider stakeholder group. After meeting with CT SBIRT (a group of collaborative partners who monitor quality and outcomes for SBIRT across Connecticut), and verifying with a committee member, the student researcher expanded the criteria to include service providers outside of Hartford and in communities with similar resources. Although this change poses a potential threat to external validity, the low number of health educators currently implementing SBIRT provided justification for expanding the criteria to include service providers from other cities in Connecticut who regularly serve minority populations. Service providers also had to meet one of the following criteria: (1) administer or administered the existing version of SBIRT in a community health center, (2) experience with assessing and treating substance abuse as a mental health practitioner in the Hartford community, or (3) specialized as a practitioner in an area (i.e., domestic violence) that is often inter-related to substance abuse and required some skillset for administering substance use assessments.

*Rationale for diversity among the community leader and service provider groups.* Community leader and service provider participants differed in racial and ethnic background, age, socioeconomic status, education level, and exposure to each form of substance use and abuse in the Hartford area. In accordance with community-based research approaches, community organizations and agencies do not need to identify as members of the identified community, particularly if they are committed to addressing issues that are important to the identified community (Israel, Schulz, Parker, & Becker, 1998). These individuals within community organizations and agencies are recognized as partners, and developing partnerships is

an essential principle for CBPR (Bordeaux et al., 2007). These partnerships often consist of health and human service agencies, community-based organizations, and community-based researchers and academics; regardless of personal identifying characteristics. Beyond meeting the stakeholder criteria, the representative members of the community leader and service provider stakeholder groups possess the diverse demographic characteristics typically attributed to community-based partnerships. Further, diversity within stakeholder groups is viewed as a positive, given that community health improvements require diverse groups and individuals from different parts of the community to engage on a fairly regular basis (Israel et al., 1998; Israel et al., 2001; Minkler, Blackwell, Thompson, & Tamir, 2003).

**Primary research team and auditor.** The research team consisted of three individuals (i.e., student researcher, secondary coder, and auditor) with varying degrees of clinical experience, research experience, and worldviews (i.e., values and beliefs). Each individual was involved in the data analysis or implementation of the data collection procedures and, as such, their views influenced and assisted in various aspects of this research (Hill, Knox, Thompson, Williams, Hess, & Ladany, 2005).

The student researcher was a 29-year old, African American female with clinical experience focused on treating substance abuse, experience collecting, analyzing, and interpreting mixed methods research, and a personal affiliation with the Black community in Hartford, Connecticut. Although she led some of the key components of the study (i.e., designing the research protocol, conducting focus groups), the following phases of the study were implemented in collaboration with others: conceptualizing the study design and research questions, communicating with and recruiting participants, collecting survey data, and data analysis.

The secondary coder was a 29-year old Caucasian, American female with a history of providing counseling within communities of racially diverse compositions, and experience collecting, analyzing, and interpreting qualitative data. The secondary coder joined the research team after the qualitative data collection was complete and remained active throughout each stage of the analysis, ending after examining the outcomes from the third phase of theme development. Throughout this process, the student researcher and secondary coder discussed differences in their worldviews and the ways in which these could impact how they interpreted the data. We also discussed how our process of interpreting the data and drawing conclusions interacted with cultural and institutional norms that further contextualized our understanding of each stakeholder group (Riley & Hawe, 2005). For example, during a coding meeting, there was an instance after reviewing the community leader stakeholder group transcript, where the secondary coder identified a passage in the text and shared her perspective that it appeared that the group engaged in pro-social dialogue over drug use. The student researcher provided the secondary coder with additional cultural and contextual details as it pertained to the individuals in the focus group to offer a broader perspective of that text passage. This act of disclosure lead both researchers to discuss their biases (i.e., personal issues that impact objectivity) and worldviews, a procedure that continued throughout the research process to ensure that the biases of both researchers did not affect the data analysis process (Hill et al., 2005).

The auditor is a 60 year old, 2nd generation Italian-American female living with a chronic disability for 35 years. She is a licensed psychologist and Marital and Family Therapist who has been treating under-represented populations throughout her career. The auditor had applied, conceptual, and trained experience in qualitative interviewing and data analysis. The auditor was involved in some of the decision-making process for this research before the study



was proposed. Before, during, and after data collection, the auditor help to reinforce saliency of the proposed procedures, and to suggest instances in which the actual implementation posed threats to the internal and external validity (Krefting, 1999).

*Memos.* The student researcher used memos to record her awareness of her own worldview, instances when it appeared to differ from others in her research team, and where it aligned and differed with each stakeholder group. She also recorded the actual events that developed throughout the research process to reflect on the methods and approaches she used as she connected with different individuals, groups, and organizations affiliated with the Hartford community and the surrounding areas. The purpose of memoing is for researchers to document their reflective notes to maintain a record of what they learn about the data and the research process (Groenewald, 2008). These reflective notes also add to the credibility of the research because it provides a descriptive record of the data and the analysis (Golafshani, 2003). It is an important element for qualitative data analysis purposes (Groenewald, 2008), but the student researcher also used it as a way to keep track of her CBPR approaches to the research and her communications with each stakeholder group. The student researcher maintained an electronic record of her memos, and typically recorded details in a reflective manner, directly after communicating with a potential stakeholder or after completing a component of the analysis. She referred back to them when she needed to recall a conversation before reconnecting with a stakeholder, and specifically towards the end of the analysis to ensure that the outcomes were reflective of the initially developments.

## **Measures**

**Semi-structured focus group interviews.** Semi-structured focus group interviews were created to elicit responses from each representative stakeholder group regarding their perspectives about: (1) the severity of substance use in the community, (2) the accessibility and

quality of services, (3) the effectiveness and relevancy of SBIRT, and (4) the feasibility of joining future efforts to adapt SBIRT to meet the needs of the community.

*Question development.* To develop these interviews, a focus group protocol was constructed to diagram how each of the potential focus group questions could be tailored to the representative stakeholder groups. In collaboration with dissertation committee members and the added input of Hartford community representatives, the student researcher used the focus group protocol to structure slightly different versions of the focus group questions and the aligning survey questions (which are further detailed in the section below labeled Survey Instrument) for each stakeholder group. The content was similar across the different versions of the focus group questions, but tailored to each stakeholder group and data collection method. Appendix A is an illustrative example of this process in the early stages of development. The table was divided by columns for each stakeholder group, and by rows to show that the questions differed to account for the three perspectives. Focus group questions were identified by the acronym FGQ (i.e., Focus Group Question), and initial survey questions (also included in this table) were identified by the acronym CSQ (i.e., Corresponding Survey Questions).

Question development was informed by the objectives of this study. The first set of focus group questions revealed responses that informed the first objective, which is to advance our understanding of the ways in which representative members of three stakeholder groups perceive the severity of the substance use / abuse issues within the local Black community in Hartford, CT. In accordance with the sequence of questions, the next set of focus group questions informed the second objective, which is to advance our understanding of the ways in which these same representative members perceive the accessibility and quality of current services and

resources available to members of the local Black community to address substance use / abuse issues.

Keeping within sequence of questions, the next set of focus group questions informed the third objective, which is to enlist the assistance of representative members from these same three stakeholder groups in assessing the effectiveness and relevancy of the SBIRT protocol for members of Hartford's local Black community. While some of these questions required dichotomous yes/no responses and provided opportunity for further explanations, most of the questions requested open-ended responses and directly related to the SBIRT materials that the researcher provided the participants. The last set of focus group questions informed the secondary objective, which is to explore the degree to which and the ways in which representative members from these same three stakeholder groups might be willing to inform those committed to culturally and contextually adapting the protocol to increase its utility and relevance for use in Hartford's local Black community.

After the student researcher received Institutional Review Board (IRB) approval for the complete set of focus group questions and to ensure that the questions were clear and understandable, representative members of each stakeholder group (who were not involved in the question development or as participants) reviewed a draft of the focus group question (for community members, community leaders, and service providers). The student researcher adapted the focus group questions to match the feedback received from the representative members, and resubmitted the newly constructed focus questions to the IRB to be reapproved. The finalized versions for each semi-structured focus group interview resulted from this construction process (see Appendices B, C, and D).

**Rationale for the semi-structured focus group interviews.** The semi-structured focus group interviews were comprised of questions that specifically asked participants to use their own language to describe (1) their substance abuse concerns for the Black community in Hartford, and (2) their perspectives about the quality of the substance abuse services in the Hartford, with further emphasis placed on their perspective of the SBIRT protocol. The structure of the focus group questions assisted in understanding the participants' perspective about current substance abuse treatment approaches in Hartford, and the scope of dynamics and interactions between the Black community in Hartford and the local health care networks.

Each focus group consisted of individuals who had an affiliation with each other because each group was arranged by a coordinator, with whom the student researcher had developed a relationship. The focus groups were intended to understand and provide insight, rather than infer or generalize responses to a larger population, so focus group inclusion was not based on random selection (Krueger & Casey, 2000).

Additionally, the student researcher employed microskills throughout the focus groups. Microskills are the communication building blocks that provide the foundation for meaningful interaction (Ivey & Ivey, 2007). They are a range of non-vocal and vocal responses (i.e. good eye contact, active listening, reflecting feelings) that facilitate communication. The student researcher used attending probes, tracking probes, and active listening probes (Rigazio-DiGilio, 2007; Ivey & Bradford Ivey, 2007) to facilitate each focus group, which encouraged participants to elaborate on their responses and provided them with cues to know that, as a facilitator, the student researcher was attentive to their responses. These three probes are described with examples under Appendix E. In the following passage, the student researcher uses tracking probes, specifically "encouragers", to invite a participant to provide additional details for her

response to a question asking if they or others in the community would accept advice from a health care provider.

*Diane:* Trust.

*Moderator:* Trust. Can you say a little bit about that?

*Diane:* Um, the ones that I'm around, they have a trust issue. If they came here when they were like, older than I was, like in their twenties, they have a trust issue with society here. So with me, it's a trust issue. I came here when I was 17. And I still hard to trust people in this country. And I'm 47.

*Moderator:* So if they have that distrust for society, then it's not going to be –

*Diane:* They're not going to be open, no.

The individualized nature of microskills allowed the researcher to tailor interview strategies to the unique needs of each participant.

**Survey instrument.** Surveys were administered to all participants for the following purposes: (1) To ensure that focus group participants had another opportunity to validate their responses to the questions asked during the focus groups. (2) To provide a quantifiable collection of responses to determine if there was a consensus among each stakeholder group (as described in the initial paragraphs of this study method section), (3) to include the voices of individuals who wanted to provide input, but could not participate in a focus group, and (4) To collect descriptive information about the research participants (including demographic characteristics) for statistical analyses and to describe the samples. The survey items developed from the same process described in the above subsection on *Question development* (see Appendix A), and consisted of two components: (1) the demographic questionnaire, and (2) the questionnaire that aligned with the focus group questions. The student researcher referred to the combination of the

two questionnaires (i.e., the Demographic Questionnaire and the Questionnaire - related to the research questions) as the survey.

The survey items were comprised of quantitative, multiple choice response sets that were as similar as possible to the focus group questions (see Appendices F, G, and H). These items varied in response format depending on the question; including Likert-type answer choices, dichotomous yes/no answer choices, and multiple choice answer sets with the option for providing an open-ended response. Open-ended response options were included to ask questions that were limiting in the form of multiple choice answer set (e.g., What does a health care provider need to understand about your culture, beliefs, neighborhood, or environment before you respond to substance use related questions?) or included to allow for an additional response to a multiple choice question (e.g., Please provide any additional thoughts or comments about your comfort level responding to a health care provider's efforts to follow this protocol.). While these open-ended questions were asked, the student researcher determined along with my committee that I have sufficient data for this study and some data (i.e., the open-ended) would be archived for analysis as part of the student researcher's broader, future research agenda. Clear instructions were provided before each item that alternated to a different response format to increase the likelihood of gaining accurate information.

The questionnaire (related to the research questions) items were listed in a sequence to match the order of the focus group protocol, which was based on the objectives of this study. Following the last survey item, the student researcher included a question that provided a manipulation check. The manipulation check was an open-ended question to inquire if the participants skipped or declined to answer any of the previously listed questions, and to request

an explanation if they provide an affirmative response. The original intent for the manipulation check was to provide insight regarding any omitted responses.

The student researcher requested that every participant in each of the three stakeholder groups complete the survey. The student researcher aimed for a 100 percent response rate for the survey from individuals who agreed to participate in the study. Individuals who agreed to participate in a focus group were given the option to complete the survey at the end of the focus group, or take it home and have the researcher pick it up within a week. All focus group participants completed the survey, except for two community member participants.

Individuals who agreed to participate in this study, but did not participate in a focus group were considered to be survey-only participants. Initially the concern for response error was greater for survey-only participants than for focus group and participants. To ensure that the survey-only participants had the necessary information to complete the survey (particularly regarding the SBIRT protocol), the student researcher briefly described the SBIRT protocol and provided hardcopies of SBIRT printed materials (see Appendices I and J) (these items are further detailed in the section labeled SBIRT materials) to each survey-only participant. Furthermore, the student researcher was present at the time that the survey-only participants completed the survey to clarify any items as needed.

**Demographic questionnaire.** The demographic questionnaire (see Appendices K, L, and M) was placed at the beginning of the survey. According to Savino (2009), the response rate for non-sensitive survey questions (i.e. demographic questions) are higher when these questions were placed at the end of the survey rather than the beginning of the survey. However, the student researcher placed the demographic questionnaire at the beginning of the survey to help orient participants before asking substance-related questions. The demographic questionnaire

included variables adapted from other studies that examine cultural adaptations for under-represented minority populations (e.g., Cannon, 2013; Johnston, 2000); which consisted of age, gender, race/ethnicity, and education. Additionally, questions were added that directly apply to each stakeholder group and provide details that further validated that each participant met the criteria for his/her identified stakeholder group (i.e. personal and professional characteristics of the participants). The demographic questionnaire was used to provide descriptive statistics about the stakeholder groups within and across the sample.

**SBIRT materials.** SBIRT program evaluators at the University of Connecticut Health Center have acknowledged that SBIRT can be adapted to ensure the functionality of the protocol in specific real world settings (McRee, n.d). For each participant, the student researcher carefully described the SBIRT protocol in a manner that would allow participants, with no prior experience with or awareness for SBIRT, to provide feedback and make informed suggestions to improve the protocol. For participants in focus groups, the student researcher provided a verbal explanation of the SBIRT protocol and answered questions that the participants asked. Additionally, the student researcher showed focus group participants a four-minute video clip showing how the ASSIST (further detailed in the next paragraph) is used, and a 9-minute video clip showing an example of the brief intervention (further detailed in the next paragraph) to provide a visual depiction of practitioners going through the ASSIST and brief intervention in various settings. The survey-only participants were provided the option to view the video clips, but only two community member participants opted to view the video clips after the student researcher's detailed explanations.

The hard-copied SBIRT materials consisted of the following items: (1) the eight question Alcohol, Smoking and Substance Involvement Screening Test (ASSIST v3.1)



([http://whqlibdoc.who.int/publications/2010/9789241599382\\_eng.pdf](http://whqlibdoc.who.int/publications/2010/9789241599382_eng.pdf)) (see Appendix I), (2) the ASSIST v3.1 feedback report card, (see Appendix I) and (3) the Ten-Step ASSIST-linked Brief Intervention (BI) ([http://whqlibdoc.who.int/publications/2010/9789241599399\\_eng.pdf](http://whqlibdoc.who.int/publications/2010/9789241599399_eng.pdf)) (see Appendix J). The ASSIST is a brief interview designed to determine a client's risk score for each substance that a client's uses. According to World Health Organization (WHO) (2010a), it is described as a culturally neutral screening instrument, and it is used to initiate a discussion (the BI) with clients related to their substance use. The 3.1 version of the ASSIST introduced the use of the feedback report card, which emphasizes the importance of providing clients feedback about their level of risk along with the ASSIST score. The BI is a combination of evidence-based practices, based on the FRAMES model (Bien, Miller, & Tonigan, 1993) and a motivational interviewing approach (Miller & Rollnick, 2002), used to engage clients in a process of acknowledging their level of concern for their substance use and evaluating the pros and cons associated with their use (WHO, 2010b). Each of these items are presently used in healthcare settings across Connecticut to examine a client's current substance use and intervene within the context of the client's health-related appointment.

### **Data Collection**

Qualitative data was collected by focus groups, and quantitative data was collected by surveys. Members of each stakeholder group (who consented to participate) were either asked to participate by completing a survey or by participating in a focus group and completing a survey. CBPR and qualitative researchers both insist that researchers need to remain flexible to modify the plan across time as relevant information surfaces (Holkup et al., 2004 as cited in CADCA National Coalition Institute, 2011; Lincoln and Guba, 1985). The sequence of data collection was the only procedure that lacked flexibility. The data collection always abided by the

sequence of focus group questions first, and survey responses second for participants who elected to complete both response options. This sequence ensured that the participant voices remain uninfluenced during the focus groups by the multiple choice response options available through the survey. For all other procedures, and when appropriate, the researcher was open to modifying the design as needed (Hennink, Hutter, & Bailey, 2011; Patton, 1990). Table 1 lists the outcomes for the number of participants per stakeholder group for each of the following data collection methods: focus group and survey, survey-only, and phase two. The service provider stakeholder group is divided by location (i.e., Hartford community and other community) to show the representation for stakeholder group, given that the criteria for this group was expanded after this study was proposed.

**Recruitment.** The student researcher made concerted efforts to recruit participants for each of the stakeholder groups; a process which has been deemed by the University of Connecticut IRB ([http://www.irb.uconn.edu/adv\\_guidance.html](http://www.irb.uconn.edu/adv_guidance.html)) as appropriate for research involving under-represented minority groups. Concerted effort was further justified for this study, because the research design included focus groups. According to the University of Connecticut IRB ([http://www.irb.uconn.edu/focus\\_group.html](http://www.irb.uconn.edu/focus_group.html)), researchers need to provide potential participants information about the proposed study in advance, before the date of the focus group.

In compliance with these guidelines, the student researcher employed purposive sampling methods to connect with community groups, leaders, and organizations within the Black community of Hartford via phone calls, emails, and in-person introductions. Given that this study was not driven by the need to generalize findings to a broader population or to measure prevalence, purposive sampling approaches were deemed appropriate for recruiting participants

with specific characteristics. To provide potential participants sufficient information regarding the topic of the research and essential components of the focus groups and surveys, the student researcher conducted formal and informal presentations describing the study, complete with handouts (see Appendix N). Additionally, the student researcher provided agencies, organizations, and key contact persons with recruitment flyers to display and distribute among potential participants (see Appendices O, P, and Q). These initial contact efforts resulted in community group representatives referring the student researcher to other community stakeholders, in a process resembling a snowball sampling method. Snowball sampling increased the credibility of the research, and further shows continuity to CBPR, because it involves the participants in the research process. Details about how the student researcher connected with and maintained connection within each stakeholder group is described below. In accordance with CBPR, the collaborative partnerships extended throughout the trajectory of the research study (Israel et al., 1998).

*Community member recruitment strategies.* For the focus groups, in collaboration with members of the community, the student researcher selected two groups (i.e., one containing four individuals, and one containing six individuals) from a family center in Hartford that primarily serves local Black Americans of Caribbean descent. The student researcher periodically visited the family center to develop relationships with the staff and adults/parents who regularly participated within the center. The student researcher and community members affiliated with the family center determined that individuals within this family center were appropriate as representative members for the community member focus group after discovering that numerous individuals had strong viewpoints about the substance use issues within their families and the

community. These viewpoints were shared prior to the focus groups, during occasions when the student researcher was present and engaged in various events that took place within the center.

Survey participants were obtained from different locations within Hartford. Some participants were informed about the study while in Hartford area church settings, the Hartford Public Library, or when attending periodic community events that were directed towards public engagement in community-based issues. A larger portion of the participants came as referrals (i.e., snowball sampling) from individuals who, after completing the survey, felt that they knew other individuals who could provide an interesting perspective given the criteria for this stakeholder group.

*Community leader recruitment strategies.* The focus group was selected based on the recommendations of two directors from a community agency (i.e. Hartford Communities that Care, Inc.) that is actively involved in the on-going issues most prevalent for the Hartford community. After the student researcher described the criteria for the community leader stakeholder group, the two directors indicated that a young adult leadership initiative had formed that primarily consisted 18-24 year old Black Americans living and working within Hartford neighborhoods. The student researcher determined that individuals from within this group would be appropriate as representative members of the community leader focus group, after the two directors indicated that this age range is often overlooked within the Hartford Black community and their perspectives would be vital to the overall representation of the current and future leaders of the community. The focus group consisted of eight individuals who were active members of this young adult leadership initiative.

The student researcher purposively recruited survey participants for the community leader stakeholder group. After attending rallies and forums addressing the violence and

policing problems in the Hartford community, the student researcher identified individuals (whom she repeatedly saw as coordinators and supporters of these events) to inform them about the study. In many instances, these individuals referred the student researcher to other individuals and organizations who were not as visible at these events, but generally worked directly with community members. Three participants, agreed to complete a survey and assist in recruitment efforts after the student researcher mentioned the study in conversations while volunteering alongside the community leaders at Hartford area events.

*Service provider recruitment strategies.* Service provider focus group participants were identified by individuals who oversee the health educators administering SBIRT in different community health settings across Connecticut. Given the limited number of health educators (previously described in the Participants section), the student researcher expanded the criteria to include health educators who work with minority populations in community health centers within and outside the Hartford area. The focus group was held as one of the agenda items during scheduled in-service meeting for the health educators. There were seven service providers in attendance (two from the Hartford area, and five from other cities), all of whom consented to participate in the focus group.

Service provider survey participants were primarily recruited from Community Health Services (CHS) in Hartford (i.e., a comprehensive health center available to all populations in Hartford area) after the student researcher met with the Chief Executive Officer of CHS who then helped to inform other providers about the study. Other service providers came from recommended contacts from community leader and service provider participants who were not affiliated with CHS. Two health educators who participated in the focus group assisted with the process of describing the study to providers who they readily interact with at CHS as they

administer SBIRT. Other providers within CHS were informed of the study after the student researcher met with the Chief Executive Officer of CHS and he helped to inform other providers about the study.

**Phase one.** The developed partnerships between the researcher and stakeholder groups impacted the collection of data in several ways. First, focus groups were decided upon while the student researcher was waiting for the second phase of IRB approval, in which focus group and survey questions were altered to include the feedback from each stakeholder group. Each focus group consisted of four to eight individuals from a pre-existing identified community group (i.e. for community members and community leaders), and from community health centers (i.e. for service providers). Second, the focus groups were held in spaces offered by the community agencies to provide ease of participation and to reduce the chance that environmental factors would affect the outcomes. Third, with respect to the desired number of focus groups for each stakeholder group, the original plan was to base the number of focus groups on the number of groups that the student researcher was referred to, but the recruitment process did not lead to referrals for focus group participants. In actuality, the groups developed when key contacts (i.e., individuals who were able to provide input during times before and after the study was proposed) mentioned that they knew individuals who met the criteria and might want to participate, which is better known as snowballing sampling. This process ultimately resulted in a total of four focus groups: two community member focus groups, one community leader focus group, and one service provider focus group. This development aligned with CBPR principles because community-based researchers adhere to the relationships that exist within an identified community because these relationships not only represent structures within a community, but also are built on foundations of trust, mutual commitment, and cooperation (Israel et al., 1998).

Each focus group consisted of the following procedures: (1) The student researcher verbally explained the objective of the proposed study and the consent form before asking participants to complete the consent form (see Appendices R, S, and T). (2) The student researcher asked the focus group questions directed at understanding individual perspectives about the continuum of substance use, from recreational use to chronic substance abuse, among the Black community in Hartford and the availability of services. (3) The student researcher showed a four-minute video clip depicting a health educator administering the ASSIST, and passed out two items (the ASSIST v3.1 and the ASSIST v3.1 feedback report card). (4) The student researcher asked focus group questions that directly related to the ASSIST v3.1 and feedback report card. (5) The student researcher showed a nine-minute video clip depicting a health educator administering the Ten-Step ASSIST-linked Brief Intervention and distributed handouts that briefly describe the steps; then asked focus group questions that directly related to the ASSIST-linked Brief Intervention. (6) The student researcher asked the remaining semi-structured focus group questions and solicited participant responses. (7) Participants were asked to complete the brief survey that reiterated the questions asked during the focus group. Each focus group was audiotaped and transcribed. On average, the focus group lasted from 70 to 90 minutes, and for the participants who opted to complete the survey directly after the focus group, the surveys took approximately 15 to 20 minutes to complete.

The same survey that was distributed at the end of the focus groups was distributed to survey-only participants. However, the procedures were slightly modified for this group. The student researcher verbally explained the objective of the proposed study and the consent form before asking those who wished to complete the survey to sign the consent form. These participants received hard copies of the ASSIST v3.1, the ASSIST v3.1 feedback report card, and

the Ten-Step ASSIST-linked Brief Intervention along with the survey. Each of these participants were offered the option to view the video clips after the student researcher explained the SBIRT materials, but only two community member participants opted to view the video clips. The survey-only participants generally completed the surveys within the range of 30-40 minutes.

**Phase two.** The student researcher contacted individuals who participated in the focus groups during phase one of this study and indicated on their consent forms that they would like to review the analysis that developed from the focus group data. In these secondary meetings, the student researcher presented participants with a one-page summary of the themes that emerged from the data of their stakeholder group (see Appendices U, V, and W). The student researcher asked participants to provide yes or no responses to indicate whether they agreed or disagreed with each theme. For the instances in which the participants disagreed with a theme, the student researcher asked participants to provide one sentence that best described the reason for their disagreement; thus, engaging participants in the data analysis phase of the research (Aronson, 1994), and implementing member checks (i.e., a validity strategy of verifying the research outcomes with the participants to ensure credibility).

### **Qualitative Analytic Procedures**

**Transcriptions.** The student researcher sent the audio recordings for each focus group to a secure transcription service to be transcribed verbatim. To maintain confidentiality of the participants, the student researcher removed personally identifying information about participants from the transcriptions. Each transcript was analyzed based on the data analysis procedures identified below.

The transcribed audio recordings provided the data for the qualitative analysis. Additionally, the feedback from phase two of the data collection procedures (i.e., the one-



sentence statements that provide responses to the member checks and best described the reason for participant disagreement with specific themes) was incorporated into a secondary phase of the theme development (further detailed below under Theme Development) to either further validate or add to the selected themes.

**Justification for the use of thematic analysis.** The student researcher analyzed the qualitative data using thematic analysis; a method utilized for examining manifest and latent themes, and further used to extract the most salient patterns of meaning from data (Braun & Clarke, 2006 as cited in Joffe, 2012). As a method, thematic analysis aligns with the social constructionism theoretical framework that underlines the rationale for this study. Thematic analysis helps to explicate the process of social constructionism, which explains the development of a particular representation (Joffe, 2012), more specifically the range in data that represented each of the stakeholder groups and their statements in reference to SBIRT.

Thematic analysis also has been recognized as an appropriate method for mental health research surveying service users (Joffe, 2012), particularly for studies aimed at examining barriers to the non-use of services (Johnston, 2000); a key component of this study. Additionally, thematic analysis is recognized as an appropriate method for examining focus groups responses (Joffe, 2012). Given that participants talked about different topics prompted by the researcher, thematic analysis encourages the researcher to consider the context while interpreting meaning from participant statements regarding a particular phenomenon (Joffe, 2012).

**Codebook development.** To guide the thematic analysis, a codebook was created and organized into sections according to the seven research questions (i.e., domains). The codebook is a combination of initial deductive codes (i.e., derived from the research questions), and the

inductive codes (i.e., based on direct observation from the data), and theoretical codes that develop from other related studies, particularly studies addressing barrier to health and mental healthcare services (Johnston, 2000). Codes were words or short phrases that represented key concepts from the research questions and the emergence of ideas and concepts directly drawn from the information shared by individuals within each of the stakeholder groups during focus groups. The codebook followed the format, described in Joffe (2012) of columns arranged by (1) name of the code, (2) brief and full definition of the code, and (3) an example of a text segment that directly applied to the code (see Table 2). A narrative of the codebook development is included below, along with an example of how a code was created and refined.

First, the student researcher created nine deductive codes that were based on the research questions, and nine theoretical codes that aligned with each deductive code. For example, from the research question, “What are the ways in which the three stakeholder groups perceive the effectiveness and relevancy of the substance use and abuse services and resources currently available to the local Black community in Hartford?”, the student researcher created a deductive code labeled “exchange”. Exchange was defined as the perceptions and perceived comfort of the patient-provider interaction before the ASSIST is administered, and the aligning theoretical code, distrust, represented the attitudinal barriers that exist due to community distrust for healthcare systems (Hall, 2001). To enhance reliability and assess for biased interpretations during the codebook development and the coding process, the student researcher employed a secondary coder (a fellow doctoral student health researcher). To orient the secondary coder to the data, she conducted a post-hoc review of one of the two community member focus group audio recordings, for which she shared her viewpoints on how the student researcher’s style of focus group facilitation allowed for individual opinions as well as collective narratives to emerge.

The post-hoc review was a diversion from the procedures initially described in the dissertation proposal. According to Morse, Barrett, Mayan, Olson, and Spier (2002), there is a concern for research that diverts from the original research strategies because it deemphasizes the self-correcting mechanisms that were originally proposed to eliminate threats to internal and external validity. However, in accordance with seminal contributors to the concept of “trustworthiness” in qualitative methodological strategies, Guba and Lincoln (1989) suggests an authenticity criteria that can be used to evaluate research that diverts from the original research procedures. As indicated in Guba and Lincoln (1989), the student researcher used peer debriefing throughout the analysis and member checks in phase two, which may lessen the impact to validity that may have resulted from this diversion. Although it was originally proposed that “Before examining the codebooks for biases interpretations, the secondary coder will review one focus group transcript for each of the stakeholder groups, and any additional codes will be added to each codebook”, this step was proposed because the student researcher originally overestimated the number of focus groups needed. In actuality, there were only four focus groups, and they occurred with little time in between for extensive, constructive (i.e., during the process) inquiry. To replace this step, the secondary coder agreed to conduct a post-hoc review before both researchers initiated the coding process, given the need to remain flexible is often required for CBPR (Holkup et al., 2004 as cited in CADCA National Coalition Institute, 2011; Lincoln and Guba, 1985). Although the secondary coder’s post-hoc (i.e., evaluative) review of the audio recording still occurred at the beginning of the data analysis process rather than at the end of the study (which is the true nature of post-hoc inquiries) (Morse et al., 2002), it still merits attention because it was a diversion from the methodologies proposed for this dissertation research.

Given that the secondary coder's role was instrumental throughout the coding process, the codebook was structured to facilitate a teamwork approach that initiated with the codebook development. MacQueen, McLellan, Kay, and Milstein (1998) indicated for research in which two or more individuals are part of the coding process, the codebook development strategy needs to be congruent with the group effort. Abiding by this concept, the student researcher constructed the initial codebooks (containing codes based on each research question and the affiliated theoretical constructs) in a format that was adaptive for the secondary coder, given prior knowledge of her qualitative experience and organizational style. The student researcher met with the secondary coder to gain feedback on the following three questions to critical analyze the codebook: (1) do the descriptions and examples make sense for each code, (2) do the deductive codes match the theoretical codes, and (3) do the code descriptions seem applicable to all three stakeholder groups. The secondary coder indicated that the codes appeared to be applicable across each stakeholder group, and to address the other two questions, both coders (referring to the student researcher and secondary coder) agreed to further refine the codebook as we coded the transcripts.

After meeting with the secondary coder, the decision was made to combine the codebooks that were separated by stakeholder groups because each code was applicable to each stakeholder group. The student researcher and secondary coder made several alterations to the codebook throughout the coding process. First and in accordance with MacQueen et al. (1998), three of the codes were renamed to better reflect the voices of the participants, and to reduce the likelihood that the coders' preconceptions could impact the analysis. For instance, and in keeping with the above example, the coders decided to rename the code "exchange" to "engagement" and expand the definition. Our continuous discussions of worldviews facilitated

the alteration to this code because in realizing that we initially differed in our understanding of the observed communication styles (particularly for participants who identified as members of the Black community), we agreed that ease of communication factors into comfort level. The inclusion criteria for “engagement” was expanded to include any disconnection or connection between patients and providers due to differences or similarities in communication styles.

Secondly, after coding the first two transcripts, the coders decided to add an inductive code to the codebook that emerged from the transcripts (e.g., self-reflection) and the quantitative outcomes (i.e., suggestions for how health care providers should initiate asking members of the Black community in Hartford substance use questions). Only essential inductive codes were added to the codebook because this study is ultimately a mixed methods design, and it is generally recommended to limit the number of codes in order to facilitate analysis with the quantitative outcomes (MacQueen et al., 1998).

Thirdly, the coders decided to combine the codes that co-occurred (i.e., were so similar in nature that they were difficult to distinguish at times). For example, two codes (i.e., collaborations and integrative approach) were combined to create a new code “collaborative approach.” During a coding meeting, the student researcher and secondary coder came to a consensus about combining these two codes after the secondary coder expressed concern that as a coding team, they were using the codes interchangeably. From that point forward as they continued to independently code, they both use the combined code that developed. Throughout the codebook development and coding process, the student researcher met with the secondary coder to reexamine the codebook and re-review the analyzed data to discuss the differing outcomes. The procedures for determining the reliability for the codebooks is further described in the validity and reliability section.

*Frequency labels.* According to Hill et al. (2005), frequencies (i.e., code frequencies) are difficult to fully utilize in studies that involve a cross-analysis of samples. This notion applies to the current study given that each focus group had a different number of participants, ranging from four individuals to eight individuals. Given this degree of variance, the student researcher applied the criteria established in Hill et al. (2005) for frequency labels as the following: (a) General means all or all but one case, and these cases were referred to as “all” in the Results section; (b) Typical means more than half of the cases up to the cut-off for general, and these cases were referred to as “most” in the Results section; (c) Variant means at least three cases up to the cut-off for typical, and these cases were referred to as “few” in the Results section; (d) Rare means one to two cases, and these cases were identified by number in the Results section.

**Coding procedures.** Once the first phase of the codebook development was complete, the student researcher and secondary coder began the process of coding the data. Coding is described as a process in which segments of the text are selected and categorized by the previously established codes. It also allows researchers to link separate codes into sequences, and identify patterns and co-occurrences between linked codes (Joffe, 2012). In congruence with MacQueen et al. (1998) recommendations, the student researcher established guidelines for assigning segments of text to code prior to initial coding. In order to assess the secondary coder’s understanding for the guidelines, the student researcher selected a portion of one of a transcript to review for training purposes, rather than inclusion of the analysis. Both the student researcher and the secondary coder used the same coding guidelines to code each transcript, which consisted of identifying text segments and counting the number of focus group participants who agreed with or added to each statement to establish the weight of each coded segment of text. Reappearing ideas that were expressed by the participants within the focus groups were

identified by code and the number of individuals involved (DeZutter, 2008). For example, the following passage (with pseudonyms) depicts an illustration in which the collective voices within the community leader focus group was identified by a code and frequency.

- Tony:* Yeah, so it's like we gotta try to change that to set a better example for the younger ones.
- Mike:* If you're gonna drink, don't do it around no kids or –
- Tony:* I suggest don't drink at all.
- Damien:* Don't do any at all.

For these passages, the coders agreed that these statements fit the code for “responsiveness” because it represents an instance in which the individuals affiliated with the community aim to influence behaviors associated with substance use. In terms of frequency, the coders indicated that three participants contributed to this code. According to DeZutter (2008), higher code frequencies suggest that a specific idea is important to the group of individuals involved and represent a collective voice.

The statements that did not fit with a code from the codebook were identified and the coders determined if an inductive code was needed. During the coding meetings (that occurred after each transcript was independently coded), the coders identified and discussed the segments of text that could lead to the development of inductive codes. The student researcher reviewed the tentative inductive codes against the previously reviewed transcript(s), and informed the secondary coder if the tentative codes would be added to the codebook as inductive codes. This process resulted in the inclusion of one inductive code (i.e., self-reflection) and the renaming and re-definition of three deductive codes (i.e., engagement, patient-centered care, and responsiveness).

These coding procedures were implemented separately for each stakeholder group transcript to allow for comparisons across stakeholder groups, and to ensure that the resulting codes were applied while the coders considered the context for the representative members of each stakeholder group. After reviewing each transcript independently, the coders met to compare and contrast their independent codes, discuss instances of agreement and disagreement for each identified code, and made any necessary modifications to the codebook in between transcripts (Braun & Clarke, 2006; Maguire & Delahunt, 2009). Intercoder reliability improved with each transcript and resulted in the following scores: .95 for chunking (i.e., grouping of data), .80 for independent coding, and .90 for consensual/collaborative coding. The scores for intercoder reliability were aligned with the calculations of  $(\text{number of agreements} / (\text{number of agreements} + \text{number of disagreements}))$  (Miles & Huberman, 1994).

**Theme development.** The coded segments of text were examined for themes through the following phases and procedures:

*Phase one.* In phase one, first the student researcher and secondary coder identified themes by examining the codes one at a time, specifically focusing on the text segments that had at least two or more participants who agreed with or contributed to that statement. When examining for themes, the student researcher focused on identifying relationships between codes, and how the number and patterns of codes varied for each stakeholder group. Both the student researcher and secondary coder looked for re-occurring patterns and associations that were relevant and specific to each stakeholder group for comparisons across stakeholder groups. The connections between the text segments for each code, as well as the inter-related codes, were identified as preliminary themes. For example, we had a noticeable number of codes that related to the belief that addiction results from poor personal choices and weak character, and to the



belief that social and environmental factors influence addictive behavior. We collated these two perspectives to form the initial theme “Strong assumptions about substance users” (Braun & Clarke, 2006; Maguire & Delahunt, 2009). This process lead to the development of preliminary themes that represented basic ideas and concepts that signified barriers and facilitators of (1) accepting services (range from acknowledging the existing sociocultural problems to key factors of the assessment) and (2) following through (ranging from the relevancy of the brief intervention through to potential post- brief intervention planning) (see Table 3). Table 3 is an illustration of the preliminary themes (i.e., broader and weaker themes), some of the associated codes that lead to these themes, and text examples that supported the themes in this phase of the research.

Table 3 follows the qualitative approach of providing additional details through the use of illustrative examples of themes, rather than a summary table depicting the frequency of each theme, as advised in Cunningham, Weathington, & Pittenge (2013). The identified themes were cross-examined with the preliminary quantitative outcomes (this analysis is further detailed in the section labeled Quantitative Analytic Procedures), which consisted of the outcomes for each stakeholder group and were organized into sections based on each research question. For each theme, the student researcher and secondary coder determined if the theme converged or diverged for each quantitative outcome for each stakeholder group. By the end of this first phase of theme development, the codes and preliminary quantitative outcomes were identified with the now developing broader themes, weaker themes (formerly labeled as subthemes in the proposal) were eliminated, and the broader themes provided specific responses to the research questions (Braun & Clarke, 2006; Maguire & Delahunt, 2009).

*Phase 2.* In the second phase of theme development, the student researcher examined the coded text segments that were only supported by one participant, and assessed for relationships between these coded segments and others of the same code that also were only supported by one participant; these statements were used to further refine the descriptions of the broader themes. Illustrative examples of the one-participant text segments that helped to add dimensions to the themes are provided in Table 4. The secondary coder was not involved in this process of re-examining the one-participant text segments, but she independently reviewed the outcomes and met with the student researcher to discuss the implications for each of the established themes. The goal behind identifying these one-participant text segments was to ensure that any data segments that were coded into reoccurring themes, and lacked any association to other themes, would be incorporated into the findings to enrich the outcomes. Given that this data is specific to an under-represented minority group, the idiosyncratic themes are still important to acknowledge because these could contain critical information that may not be articulated in conventional ways (Joffe, 2012).

To verify each decision to incorporate one-participant text segments as added dimensions to the broader themes, the student researcher re-examined them for direct and indirect associations with the themes (and reviewed earlier memos), to determine if meaningful interpretations emerged across the three stakeholder groups. Meaningful interpretations were determined by examining the coded sentences and paragraphs and determining if the segments were descriptive, consequential, or evaluative of the broader themes established in phase one (Riley & Hawe, 2005). The student researcher also examined the one-participant text segments to determine if each one was coherent and distinct from other text-segments. According to Maguire & Delahunt (2009), at this stage of theme development, it is important to determine if

themes overlap or provide interpretations that is too broad. For example, the student researcher eliminated the weaker theme “Racism/classism/sexism” (listed in Table 2) because it overlapped with other themes (i.e., “trust and confidentiality” and “underutilization of SA service”).

Thematic analysis is known for presenting a balanced view of the data within a specific context, rather than focusing on the prevalence of reoccurring themes.

*Phase three.* In the third and final phase of theme development, the one-sentence statements that were obtained from participants during phase two of this study (i.e., member checks) were used to contextualize the data. Contextualizing the data typically allows the researcher to provide a rationale for unexpected results, explain processes by which opinions and beliefs are established, and reveal the additional perspectives about a developing issue (Schatz, 2003). The one-sentence text segments were coded following the same coding process that was implemented for the data collected during phase one of the study. At this stage of the research, the codes were attached to clearly designated broader themes, so the student researcher included some of the one-sentence statements to further provide dimension to the established themes if they provided an additional perspective. Table 5 provides examples for the one-sentence text segments that helped to add dimension to the themes. In their final meeting, the student researcher and secondary coder discussed the implications for each of the established themes. For this stage of the theme development, the focus of the contextualization was to expand upon the relevant findings that were identified through the codes and themes in phase one of the study, and to assist in operationalizing the wider context of these findings.

**Validity and reliability strategies.** Lincoln and Guba (1985) provide a framework for assessing and ensuring rigor and trustworthiness in qualitative research, which include: credibility, transferability, dependability, and confirmability.

*Credibility* (the equivalency of internal validity for quantitative research) is an evaluation of whether or not the research findings represent a “credible” or believable conceptual interpretation of the participants’ perspectives. It was initially determined that the data from this study would only be considered credible if each of the stakeholder groups agreed that the results were representative of their perspectives (Lincoln & Guba, 1985). In order to achieve credibility (as previously described under Focus Group Protocol), the student researcher used active listening probes during each focus group to ask for clarifications and additional explanations for brief statements, and used participant feedback to adjust accordingly. The student researcher also engaged in member checks during the phase two of the data collection to verify and clarify my understanding of the participants’ experience through feedback from the participants (Lincoln & Guba, 1985).

*Transferability* (the equivalency of external validity for quantitative research) is the degree to which the findings can apply or transfer beyond the boundaries of the project to other contexts and settings. In order to ensure that the findings were transferable, the student researcher collected detailed information about the research setting context and the underlying assumptions upon which this context exists (Krefting, 1999; Shenton, 2004). The primary intent of this study was to transfer the voices of the three stakeholder groups into concrete suggestions for the task of culturally adapting SBIRT for the Black community in Hartford. The student researcher was further able to determine instances in which information gained from the representative voice of the Hartford community could also generalize to inform adaptations for other community health centers.

*Dependability* (the equivalency of reliability for quantitative research) refers to the consistency of findings (Guba, 1981), or more specific to this study, how replicable is the data

analysis. Two common methods for establishing dependability are the use of multiple coders and peer review and discussion. The student researcher introduced a secondary coder to the data from this study by reviewing and discussing an audiotaped focus group recording. The secondary coder re-examined the codebook for biased interpretations and analyzed a focus group transcript for each of the stakeholder groups. Additionally, the student researcher met with the secondary coder to review the analyzed data and discuss the differing outcomes. Peer review acts for qualitative research as inter-rater reliability acts for quantitative research. To further ensure dependability, student researcher employed the use of low-inference descriptors (Johnson, 1999). As such, the student researcher included direct quotations from individuals in each of stakeholder groups to support themes she reported in the findings.

*Confirmability* (the equivalency of objectivity for quantitative research) is the degree to which the outcomes are supported or validated by others (Guba, 1981). To enhance confirmability, the student researcher conducted a data audit, in which an external reviewer (the auditor previously mentioned) examined the data collection and analytic procedures to determine if any biases had distorted the data. The auditor and student researcher discussed the processes by which a researcher made decisions about the data in order to determine if she would come to comparable conclusions (Krefting, 1999). The secondary coder served in this capacity during all phases of data analysis. These steps were in place to ensure that the student researcher's meanings, values, and biases had limited impact on the analysis of the information provided by each participant throughout all phases of data analysis.

### **Quantitative Analytic Procedures**

The surveys were constructed to provide a quantifiable version of the focus group protocol. As previously stated, the quantitative data (consisting of survey items and a

demographic questionnaire) provided a supplemental consensus for the qualitative responses. The student researcher initially intended to aggregate the information from the surveys immediately following the first focus group, so that the statistics could be considered throughout the time that the student researcher and secondary coder analyzed the qualitative data. In actuality, the process of aggregating the information started after the first focus group, but the largest portion took place during theme development. Although it was the student researcher's belief that the incorporation of the survey data needed to take place during theme development rather than during the coding process, other researchers indicate that when the qualitative data is used to identify reoccurring themes, it is beneficial to have the quantitative data verify the congruencies and incongruences with the population (Dhoest, 2012) – a process that took place during the qualitative theme development.

Survey and demographic data was inputted into a data file for analysis in the Statistical Package for the Social Sciences (SPSS). SPSS allowed the student researcher to create a variable for each of the survey items and demographic characteristics. Additionally, the student researcher created a variable to identify each of the three stakeholder groups, which allowed for comparisons across the stakeholder groups. As data was added to the data file, the student researcher was able to identify any missing data and outliers. The student researcher did not remove outliers from the dataset because these outliers provide valuable information about the diversity that existed within each stakeholder group. Participants were allowed to provide multiple responses for most of the survey items, which affected the student researcher's originally proposed decision to gather descriptive and inferential statistics for the survey items. The analytic feature in SPSS for handling survey items that allowed for multiple response options is called Multiple Response in SPSS. The use of this feature for multiple category sets

only allows for analyses of frequency and crosstabulations; which inhibited the student researcher from performing the full range of descriptive and inferential statistics. The student researcher obtained percentages for each independent and comparative analysis.

**Validity and Reliability Strategies.** *External validity* is the extent to which the sample considered for this study could be generalized to the larger Black American community in Hartford, CT. The researcher has selected three stakeholder groups to represent the voices of individuals associated with the larger population of Black Americans in Hartford; thus enhancing the external validity of the study. The decision to select three stakeholder groups has been used in previous studies as an appropriate means for gathering a range of voices within a select community (Windsor & Murugan, 2012). The student researcher conducted four groups, each one consisting solely of the persons within each stakeholder groups. The researcher had two focus groups for the community member stakeholder group to improve the external validity of this study by means of repetition.

*Internal validity* is the extent to which the survey items measure what they intend to measure. Pertinent to this study, internal validity is the extent to which the survey items measure the participants' thoughts and ideas about the SBIRT protocol, and their perspective of substance abuse in the Black community in the Hartford, CT. Given that the quantitative portion of this study primarily consisted of locally developed survey questions (replicating the focus group questions) tailored to each stakeholder group, there are advantages and disadvantages to this method that impact the internal validity. One advantage is that the content and wording of each survey item was constructed with the consideration of the position and perspective of each stakeholder group, and to address specific concerns that directly relate to the SBIRT protocol.

To ensure that the items on the survey were clear and understandable, a draft of each survey (for community members, community leaders, and service providers) was reviewed by representative members of each stakeholder group who were not involved in the survey construction or as participants. Despite efforts to adapt the surveys to represent different groups within the Hartford community, these stakeholder-specific surveys also are considered low in internal validity because they do not include externally-referenced items (i.e. items that have been used to collect national data) (Suskie, 1996). The surveys for this study did not contain items supported by national data, because the primary intent for the survey was to provide consensus responses about the SBIRT protocol that are specific to the programs in the local community.

*Reliability* for quantitative research is the extent to which an instrument can consistently produce the same results when repeated over time, or the consistency between two raters observing the same phenomenon. The student researcher was only able to observe the inter-rater reliability over time for specific items throughout the phases of theme development (Biddix, 2009). By monitoring inter-rater reliability, the researcher became cognizant of the consistencies in responses across different participants. The student researcher monitored inter-rater reliability across participants in the same stakeholder group to estimate whether or not a consensus in survey responses was developing within a stakeholder group. The developing trends in consensus within the quantitative data further informed and validated the developing themes in the qualitative data.



## **Chapter 4: Results**

In Chapter 4, the student researcher presents the findings that emerged as a result of the methods and procedures described in Chapter 3. This results section is organized by first presenting the demographic outcomes for each stakeholder group. Secondly, each phase of the data analysis reinforced five overarching themes and each one is detailed in this section, as well as the corresponding points for each stakeholder group. For each theme, the student researcher has identified (1) the qualitative supporting details, (2) the corresponding quantitative findings, and (3) the comparisons or integrations between the quantitative and qualitative for each theme. The student researcher also describes how the data converges and diverges across the stakeholder groups and between the qualitative and quantitative outcomes for each theme. It should also be noted that the findings for the service provider stakeholder group may need to be addressed with caution, given that the criteria for this group had expanded beyond the originally proposed criteria.

### **Demographic outcomes of the sample**

As a total participant sample, the student researcher intended to recruit approximately 20 to 30 participants for each of the three stakeholder groups. The final numbers for each stakeholder group were 35 community member participants, 25 community leader participants, and 25 service provider participants. Table 6 presents the demographic characteristics of the study participants for each stakeholder group. The community member sample had an average age of 41.57. About 57% were male, about 91 percent identified as African American or Afro Caribbean Islander, and high school was the highest level of education achieved for almost 40% of the sample. The community leader sample had an average age of 23.20. Fifty percent were male, 80 percent identified as African American or Afro Caribbean Islander, and high school was

the highest level of education achieved for 60% of the sample. The service provider sample had an average age of 42.54. About 33 percent were male, about 39 percent identified as African American or Afro Caribbean Islander, and high school was the highest level of education achieved for less than 8% of the sample (see Table 6).

### **Theme 1: Sustained assumptions about substance users**

This theme “sustained assumptions about substance users” generated across the three stakeholder groups because participants generally described how substance users were perceived in the community, and the existing problems in the community that they believe substance use has impacted. This theme was drawn from the combined code “Self-reflection / problems / disparities”. The section below describes the qualitative, quantitative, and integrative findings that support the rationale for and provided dimension to this theme.

**Qualitative.** Among community members, there were general assumptions about the people who use substances and the reasons why they use. Most members believed that every individual is different, but there are common social problems (i.e., the accessibility of drugs, job loss, family disenfranchisement) and beliefs about substance use that continue the cycle of use. For example, one participant stated, “We have a family member that may be a bread winner – That happens to get on drugs or abuse substances um, you know they could become abusive – They could, they could lose their job –They could, you know how they do things that will break apart the family”. Few members also acknowledged that some individuals use substance to self-medicate when underlying issues are not addressed.

Community leader responses converged with community member responses about having general assumptions about the people who use substances and the reasons why they use. Leaders generally believed that problems (i.e. unemployment, family stress, gambling) develop from the

substance use. More specifically, the type of substance can impact how they believe the community views an individual's circumstances (i.e., a person who smokes Black and Milds is viewed differently (less negatively) than a person using Angel Dust). Amongst this group, they agree that the community's understanding about the severity of the "culturally acceptable" substances is debatable. They strongly believe that adults using substances are highly influential to the youth and their behaviors. For example, as one participant explained, "I've seen that most adults, they be like drinking alcohol and then the youth see the adults and think that's good for them, they'll start doing it. And then what they don't know is that, when they start young, they're already messing up their lives right there".

Service providers partially converged with the community members and community leaders with regard to the reason for use. It appeared that providers saw substance use as a coping mechanism or symptom to larger problems (i.e., mental health issues, homelessness). Some providers indicated that they believe that the individuals in the community need to resolve other issues (i.e., meet their hierarchy of needs) before actually acting on the behavioral health options. Some also believe that cultural background plays a role because they have noticed that certain groups tend to abuse substance while others tend to abstain; continued use often relates back to the underlying issue that there is shame associated with seeking behavioral health services. As stated by one participant,

"A lot of times the patients when they screen positive they'll, they'll say they're continuing to use because of the underlying what they said about the behavioral health, but because of in their family culture Hispanics or African Americans you can't go see somebody from behavioral health, so what do they continue to do? They continue to use because culturally it's like there's nothing wrong with you. "You don't need to talk to

nobody and you can't take it outside of our family" type attitude. So they'll continue to use because of that”.

**Quantitative.** Among the sample of community members, when asked to indicate the ways in which they saw drug, alcohol, or tobacco use negatively affect their homes, neighborhoods, or Hartford in general, 32.7% identified employment, 32.7% identified safety, 28.6% identified health, and 6.1% identified other (i.e., family and the streets). Among the sample of community leaders, 33.3% identified health, 33.3% identified safety, 25.9% identified employment, and 7.4% identified other (i.e., education). When asked to describe the health, mental health, and social problems specific to drug, alcohol, and tobacco use within the local Black community, 61.5% of service providers indicated that these problems seem to impact the Black community just as much as other populations.

**Comparison or integration.** Both qualitative and quantitative data show that the participants (among all three stakeholder groups) either had a personal or general understanding of the sociocultural problems that impact the Black community in the Hartford area. The stakeholders all generally acknowledge the outcomes that negatively affect substance users and their families, but they varied with the degree to which they attributed the substance use to the existing disparities in the community.

## **Theme 2: Under-utilization of substance abuse services differs from lack of community knowledge**

This theme “Under-utilization of substance abuse services differs from lack of community knowledge” generated across the three stakeholder groups because participants generally described a two-fold rationale for the broad perception that substance use services are less accessible for and from within the Black community in Hartford. This theme was drawn

from two codes, “accessibility concern” and “services”. The section below describes the qualitative, quantitative, and integrative findings that support the rationale for and provided dimension to this theme.

**Qualitative.** Whereas some participants suggested that the Hartford Black community is generally uninformed about substance abuse intervention options that are available to the community, at least one participant felt that the Black community generally avoids these options because of the stigma associated with mental illness and receiving counseling. Among the individuals who believe the community is uninformed, they indicated that individuals want to be provided information about the different options, in order to feel empowered to pursue the option that is the best fit. Some individuals want health care providers to ask them, “Have you ever considered any of these option?” – as a way to initiate this conversation.

Community leader responses converged with community member responses because many leaders believe that there is not enough information being distributed about substance abuse intervention options that are available to the community. They expressed that people in the community typically do not talk to them about problems related to substance use, or go to them to receive information about available services. Some leaders connect the issue to underutilization because they felt that there should be better advertisement (i.e., posters and rallies) to inform the community and encourage them to use the available services.

Service provider responses converge with both community member and leader responses primarily with regard to underutilization, but also out of concern that the community is uninformed. Some providers appeared to question the accessibility of behavioral health services, given that patients had repeatedly mentioned their difficulties getting appointments. This issue is further complicated, given that some service providers feel that patients are not always truthful

about the problems related to their substance use. As stated by one participant, “So they try to minimize their use a lot. That's what I've been finding”. Two providers mentioned that the community appears open to seeking help for physical problems, but not for behavioral health-related issues. With regard to the community being uninformed, one service provider mentioned that the community does not know to ask, so they don't know that they can provide some other service in the same visit or connect them to another service. When asked about the concerns that they believe are contributing to substance use problems in the area, one participant indicated, “In my case, it's patients, the lack of education in terms of services provided in the community, point of contact, where to go”.

**Quantitative.** When asked to indicate who they would refer to if they wanted information about available services, 26.3% of community members identified family and friends, 21.1% identified primary care physicians, 18.4% identified social services, and 15.8% identified ministers or deacons of a church. When asked to indicate the resources they have or would suggest to the community, 28.6% of community leaders were unsure of what resources to suggest, while 28.6% would refer them to a treatment center, and 21.4% would refer them to a social service agency. When asked “What are some of the reasons why you might not consider using the available services?”, 32.4% of community members indicated that the reason would be due to shame, 27.0% indicated no desire to stop using, 18.9% indicated cost, and 10.8% indicated consequences/might get in trouble.

A comparative analysis across all three stakeholder groups revealed that when asked how the Black community would respond to any information about available services to reduce tobacco, alcohol, or drug use, 73.7% of community members (compared to 5.3% of community leaders and 21.1% of service provider) indicated that the community would be receptive to the

information and consider it. In addition, when service providers were asked “how do patients from the local Black community initially respond to you asking substance use-related questions during their appointments with you?”, 58.3% indicated that the community seems okay with these questions. When asked “if a health care provider was of a different race or class, would this impact how you would respond to information about available services?”, 39.3% of community members indicated it would not impact their decision - or lack thereof - to pursue substance use services if the health care provider was of a different race.

**Comparison or integration.** Findings converge between community members and service providers relating the stigma or shame associated with seeking behavioral health services as a barrier to accepting services. The quantitative data across stakeholder groups appear to reveal that upon receiving services, the community would generally feel open to the information that health care providers distribute, however the qualitative and quantitative data reveals that some of the individuals whom the community trusts to provide information and resources (i.e., community leaders) are generally uninformed about the different substance use resources available in the area.

### **Theme 3: Trust and confidentiality facilitate substance use questions**

This theme “trust and confidentiality facilitate substance use questions” generated across the three stakeholder groups because participants generally described confidentiality as a key element of developing trust between patients and providers, particularly when substance use questions are involved. This theme was drawn from two codes, “engagement” and “distrust”. The section below describes the qualitative, quantitative, and integrative findings that support the rationale for and provided dimension to this theme.

**Qualitative.** From the perspective of the community members, when substance use questions are asked, individuals generally feel comfortable answering questions (if there is trust in the healthcare provider), but they still question the confidentiality. Many individuals express concern about the consequences to responding to questions truthfully. For instance, one community member stated, “these doctors are mandated reporters and then if that person will reveal exactly what's going on in their life they probably will be arrested or have their children taken from them”. Some individuals believe cultural diversity training is needed so that health care providers can be more sensitive to the beliefs and circumstances of the community they serve.

When the community leaders were asked to respond based on their personal comfort level, like community members, these individuals generally feel comfortable answering substance use questions (if there is trust in the healthcare provider); and the race and class of the health care provider generally does not matter. One participant emphasized the importance of feeling comfortable when he stated, “Like, in order for me to get the help, I gotta feel comfortable – ‘cause you’re not gonna just talk to anybody you don’t feel comfortable with”. When leaders were asked to refocus their responses to the Black community, some believed that people in the community need support (i.e., a push) to get help, and it’s good to ask them questions that show concern (i.e., “What initiated your substance use?” or “How can I help?”). A couple leaders would question the need to continue helping someone who keeps using despite the leader’s involvement.

When substance use questions are asked, in congruence with community members and leaders, service providers also feel that patients appear comfortable answering questions (if they sense that the patient trusts them), but like community members and leaders, providers generally



believe patients either question the confidentiality or the inclusion of substance use questions in the appointments. Some providers feel that their own comfort level is dependent on their personal upbringing and whether they have developed biases towards certain groups. While some feel that race has nothing to do with it because trust is more important, at least one provider felt that the Black community lacks trust in some providers, which creates a barrier and can prevent them from seeing some providers as a resource. As one participant stated,

“For me, it's harder to um, communicate with the African American population. I don't know if it's the cultural thing, but they seem like, uh, they don't trust. They see me as a person that no matter how I explain to you, how I talk to you, you will never understand me because there is a cultural difference. So it's a little harder, you know, to, to make them open honestly to you and see you there as a resource and not as someone that is prying on your personal life, asking personal questions”.

Some of the providers believe that the confidence level of the provider is noticeable. Health educators feel more confident regardless of the race of the patient, if the doctor or medical assistant is involved in introducing them to the patient because it connects them as a medical team.

**Quantitative.** Among community members, 38.5% indicated that it feels uncomfortable when a health care provider asks about drug, alcohol, or tobacco use, and 59.1% indicated that neither the race nor class of the health care provider impacted this feeling. Among community leaders, 41.7% indicated that it feels expected and reasonable when a health care provider asks about drug, alcohol, or tobacco use, and 80% indicated that neither the race nor class of the health care provider impacted this feeling. Among service providers, 30.8% indicated that

differences in either race or class that exist between them and patients influence how they introduce the ASSIST, while 21.3% indicate that similarities in either race or class has an impact.

A comparative analysis across all three stakeholder groups revealed that when asked about approaches that they believe could help create a connection between patients from the Black community and their health care provider, the largest percentage of each stakeholder group indicated that the health care provider should explain the reason for obtaining information (i.e., 39.0% for community members, 37.5% for community leaders, and 38.9% for service providers). In contrast, when service providers were additionally asked if they had ever asked a patient from the Black community if they have any concerns or questions before they start their assessment, 72.7% indicated that they do not.

**Comparison or integration.** While many community leaders indicated that the race of the health care provider does not matter, there is some congruence with the service providers that the demeanor of the health care provider is noticeable. As one community leader participant stated,

“He [a person in the community] probably going to say, ‘I wanna switch my doctor,’ or something like that; or they’re gonna feel like they’re not getting the help that they want, because, ‘Wow, he don’t like my race or whatever,’ ... You know what I’m saying? So they probably wouldn’t even feel comfortable with him like that”.

Additionally, the qualitative and quantitative data both reveal that the Black community generally has concerns about the consequences that can result from speaking truthfully about their substance use. It appears that reassuring confidentiality could help to initiate some form of trust among hesitant patients, and given that quantitative data shows that each stakeholder group agrees that providing patients with the rationale for obtaining substance use information is

important, considering both of these components seems essential when providing services within the Black community.

#### **Theme 4: Desire for patient-centered care within the provision of high service quality**

Under this theme “desire for patient-centered care within the provision of high service quality”, patient-centered care does not represent the entire model for patient-centered care, and even though the patient-provider relationship is highlighted, issues of trust that were captured in the third theme did not contribute to this theme. This theme generated across the three stakeholder groups because participants generally suggested that there were key elements with regard to interactions with the provider, and the context of the appointment, that can impact efforts to implement SBIRT within the Hartford Black community. This theme was drawn from the combined code “ASSIST suggestions / patient-centered care / cultural adaptations” and the following codes: evaluate ASSIST, usability, BI [brief intervention] exchange, working alliance, BI relevance. The section below described the qualitative, quantitative, and integrative findings that support the rationale for and provided dimension to this theme.

**Qualitative.** Community members generally feel that health care providers need to consider other factors beyond the questions and conversation about substance use, if the aim is to follow a patient-centered approach. Many indicated that they need to feel welcomed into the environment, and it helps if the health care provider has a familiarity with the community – i.e., they should know the people and consistently be there. Many community members feel that the lack of service in some medical settings (i.e. the wait times and cleanliness of / restrictions on the amenities) contribute to some of the feelings of distrust between the Hartford community and medical professionals. When explaining the differences in restrooms between Hartford and other locations, one participant indicated, “[In other neighboring towns] You don't need a key with a

big fancy thing on it to open the door... So I ask her why is it, when it, why do we get treated this way when we live in Hartford... There's no trust, there's no trust”.

Community leaders generally feel that health care providers need to be aware that their own biases could impact how the questions and conversation about substance use are received by the community. Some leaders feel that the community could easily believe that the health care provider is accusing them of using a substance, depending on their approach. Like community members, some leaders feel it helps if the health care providers has a familiarity with the community (i.e., understands what is going on in the community or a person’s daily life that could factor into why that person uses). They also generally believe that asking questions is better than making assumptions. For example, at least two leaders made suggestions that health care providers should always give each individual the benefit of the doubt, which could also be shown in question form, (i.e., “Is there anything I need to know about you to better understand your circumstance?”). One participant suggested that providers also need to ask questions that gauge the patient’s readiness to change.

Similar to community members and leaders, service providers generally believe they need to consider other factors beyond the questions and conversation about substance use, but these factors are centered on ease of communication. Many providers have strategies that they rely on (i.e., involving the use of humor to probe for additional responses and providing health-related information that may be new to the patients) to create a rapport with patients from the Black community and ease any beliefs that they are being judged. For example, one participant described this process as, “Another skill that I use, you know, to my favor is humor. I go in and I say ‘It's gonna be brief and it's not gonna hurt’, and right there they crack up laughing and say ‘Go ahead. It's okay.’”. Providers are more likely adjust their approach to the age range of the

patients (i.e., being more formal with older adult patients), rather than the race or culture. Many providers feel that the factor that is most influential to the dynamics in the appointment is the length of the wait time before a patient gets to them. Some providers can see that there are cultural differences in the perceived severity and categorization of different substances, but they believe that awareness is key because it may require clarifications. For instance, one participant indicated,

“I have a, um, there's a big West Indian population, um, where my center particularly is. So when you're speaking to, um, Jamaicans, you ask about the tobacco, automatically, boom, they start talking about marijuana. So because I know that – I'm West Indian too – so because I know that, I always have to make sure I'm very clear on that question when I'm just saying about cigarettes, um, as opposed to marijuana”.

**Quantitative.** A comparative analysis across all three stakeholder groups revealed that when asked about community concerns about responding to substance use questions, or receiving substance use services in primary health care settings, community members and service providers converged in their responses. For community members, 29.2% identified less focus on health concern and 29% identified the duration of the appointment. Likewise for service providers, 25% identified less focus on health concern and 25% identified the duration of the appointment. Fifty percent of community leaders either did not foresee concerns or felt challenged to provide a perspective for this survey item.

Specific to the ASSIST and feedback report card, when community members were asked, “Would you personally feel comfortable completing this assessment [ASSIST and feedback report card] with your healthcare provider?”, 72.7% indicated that they would feel comfortable. Aligning with members, 60.0% of leaders indicated that they would personally feel comfortable

completing this assessment with a health care provider, and 44.4% indicated that it fits well within a primary care appointment. Likewise, 62.5% of providers (who had administered the ASSIST before with patients from the local Black community) felt very good about their comfort level completing it with this community.

Specific to the brief intervention, 44.4% of community members indicated that none of the questions or components of the brief intervention seem difficult to respond to or understand. Out of the participants who responded to the survey item asking if they felt that any components of the brief intervention prevent members of the Black community from speaking freely about matters that are relevant to them, only 30.0% of the community members and 100% of the community leaders felt that there were no components that preventing them from speaking freely. Likewise, 75.0% of the service providers indicated that they felt that none of the brief intervention components prevented patients from the local Black community from speaking freely about matters that are relevant to them. For the survey item asking members and leaders to identify the component(s) of the brief intervention that resemble questions (or remarks) that they would ask upon learning that someone they cared about has a substance use problem, 18.2% of members and 23.1% of leaders indicated the component in which the provider states, “what are the Less Good Things about using?”, most resembled questions they have or would want to ask.

**Comparison or integration.** Whereas the qualitative responses focused on the sociocultural and environmental factors that influence the relationship between the community and health care systems, the quantitative responses highlighted the unspoken dynamics and exchanges within an appointment and specific to SBIRT. Together, these two components speak to the overall health care experience that could allow the Black community to feel that their appointments are more welcoming and individualized.

### **Theme 5: Collaboration and communication across multiple systems**

This theme “collaboration and communication across multiple systems” generated across the three stakeholder groups because each stakeholder group contributed a different perspective with regard to developing and maintaining collaborative efforts focused on improving how SBIRT works for and within the Black community in Hartford. This theme was drawn from two codes, “collaborations” and “integrative approach”. The section below describes the qualitative, quantitative, and integrative findings that support the rationale for and provided dimension to this theme.

**Qualitative.** Community members generally believe that there are conversations that need to take place among the community, in group settings. One participant describe the steps to building upon collaborations within the community as,

“I wouldn’t rush it. You know? But I would try one or two, three places. Like how you did here. And then see where it goes – you know what I’m saying? And then see where it goes. And then if it doesn’t work out in this location, then go to the next. You know, ‘cause if you go rushing it to five different locations, say you don’t get an answer in not even one”.

Some community members believe it could provide opportunities to share information gained from medical personnel (e.g., Offering take home materials for the individual and another copy to share with someone else in their family or community ---helping to disperse it to the community). Some individuals want to learn how to bring up conversation about substance use

with their families and others so that the problem remains visible (i.e., to reduce the shame by talking openly with others).

Similar to community members, community leaders generally feel that different stakeholders need to collaborate with individuals from within and outside the community to address the issue of substance use in the Hartford community. They believe in collaborating with other cities to help and learn from each other. For example, one participant stated, “every other city, I’m sure they have a lot of problems – like, people that have a lot of problems and stuff and want, like – hopefully they’ll want somebody to reach out to them. But it’s like – some people, they just shut them out”. Additionally, some believe that the youth need to be included in this process.

Service providers appeared to emphasize the importance of intra-collaboration (i.e., more collaborations among the different medical personnel) more so than intercommunity collaborations. For instance, one participant stated,

“I have medical assistants that have great rapports with their patients. So like if they, they're introducing you to the patient it makes it a lot easier. ‘Hey, this is XXXX, you know, he's our health educator here. He's gonna come in and ask you a few questions about different substances’ and the door is open, because like I said they trust the medical assistants to come in”.

With regard to collaborations with the community, many providers believe that offering patients take home materials, additional resources, and an opportunity to return when they are ready encourages personal accountability, and alleviates the likelihood that patients will get defensive if they don’t want the help.



**Quantitative.** A comparative analysis across the stakeholder groups was examined for the survey item which asked if there were concerns related to substance use in the community that could be addressed in collaboration with others. Responses varied among the stakeholder groups with 57.1% of community leaders indicating yes, 54.5% of providers indicating no, and 45.5% of community members indicating unsure. When asked how they felt we should develop these collaborations, 52.9% of members felt that health care professionals should be invited into community settings, 50.0% of leaders and 44.4% of providers felt that there should be periodic meeting with health care professionals and community leaders.

**Comparison or integration.** Both the qualitative and quantitative outcomes show that the each stakeholder group has differing viewpoints of how they would envision collaborations, and the degree to which each group appears ready to embrace the concerns of another stakeholder group. When compared to members and leaders, service providers appear less willing to step outside the boundaries of their facilities to further address the substance use concerns of the community, but they also have more experience addressing this issue than the other two stakeholder groups.

## **Summary**

In this chapter, the student researcher detailed the five themes (i.e., sustained assumptions about substance users, under-utilization of substance abuse services differs from lack of community knowledge, trust and confidentiality facilitate substance use questions, desire for patient-centered care within the provision of high service quality, collaboration and communication across multiple systems). Each theme was informed by the research questions and reflected through the data. In the next chapter, these themes will be further explained (with supporting literature), and incorporated into the broader context.

## **Chapter 5: Discussion**

The overarching purpose of this exploratory study was to contribute one step toward validating, modifying, and evaluating a cultural and community adaptation of SBIRT for the Black community in Hartford. The aim of this current study was to utilize CBPR (Minkler & Wallerstein, 2010; Viswanathan et al., 2004) to capture the voices of three stakeholder groups within one local Black community (comprised of multiple ethnic groups of African ancestry) to inform the development of a culturally adapted version of SBIRT. The findings also outline an agenda for incorporating information of this nature into modifications specific to other under-represented groups and other underserved communities.

In this chapter, the main findings from this study are related to the literature associated with the themes that were identified in chapter four. In the first section, the findings and conclusions relating to each of the research questions are differentiated between each stakeholder group. Although the original inspiration behind this study was to create a version of SBIRT that is culturally relevant for the Black community in Hartford, this study presents the initial stage of that process. Specifically, the findings from this study can be used to guide future studies designed to implement and test the use of a culturally adapted version of SBIRT. Quantitative outcomes provided responses to the research questions, and the qualitative outcomes provided the details about the interpersonal exchanges that encourage or deter full and active involvement of substance users in their local health care systems Research question 6, “What are the similarities and differences in perceptions across and within each stakeholders group for the other research questions?” is addressed through each description of the outcomes for the other research questions. This chapter concludes with the practical implications that the student researcher identified throughout process of developing this study and recommendations

grounded in participant responses, followed by the limitations, significance of the research and suggestions for future research aimed at culturally adapting SBRIT.

### **Findings by Research Questions**

**Sustained assumptions about substance users.** Theme 1 addressed the research question 1: “What are the ways in which the three stakeholder groups perceive the severity of substance use and abuse issues in the local Black community in Hartford?” While the quantitative data revealed the perceived problems that different stakeholder groups in the Hartford area identified as prevalent, the qualitative data revealed how substance users in the community are further disenfranchised by the biases and assumptions that they encounter within their homes, neighborhoods, and the wider community (which include health care settings). The quantitative data accounted for the concerns that were specific to the community in Hartford. The largest percentage of community members (32.7%) identified employment as an issue of concern due to substance use in the area, while community leaders identified health (33.3%) and safety (33.3%) as issues of concern, and 61.5% of the service providers indicated health, mental health, and social problems as the major concerns.

Supporting research suggests that determining the key elements of the community context should precede the implementation of a community intervention (Chen et al., 2012; Hall, 2001; Trickett, 2009). It reinforces the notion that communities of similar ethnic compositions are not culturally homogenous, which is consistent with the statement by service providers that the problems identified in the Hartford area seem to impact the Black community just as much as other populations. This notion is further supported by the social constructionism framework, which suggests that the shared realities and viewpoints of a community are constructed and may differ from the realities and viewpoints of another community, especially with regard to their

perspectives about the substance use problems in their areas (Best, 1995; Freedman & Combs, 1996; Gergen, 1999). When a preventative intervention is grounded in the local context, it ensures that it is not just community-based, but also culturally situated and adaptive to the customs and values of the community (Trickett, 2009). Although this theme is adaptable for multiple communities, this procedure of identifying the specific concerns that a community associates with substance use in their locale should be conducted separately for each community implementing SBIRT (Korcha et al., 2012; Liu & Satterfield, 2015; Satre et al., 2012).

One area of agreement across all three groups was that the socio-cultural context does influence help-seeking behaviors. Rather than a focus on the severity of substance use (of which community leaders revealed that the type of substance impacts the degree to which an individual is perceived negatively for his or her use), the qualitative data revealed that the negative reactions with regard to the substance use is directed at the substance user from multiple avenues, which could ultimately deter a substance user from acknowledging the problem to close family and friends, and reinforce the shame associated with seeking help from the services available to the community. This conclusion is supported by Fish (2012), who suggests that personal characteristics associated with substance users are more impactful in predicting abuse, than the drug itself. While the current study revealed that despite the close nature of familial relationships common to the Black community and quite possibly the Hartford area, substance users may receive overt and covert messages from their support systems that discourage help seeking behaviors. After acknowledging that these assumptions carried by the community exist, Fish (2012) indicated that marginalizing substance users is counterproductive, and more efforts should be made to reduce the harm that these individuals experience as a result to their substance use and impact that others may indirectly experience.

**Under-utilization of substance abuse services differs from lack of community knowledge.** Theme 2 addressed the research question, “What are the ways in which the three stakeholder groups perceive the effectiveness and relevancy of the substance use and abuse services and resources currently available to the local Black community in Hartford?” The quantitative data revealed that the largest percentage of community members (26.3%) would refer to family and friends for information about services available to address substance use issues, but the largest percentage of community leaders (28.6%) indicated that they would be unsure of what resources to suggest. Given that many of the leaders identify with Hartford as members as well as leaders, they also represent the family and friends that people in the community could want to reach out to for information; which contributes to the lack of dissemination of information throughout the community. These outcomes suggest a need for community outreach personnel who can familiarize community members and leaders of the available resources (Steinberg et al., 1998). Similarly, the co-constructive/developmental framework suggests that agencies and healthcare systems could be more influential to the community when they employ available resources that are adaptive to the needs of the communities they serve (Rigazio-DiGilio, 2000, 2001, 2012). Specific to SBIRT, some health educators are willing to engage in outreach tasks and could be in one of the most instrumental positions to facilitate outreach from within community health care settings. In support of this idea, here is a quote from one of the SBIRT health educator focus group participants explaining her outreach efforts,

“But sometimes with the patients you have to go the extra mile. Like in my case constantly when they say “Miss, how do you think I’m gonna go and get a service when I don’t have even money to eat?” And I say “Well, uh, that’s not something to worry

about. I'm gonna make sure I'm gonna find you, talk to the person that's gonna give you passes for the bus. We can arrange to have transportation pick you up and then, uh, take you back. Just let us know when you're available and we're gonna take care of the rest." And then you have to go to the clinician, you have to go to your supervisor, you have to go to the person that works with the homeless population. I mean you have to sometimes put seven hats on to make the patient agree to get the help that they need."

Ultimately, providing resources to each individual who receives assessments through SBIRT can help to inform the community, but it also attends to the 21.1% of the community members who indicated that they would seek information about available services from primary care physicians.

Another option to address the issue of community knowledge about available services was suggested from the community leaders. Some of the leaders indicated that better advertisement (i.e., posters and rallies) would inform the community (and better inform the community leaders), which could therefore increase the uptake and utilization of substance use services; this conclusion is also recognized in the literature. One study examining barriers to treatment among problematic substance users not in structured treatment, revealed that the advertisement should alert the community to service expectations and wait times to ensure that substance users are better informed as they consider seeking help (Notley, Maskrey, & Holland, 2012). These suggestions would be applicable for community health centers across Connecticut, but also specifically for the Black community in Hartford given the following response expressed by a service provider participant, "When, when you offer them, you know, 'Are you interested in some help? We can offer you some help.' And then that's the first thing that

comes. ‘Where do I have to go? Who is gonna see me? How long it’s gonna take for the appointment?’”

The qualitative data revealed divisions within each stakeholder group with regard to their perceptions of service barriers. Specifically for members of the Black community, it is debatable whether the larger issue is that there was a lack of knowledge among the Black community in Hartford about the services available to them, or that there are other factors (i.e. accessibility and stigma) that deter use of the resources and services available to the community. Other researchers (Burlew et al., 2011; Gearing et al., 2012; Lau, 2006) have acknowledged that among historically distressed communities (HDCs), stigma is one of the most common non-structural factors, and accessibility is a common structural factor that inhibits substance abuse treatment use. Myers, Fakier, & Louw (2009) found that the stigma associated with addiction actually inhibits family members from seeking services to help individuals in need. The researchers indicated that families from HDCs internalize the shame out a fear that outsiders will associate the problem with the entire family. This outcome correlates with the outcome of the current study, for which the largest percentage of community members (32.4%) indicated shame as a reason they might not consider using the available services. The outcomes from the current study and supporting literature suggest that despite the existence of structural barriers to seeking substance use services, non-structural barriers are instrumental to individual decisions to resist help (Myers et al., 2009).

Given that both community members and service providers appeared to attribute under-utilization of substance use services to the stigma associated with seeking services, it further suggests that the stigma substance users encounter extend beyond their households and throughout different sectors of the community. These outcomes coincide with the findings of

Notley (2012), who identified stigma as a theme for which problematic substance users not in structured treatment felt stigmatized by multiple groups (i.e., friends and family, social groups, general practitioners). Service providers also mentioned accessibility as another factor that impacts the underutilization of services. As one service provider participant stated, “Every time I ask them if they’ve gone to our behavioral health unit they say they can never get an appointment. Um, they’re never available”. Whether an individual received the ASSIST and brief intervention, or made the decision independently to control or reduce their problematic substance use, their openness to receiving further services could diminish after they experience a challenge accessing a service.

**Trust and confidentiality facilitate substance use questions.** Theme 3 addressed the third research question, “How does each stakeholder group perceive the comfort and relevancy of the patient-provider exchange of the SBIRT protocol?” Across each of the stakeholder groups, the qualitative data revealed that individuals in the Black community in Hartford are generally comfortable answering substance use questions in a health care setting; however, the quantitative data revealed that almost 40% of community members indicated that it feels uncomfortable when a health care provider asks about drug, alcohol, or tobacco use. Beyond comfort level, a more conclusive outcome was that the Black community generally has concerns about the consequences that can result from speaking truthfully about their substance use. One step towards reducing this concern is by following the standard of care with regard to confidentiality, which states that providers are required to inform patients about the limits of confidentiality (i.e., reporting instances of safety concern) and how their information is used (Petrik, Billera, Kaplan, Matarazzo, & Wortzel, 2015). Given that quantitative data show that each stakeholder group agrees that providing patients with the rationale for obtaining substance



use information is important, this step, along with reassuring confidentiality, could help to initiate some form of trust among hesitant patients in the Black community.

While both community members and leaders indicated that the race of the health care provider does not matter, there was partial congruence with the service providers that the demeanor of the health care provider is noticeable. Trust was often emphasized as a factor that impacts this comfort level. Some individuals in the community member and leader groups who referred to trust stated or implied that there is generally a sense of trust in doctors because it is their job to help their patients; and the ethnic background of the doctor is even less of a factor. As stated by one community leader, “My doctor is Jewish, and he talk, like, a really heavy accent. I tell him everything.”

There were others within each stakeholder group, but more specific to the community member and service provider groups who, given the personal nature of substance use questions, believe that trust is primarily established after a connection is made, confidentiality is reassured, or there is a familiarity with staff. This outcome coincides with the literature that indicated that the patient-provider relationship is essential to the uptake and utilization of services (Boyer & Lutfey, 2010; Whetten et al., 2006). Other qualitative studies examining patient-provider relationships in which trust is considered a theme, recognize it as an essential element to the continuity of care (Gourlay, Wringe, Birdthistle, Mshana, Michael, & Urassa, 2014). Although trust is difficult to establish in one meeting, which is often the case of the interactions with SBIRT, health educators and community leaders suggested that it could be beneficial to the patient-provider exchange if the providers incorporated instances or questions that showed genuine concern for the individuals (i.e., worked to develop a connection). As one community leader stated, “So if the health provider to me is real up front, you know, I’m gonna keep coming

back to them. I'm gonna feel comfortable talking to them.” According to Gourlay et al. (2014), continuity within a specific provider or facility may not immediately establish trust between patients and providers, but finding instances to avoid referring patients to other facilities is a step towards establishing trust within a community. Essentially, strengthening the comprehensive qualities of a program helps the providers to learn about and adapt to the specific needs of the community, and enables individuals within a community to remain open to the providers and staff.

**Desire for patient-centered care within the provision of high service quality.** Theme 4 addressed research questions 4 and 5 which asked for specific feedback on the process of administering the ASSIST and feedback report card, and how to alter components of the brief intervention. Both of these objectives account for the increasing trend among medical professions to provide patient-centered care. The concerns that have been raised about addressing racial disparities by adapting practices is that there are no set guidelines (Casalino et al., 2007; Hwang, 2006). The outcomes from this study do not provide guidelines, but it provides insight about some of the components of care that either contribute to the barriers or highlight areas that support efforts to implement SBIRT that are relevant to the communities served.

The participants' feedback (specific to SBIRT and in general for health care services) align with the principles and characteristics of patient-centered primary care. With present times, patients increasingly acknowledge that they want providers to understand and meet their preferences and accessibility needs, within the provisions of receiving high quality care (Davis, Schoenbaum, & Aude, 2005). In congruence, the voices of the community members were strongest with regard to the quality of care. These participants connected the quality of the

facilities to feeling welcomed and trusted. Previous research indicates that among hospital patients, satisfaction with care is strongly associated with their perceptions of the quality of care (Jha, Orav, Zheng, & Epstein, 2008). However, quality of care recommendations (readily associated with general health care), warrant adaptations for mental health and substance abuse treatment given that it is generally known that there are greater obstacles to providing patient-centered care in these areas (e.g., a higher number of arrangements for separate care) (Pincus, Page, Druss, Appelbaum, Gottlieb, & England, 2007). This understanding coincides with the biopsychosocial perspective, which suggests that within any community, but especially within a community of underrepresented minorities, knowledge of intersecting factors (i.e., biological, psychological, and social domains) can lead to a deeper understanding for the problems within the context (Hatala, 2012; Leventhal et al., 2008).

The student researcher asked specific questions to examine how each stakeholder group generally perceives patient-provider interactions within their health care appointments, given that statistics indicate that racial/ethnic minority patients tend to rate patient-provider interpersonal care in medical settings lower than Whites (Johnson, Saha, Arbelaez, Beach, & Cooper, 2004; Neighbors et al., 2003; Penner, Albrecht, Coleman, & Norton, 2007). In a study examining racial differences in communication styles between patients and providers, Johnson, Roter, Powe, & Cooper (2004) found that physicians were more verbally dominant (i.e., talked more in comparison to the patient), less patient-centered, and expressed less positive affect with African American patients than with White patients. It is possible that participants in the current study did not foresee these same negative interactions with regard to their assessment of patient-provider exchanges with the delivery of the SBIRT components. A large percentage of community members (72.7%) and community leaders (60.0%) indicated that they would feel

comfortable completing the ASSIST with a healthcare provider, and 62.5% of providers felt very good about their comfort level completing it with this community. Likewise, 44.4% of community members indicated that none of the questions or components of the brief intervention seem difficult to respond to or understand. These outcomes from the current study suggest that the ASSIST and brief intervention appear to allow for patient-centered communication (e.g., patient input within health-related dialogue) to occur between patients and providers.

Several conclusions can be drawn from the outcomes that revealed the perception of the specific components of the ASSIST and brief intervention. Given that this study aimed to determine which aspects of SBIRT need to be the focus of cultural adaptation for the Black community, these outcomes indicated that there is less of a need to alter specific aspects of the SBIRT protocol, and more of a need to focus on patient satisfaction with patient-provider exchange and the quality, accessibility, and affordability of care. This conclusion coincides with other studies that associate satisfactory ratings of patient-centered communication with greater adherence to treatment and recall of information (Castro et al., 2010; DiMatteo, Haskard-Zolnieriek, & Martin, 2012). It is also noteworthy that the use of the ASSIST as a part of SBIRT may have lessened the need of cultural adaptations. The ASSIST was developed by an international team and field tested in both developed and developing countries (WHO, 2010a). It is possible that if SBIRT did not make use of an instrument like the ASSIST, the results may have been different.

Another key characteristic of patient-centered care aimed at improving patient engagement and access to care is to provide “publicly available information on practices” (Davis et al., 2005, p. 954). This concept connected to the theme that suggests that some of the community feel uninformed about the services that are available to them, but it extends to

suggest that patients should be provided with additional information about the service providers and their practices so that they have the option to make informed choices with regard to their care. Community members and community leaders both indicated that the Black community wants to have a familiarity with the providers, which could be potentially achieved if they were better informed about certain personal characteristics of the providers in the area. The National Committee for Quality Assurance (NCQA) recommend a standard procedure of providing patients with specific details about the providers (i.e. office locations, race, gender, age, quality of care, and peer and patient assessments of practices) (Shelton, Aiuppa, Torda, 2004). This level of transparency does not alleviate all instances of distrust that exists between some of community and the healthcare systems, but it could increase familiarity if this kind of information about the local providers (at all levels) is circulated throughout the community.

**Collaboration and communication across multiple systems.** Theme 5 addressed research question number seven, “Would members of the three stakeholder groups be willing to participate in any additional steps toward creating a culturally relevant version of SBIRT, and do they believe that their participation would make a difference?” Community involvement is an important factor in determining if any of the above mentioned cultural adaptations would be considered community-based rather than community-placed (i.e., lacking the influence of community involvement) (Trickett, 2009).

The qualitative data revealed a distinct difference between the perspectives among the stakeholder groups with regard to whom they either aspire to or envision the feasibility of collaborations. Community members were focused on connecting with other informal groups in their community and the agencies that readily work within their communities (e.g. food pantries). Community leaders were focused on expanding collaborative efforts to connect with

communities outside of the Hartford area that have interests in addressing substance use problems in their areas. Service providers were focused on building upon collaborations with personnel within their places of employment. These differing preferences are important to note if the intention is to maximize the initial sparks of interest shown by each stakeholder group to participate in this study, and to maintain a working collaboration with each group up to and throughout the process of fully implementing any culturally relevant adaptations. From an ecological/ecosystemic perspective, exploring the interacting factors of their differing viewpoints is equally as important as exploring each stakeholder group's perspective independently (Axelson, 1993; Vygotsky, 1986). According to Domitrovich et al. (2008), any adaptations to evidence-based preventative interventions (such as SBIRT) by independent researchers need a "support system" to ensure that core components (established by the support system) are being implemented, and to ensure that there is an internal capacity to sustain these collaborations over time. This support system would need to involve the developers and evaluators of SBIRT in the community, and a select collection of stakeholders who are supportive of the different stakeholder group preferences and willing to monitor the implementation. By ensuring that the community remains a part of the working system, then SBIRT in Hartford and across Connecticut would be addressing the calls for involving consumers and community members in the process of developing cultural adaptations for evidence-based interventions and practices (Macaulay et al., 1999).

Although each stakeholder group makes a valid point in their individualized perspectives on the types of conversations and collaborations that need to take place, challenges arise when each group possesses a valid yet incomplete understanding for the nature of collaboration needed to fully devise a culturally relevant protocol that is specific to the community, and adaptive for

other communities (Fischer, 2001). The strength of involving multiple stakeholder groups (of different ecological levels) can also work against collaboration because latent community disagreement and power struggles can resurface and disrupt efforts to create new norms of interactions (Trickett, 2009).

Despite the potential for challenges, an Institute of Medicine (IOM) report indicated that two essential components of next generational preventative interventions (e.g., a culturally adapted version of SBIRT) are to develop and maintain community partnerships with relevant stakeholders within a community, and to conduct assessments within the community to determine their priorities and preferences (Smedley & Syme, 2001). Based on the information gained through the current study by following CBPR approaches, the outcomes in this study supporting collaborations, and the recommendations indicated through sources such as the IOM report, the student researcher determined that the ultimate intervention goal is to promote community resource development (Trickett, 2009) through SBIRT. This intervention goal, which is further described in the Implications section, confirms a previously mentioned statement that this study highlights the ways in which developing and continuing partnerships with various types of experts within communities allows for an integration of knowledge and action (Bordeaux et al., 2007).

## **Implications**

Pilot data support the rationale for proceeding with cultural adaptations of SBIRT for the Black community in the Hartford area. As previously stated, these recommendations do not fully represent guidelines, but they provide insight about some of the components of care that either contribute to the barriers or highlight areas that support efforts to implement SBIRT within a target community.

With respect to theme 1, the student researcher, and supporting research (Trickett, 2009), recommend that the first step is to determine the elements of the community context that individuals within the community identify as an attribute to the substance use problems in the area. The outcomes that the student researcher received from Hartford are not transferable with other communities. A separate assessment of community concerns should be performed for each community of interest before proceeding with any adaptations to SBIRT. It would also help to determine if there are ways to reduce the harm that individuals experience as a result to the problems they associated with substance use. Additionally, an examination at the systems level (i.e., the services, activities, and agencies that constitute a community treatment system) should also be considered. A systems level examination would diagram how patients interact with different substance abuse providers within and between agencies to understand the processes (e.g. waiting periods, drop-out rates after referral, coordination, collaborative planning, and sharing of resources) that show how well the system functions (Rush, 2003).

In terms of theme 2, the student researcher and supporting research (Steinberg et al., 1998) recommend that researchers and SBIRT evaluators employ community outreach personnel who can familiarize community members and leaders of the available resources. It appears that some of the health educators could engage in these outreach tasks from within community health care settings, but outreach efforts should also take place outside community health centers in media recommended by each specific community. For instance, in Hartford it was mentioned that advertisement (via posters and rallies) should alert the community to service expectations and wait times.

For theme 3, the student researcher and supporting research (Petrik et al., 2015) recommend that all individuals involved in patient assessments follow the standard of care with



regard to confidentiality (i.e., informing patients about the limits of confidentiality and how their personal information is used) with each patient to help to initiate some form of trust among hesitant patients in the Black community. Additionally, given that trust is difficult to establish in one meeting, which is often the case of the interactions with SBIRT health educators, the student researcher suggests incorporating instances or questions that showed genuine concern for the individual seeking help (i.e., worked to develop a connection). These questions of concern can occur at any point during the ASSIST or brief intervention.

With respect to theme 4, the student researcher and supporting research (Davis et al., 2005) recommend increasing the amount of publicly available information about services that is distributed throughout the community, so that community members and leaders could have a familiarity with the providers at all levels. According to the NCQA, there should be a standard procedure of providing patients with specific details about the providers (i.e. office locations, race, gender, age, quality of care, and peer and patient assessments of practices) (Shelton et al., 2004) to increase the level of transparency between the community and the healthcare systems serving that community.

Regarding theme 5, the student researcher and supporting research (Domitrovich et al., 2008), recommend the formation of a SBIRT “support system” (consisting of developers and evaluators of SBIRT in the community and a select collection of stakeholders) to ensure that core components (established by the support system) are being implemented, and to ensure that there is an internal capacity to sustain these collaborations over time.

Following these five recommendations, the student researcher believes that these guidelines will help to achieve the intervention goal, which is to promote community resource development through SBIRT. The procedures that the student researcher followed to build

relationships within the community (explained in the following paragraph) would help others in the SBIRT “support system” to also form relationships within the community that would allow for each person to have an equal role in promoting community resource development.

Furthermore, by developing and continuing partnerships with various types of experts within communities the integration of knowledge and action will be maximized.

The process that the student researcher employed to obtain participants for the current study can also be used when trying to gain community involvement in the next phase of this research. In person one-on-one introductions with community members, and informal presentations to neighborhood / community groups, were two of the most instrumental strategies for recruiting participants for the community member stakeholder group. For the community leader group, attending events within the community that address a socially pertinent issue, and volunteering throughout the event or speaking with the facilitators and attendees after the event, were the most instrumental strategies. For this strategy to work, the researchers / SBIRT evaluators need to be aware of the events that impact the Hartford community, or the other communities of interest, in order to determine when the event will take place or to be aware of the events that regularly happen. For both the community leader and service provider groups, one of the more effective recruitment strategies was to connect with the directors and chief executive officer who have an influence over how and when research can be distributed through their facilities. Upon receiving higher approval, the next step is to set aside time to introduce all interested personnel to the research by hosting luncheons or sit-down meetings. The student researcher followed each of these procedures in her efforts to connect with different sectors of the Hartford community, and she recommends others follow these procedures in any future efforts to connect with a specific community of interest.

## **Limitations**

Community based studies such as this study are not without limitations. First, the scope of this research is not applicable to all Black Americans in the Hartford area. Despite identifying components of the adaptations that are specific to this target community, many individuals in this community have multiple cultural identities. Some individuals may even have stronger affiliations with identities other than their racial identity. Black Americans are very diverse, and differ greatly in life experiences and adaptability to mainstream society. Additionally, for any difference in viewpoints across stakeholder groups, as well other literature on substance abuse-related concerns, it is possible that large differences in viewpoints are related to the fact that many of the participants within each stakeholder group were not problem substance users and had no prior treatment episodes.

Second, the inclusion of non-Black stakeholders and the exclusion of an external non-Black comparison group are both viewed as independent limitations. Given the focus on the Black community, there is a concern for biases among the largely non-Black service provider stakeholder group. However, in accordance with CBPR, all stakeholder groups do not need to be the demographic of the identified community because they represent the demographic that the community would encounter in real world community-based partnerships and settings (Israel et al., 1998; Israel et al., 2001; Minkler et al., 2003). Similarly, the lack of a non-Black comparison group, particularly for the community member stakeholder group, means that the findings, however valid, may apply to other groups in the community and may not be specific to the Black community.

Third, this study is not based on a random selection of the population. Although the student researcher refers to the individuals in the stakeholder groups as representative members

of the community, these groups of participants did not reflect the actual groupings or true characteristics of the Black community in Hartford. The individuals who volunteered as participants (particularly for community leaders and members) for this study were individuals whom the student researcher deemed as socially active in the community. Many were recruited while they were involved in community groups and activities, and were invested in supporting projects that worked towards the betterment of the community. Given these characteristics, the sample in each group is not likely representative of the larger community. Furthermore, this study may have only appealed to individuals in the community who have an interest in supporting the student researcher's efforts to address a disparity within their community, rather than individuals with specific concerns about substance use alone.

Fourth, there was only a small number of individuals involved in the procedures for data collection, data analysis, and documenting the developing findings. The student researcher primarily communicated with other researchers involved in these processes on a one-on-one basis, rather than as a research team. According to the true nature of CBPR, members from each stakeholder group should receive training so that they could join the student researcher in the analysis process (Bordeaux et al., 2007). Due to limited resources, this element of CBPR was not to be incorporated into this study.

### **Significance**

This study makes two contributions to the mental health and substance abuse treatment field. First, this research responds to national calls for health professionals to adapt standard services to meet the needs of an increasingly diversifying U.S. population (DHHS, 1999). There is a general need for research that can further validate a rationale for cultural adaptations, as well as highlight the strategies that facilitate these cultural adaptations (Castro et al., 2010). Further,

this study highlights the ways in which developing and continuing partnerships with various types of experts within communities allows for an integration of knowledge and action in which all partners receive mutual benefits (Bordeaux et al., 2007). This process is also acknowledged as the first step toward adapting the SBIRT protocol to a local community.

Second, this study is one of the first to collect perceptions of the cultural relevancy of SBIRT for an underrepresented minority population. It is also one of the first to explain a process for the initial steps for developing a version of SBIRT for a specific community. Through the use of CBPR approaches, the voices of members of / leaders in / and service providers for the Black community in Hartford were heard, and these voices informed the first steps in this process aimed at culturally adapting SBIRT for this community. Through the use of community-involved approaches such as CBPR, researchers can gain a personal understanding for circumstances that indicate how and why a treatment does and does not work (Burlew et al., 2011). In summary, the specific voices informed the process that validated the need for cultural adaptations, and further supported the rationale to evaluate these adaptations for the intended community, and to determine if they further extend to other communities. Given this revelation, this study also contributes to the literature aimed at reducing health disparities among under-represented and under-resourced communities.

### **Future Research**

After examining a substance abuse treatment program designed for under-represented youth in Hartford, Conn., Simmons et al. (2008) indicated that future research is needed to provide a better quantitative rationale that interventions with a focus on outreach and engagement are more effective for under-represented communities than standard practices. In this study, the student researcher focused on building and maintaining a connection to the Black community that started from question development and recruitment, and continued through to

the analysis and interpretations of the findings. Specific to the SBIRT protocol, this completed process is just the first step in a broader research agenda that could lead to the development of an effective outreach and engagement protocol, particularly for under resourced communities.

Regarding the long-term research agenda, the next steps are to: (1) use the information to adapt SBIRT, (2) evaluate the effectiveness of these adaptations, and (3) replicate these steps in other cities where SBIRT is being used. Regarding the short-term agenda, the student researcher intends to re-examine the open-ended responses from the surveys for each stakeholder group (continuing with thematic analysis), to determine if these responses directly align with the outcomes of this study, or present additional themes for future consideration. Another direction is for other core researchers to further determine transferability by replicating this study among other communities and target populations. Overall, this study provides further support for the idea that effective outreach and engagement could be more instrumental to improving treatment outcomes than the actual treatment itself, particularly among communities that are under-resourced.

## References

- Abbott, P., & Chase, D. M. (2008). Culture and substance abuse impact of culture affects approach to treatment. *Psychiatric Times*, 25(1), 43-46.
- Agency for Healthcare Research and Quality. (2009). *National Healthcare Disparities Report, 2008* (AHRQ Publication No. 09-0002). Rockville, MD: Author.
- Agency for Healthcare Research and Quality. (2013). *2012 National Healthcare Disparities Report* (AHRQ Publication No. 13-0003). Rockville, MD: Author.
- Alderete, E., Vega, W. A., Kolody, B., & Aguiar-Gaxiola, S. (2000). Lifetime prevalence of and risk factors for psychiatric disorders among Mexican migrant farmworkers in California. *American Journal of Public Health*, 90, 608-614.
- American Psychological Association. (2012). Stress in America™: Missing the health care connection. Retrieved from <https://www.apa.org/news/press/releases/stress/2012/full-report.pdf>
- Aronson, J. (1994). A pragmatic view of thematic analysis. *The qualitative report*, 2(1), 1-3.
- Axelson, J. A. (1993). *Counseling and development in a multicultural society*. Pacific Grove, CA: Brooks/Cole Publishing Company.
- Babor T. F., McRee B. G., Kassebaum P. A., Grimaldi P. L., Ahmed, K., & Bray, J. (2007). Screening, brief intervention, and referral to treatment (SBIRT): Toward a public health approach to the management of substance abuse. *Substance Abuse*, 28, 7–30.
- Berger, P. I., & Luckmann, T. (1966). *The social construction of reality: A treatise in the sociology of knowledge*. New York: Doubleday.
- Bernal, G., & Scharró-del-Río, M. R. (2001). Are empirically supported treatments valid for ethnic minorities? Toward an alternative approach for treatment research. *Cultural*

*Diversity and Ethnic Minority Psychology*, 7(4), 328-342. doi:10.1037/1099-9809.7.4.328

- Best, J. (1995). Typification and social problems construction. In J. Best (Ed.), *Images of issues: Typifying contemporary social problems* (pp. 3-10). New York: Aldine de Gruyter.
- Biddix, J. P. (2009). *Research rundowns: Uncomplicated reviews of educational research methods*. Retrieved from <http://researchrundowns.wordpress.com/>
- Bien, T. H., Miller, W.R., & Tonigan, S. (1993). Brief intervention for alcohol problems: A review. *Addiction*, 88, 315-336.
- Blumenthal, D. S., & Braithwaite, R. (Eds.). (2013). *Community-based participatory health research: Issues, methods, and translation to practice* (2nd ed.). New York, NY: Springer Publishing Company.
- Bordeaux, B. C., Wiley, C., Tandon, S. D., Horowitz, C. R., Brown, P. B., & Bass, E. B. (2007). Guidelines for writing manuscripts about community-based participatory research for peer-reviewed journals. *Progress in Community Health Partnerships: Research, Education, and Action*, 1(3), 281-288.
- Boyer, C. A., & Lutfey, K. E. (2010). Examining critical health policy issues within and beyond the clinical encounter: Patient–provider relationships and help-seeking behaviors. *Journal of Health and Social Behavior*, 51, S80-S93.
- Branson, R. D., Davis, K., & Butler, K. L. (2007). African americans' participation in clinical research: Importance, barriers, and solutions. *American Journal of Surgery*, 193(1), 32-39. doi:10.1016/j.amjsurg.2005.11.007



Breen, L. J., & O'Connor, M. (2009). Acts of resistance: Breaking the silence of grief following traffic crash fatalities. *Death studies*, 34(1), 30-53.

Bronfenbrenner, U. (1994). Ecological models of human development. *Readings on the Development of Children*, 2, 37-43.

Buchanan, D. R., Miller, F. G., & Wallerstein, N. (2007). Ethical issues in community-based participatory research: Balancing rigorous research with community participation in community intervention studies. *Progress in Community Health Partnerships: Research, Education, and Action*, 1(2), 153-160.

Burlew, K., Larios, S., Suarez-Morales, L., Holmes, B., Venner, K., & Chavez, R. (2011a). Increasing ethnic minority participation in substance abuse clinical trials: Lessons learned in the national institute on drug abuse's clinical trials network. *Cultural Diversity and Ethnic Minority Psychology*, 17(4), 345-356. doi:10.1037/a0025668

Burlew, A. K., Weekes, J. C., Montgomery, L. T., Feaster, D. J., Robbins, M. S., Rosa, C. L., ... & Wu, L. T. (2011b). Conducting research with racial/ethnic minorities: Methodological lessons from the NIDA Clinical Trials Network. *The American Journal of Drug and Alcohol Abuse*, 37(5), 324-332. doi: 10.3109/00952990.2011.596973

Burlew, A. K., Copeland, V. C., Ahuama-Jonas, C., & Calsyn, D. A. (2013). Does cultural adaptation have a role in substance abuse treatment? *Social Work in Public Health*, 28(3), 440-460. doi: 10.1080/19371918.2013.774811

- Calsyn, D. A., Burlew, A. K., Hatch-Maillette, M. A., Wilson, J., Beadnell, B., & Wright, L. (2012). Real men are safe-culturally adapted: utilizing the Delphi process to revise real men are safe for an ethnically diverse group of men in substance abuse treatment. *AIDS Education and Prevention*, 24(2), 117-131.
- Cannon, R. D. (2013). *A study of the cultural competencies of educators as perceived by African American males in an urban high school setting* (Doctoral dissertation). Retrieved from ProQuest, UMI Dissertations Publishing. (3591902)
- Carroll, K. M., Rosa, C., Brown, L. S., Daw, R., Magruder, K. M., & Beatty, L. (2007). Addressing ethnic disparities in drug abuse treatment in the Clinical Trials Network. *Drug and Alcohol Dependence*, 90, 101-106.
- Carpenter-Song E., Whitley R., Lawson W., Quimby E., & Drake R. E. (2011). *Reducing disparities in mental health care: Suggestions from the Dartmouth-Howard collaboration. Community Mental Health*, 47, 1-13. doi: 10.1007/s10597-009-9233-4
- Castro, F. G., & Alarcón, E. H. (2002). Integrating cultural variables into drug abuse prevention and treatment with racial/ethnic minorities. *Journal of Drug Issues*, 32(3), 783-810.
- Casalino, L. P., Elster, A., Eisenberg, A., Lewis, E., Montgomery, J., & Ramos, D. (2007). Will pay-for-performance and quality reporting affect health care disparities?. *Health Affairs*, 26(3), w405-w414.
- Castro, F. G., Barrera, M., J., & Steiker, L. (2010). Issues and challenges in the design of culturally adapted evidence-based interventions. *Annual Review of Clinical Psychology*, 6, 213-239. doi:10.1146/annurev-clinpsy-033109-132032

- Chen, E. K., Reid, M. C., Parker, S. J., & Pillemer, K. (2012). Tailoring evidence-based interventions for new populations: A method for program adaptation through community engagement. *Evaluation & the Health Professions*, 36(1), 73-92. doi: 10.1177/0163278712442536
- Community Anti-Drug Coalitions of America (CADCA) National Coalition Institute. (2011). *Community-based participatory research*. Alexandria, VA: Author.
- Creswell, J. W. (2005). *Educational research: Planning, conducting, and evaluating quantitative and qualitative research* (2nd ed.). Upper Saddle River, NJ: Pearson Education.
- Creswell, J. W., & Plano Clark, V. L. (2006). *Designing and conducting mixed methods research*. Thousand Oaks, CA: Sage.
- Cuijpers, P. (2013). Effective therapies or effective mechanisms in treatment guidelines for depression? *Depression and Anxiety*, 30, 1055–1057. doi: 10.1002/da.22205
- Cunningham, C. J., Weathington, B. L., & Pittenge, D. J. (2013). *Understanding and Conducting Research in the Health Sciences*. John Wiley & Sons, Inc.: Hoboken, New Jersey.
- Davis, K., Schoenbaum, S. C., & Audet, A. M. (2005). A 2020 vision of patient-centered primary care. *Journal of General Internal Medicine*, 20(10), 953-957.
- DeZutter, S. (2008). *Cultural Models of Teaching in Two Non-school Educational Communities*. ProQuest.
- Dhoest, A. (2012). Mixed methods, bifocal vision: Combining quantitative and qualitative data to assess public service performance. *Participations Journal of Audience & Reception Studies*, 9(2), 743-756.

- DiMatteo, M. R., Haskard-Zolnierrek, K. B., & Martin, L. R. (2012). Improving patient adherence: A three-factor model to guide practice. *Health Psychology Review*, 6(1), 74-91, doi: 10.1080/17437199.2010.537592
- Domitrovich, C. E., Bradshaw, C. P., Poduska, J. M., Hoagwood, K., Buckley, J. A., Olin, S., ... & Ialongo, N. S. (2008). Maximizing the implementation quality of evidence-based preventive interventions in schools: A conceptual framework. *Advances in School Mental Health Promotion*, 1(3), 6-28.
- Draguns, J. G., & Tanaka-Matsumi, J. (2003). Assessment of psychopathology across and within cultures: Issues and findings. *Behaviour Research and Therapy*, 41(7), 755-776. doi:10.1016/S0005-7967(02)00190-0
- Fields, A. J. (2010). Multicultural research and practice: Theoretical issues and maximizing cultural exchange. *Professional Psychology: Research and Practice*, 41(3), 196. doi: 10.1037/a0017938
- Fischer, G. (2001, August). Communities of interest: Learning through the interaction of multiple knowledge systems. In *Proceedings of the 24th IRIS Conference* (Vol. 2001). Department of Information Science, Bergen.
- Fish, J. M. (2012). Rethinking Assumptions about Drug Addiction and Treatment. *Oregon Law Review*, 91, 1191-1202.
- Fouad, M. N. (2009). Enrollment of minorities in clinical trials: Did we overcome the barriers? *Contemporary Clinical Trials*, 30, 103–104.
- Freedman, J., & Combs, G. (1996). *Narrative therapy*. New York: Norton.

- Freimuth, V. S., & Quinn, S. C. (2004). The contributions of health communication to eliminating health disparities. *American Journal of Public Health, 94*(12), 2053-2055.
- Gearing, R. E., Schwalbe, C. S., MacKenzie, M. J., Brewer, K. B., Ibrahim, R. W., Olimat, H. S., ... & Al-Krenawi, A. (2013). Adaptation and translation of mental health interventions in Middle Eastern Arab countries: A systematic review of barriers to and strategies for effective treatment implementation. *International Journal of Social Psychiatry, 59*(7), 671-681. doi: 10.1177/0020764012452349
- Gee, G. C., & Payne-Sturges, D. C. (2004). Environmental health disparities: A framework integrating psychosocial and environmental concepts. *Environmental Health Perspectives, 112*(17), 1645-1653.
- Gehlert, S., Sohmer, D., Sacks, T., Mininger, C., McClintock, M., & Olopade, O. (2008). Targeting health disparities: A model linking upstream determinants to downstream interventions. *Health Affairs, 27*(2), 339-349.
- Gergen, K. J. (1999). *An invitation to social construction*. Thousand Oaks, CA: Sage.
- Golafshani, N. (2003). Understanding reliability and validity in qualitative research. *The Qualitative Report, 8*(4), 597-607.
- Gone, J. P. (2009). Psychotherapy and traditional healing for American Indians: Exploring the prospects for therapeutic integration. *The Counseling Psychologist*. In press.
- Gonzalez, R., Biever, J. L., & Gardner, G. T. (1994). The multicultural perspective in therapy: A social constructionist approach. *Psychotherapy, 31*, 515-524.
- Gordon, A. J., & Alford, D. P. (2012). Screening, brief intervention, and referral to treatment (SBIRT) curricular innovations: addressing a training gap. *Substance Abuse, 33*(3), 227-230.

- Gourlay, A., Wringe, A., Birdthistle, I., Mshana, G., Michael, D., & Urassa, M. (2014). "It is like that, we didn't understand each other": Exploring the influence of patient-provider interactions on prevention of mother-to-child transmission of hiv service use in rural Tanzania. *PLoS ONE*, 9(9), e106325. doi:10.1371/journal.pone.0106325
- Greenhalgh, T., Robert, G., Macfarlane, F., Bate, P., & Kyriakidou, O. (2004). Diffusion of innovations in service organizations: systematic review and recommendations. *Milbank Quarterly*, 82(4), 581-629.
- Groenewald, T. 2008. Memos and Memoing (Vol 2: pp. 505-6). In Given, L.M. (Ed) 2008. *The SAGE encyclopedia of qualitative research methods*. Los Angeles, Thousand Oaks, Calif.: SAGE Publications.
- Guba, E. G. (1981). Criteria for assessing the trustworthiness of naturalistic inquiries. *Educational Communication and Technology Journal*, 29(2), 75-91. Retrieved from [http://aect.site-ym.com/?publications\\_landing](http://aect.site-ym.com/?publications_landing).
- Hair, H. J., & O'Donoghue, K. (2009). Culturally relevant, socially just social work supervision: Becoming visible through a social constructionist lens. *Journal of Ethnic and Cultural Diversity in Social Work*, 18(1-2), 70-88. doi: 10.1080/15313200902874 979
- Hall, G. C. N. (2001). Psychotherapy research with ethnic minorities: Empirical, ethical, and conceptual issues. *Journal of Consulting and Clinical Psychology*, 69(3), 502-510. doi:10.1037/0022-006X.69.3.502
- Hardy, K. V. (1993). Live supervision in the postmodern era of family therapy: Issues, reflections, and questions. *Contemporary Family Therapy*, 15(1), 9-20.
- Hartney, C., & Vuong, L. (2009). *Created equal: Racial and ethnic disparities in the US criminal justice system*. National Council on Crime and Delinquency.

- Hatala, A. R. (2012). The status of the “biopsychosocial” model in health psychology: Towards an integrated approach and a critique of cultural conceptions. *Open Journal of Medical Psychology, 1*(4), 51-62.
- Hatch, J., Moss, N., Saran, A., & Presley-Cantrell, L. (1993). Community research: Partnership in black communities. *American Journal of Preventive Medicine, 9*(6), 27-31.
- Hennink, M., Hutter, I., & Bailey, A. (2011). *Qualitative research methods*. New York: Sage Publications Ltd.
- Hernandez, L. (2010). Identifying the when and how in cultural adaptation research. *DATA: The Brown University Digest of Addiction Theory & Application, 29*(8), 8-8.
- Hill, C. E., Knox, S., Thompson, B. J., Williams, E. N., Hess, S. A., & Ladany, N. (2005). Consensual Qualitative Research: An update. *Journal of Counseling Psychology, 52*, 196-205. doi: 10.1037/0022-0167.52.2.196.
- Hofstede, G. (2001). *Culture's Consequences: Comparing Values, Behaviors, Institutions and Organizations across Nations*. Thousand Oaks, CA: Sage
- Hofstede, G. (2011). Dimensionalizing cultures: The Hofstede model in context. *Online readings in psychology and culture, 2*(1), 3-26.
- Horowitz, C., & Lawlor, E. F. (2008). Community approaches to addressing health disparities. *Report for the Institute of Medicine*. Proceeding from the National Research Council: *Challenges and Successes in Reducing Health Disparities: Workshop Summary*. Washington, DC: The National Academies Press.

- Hwang, W. (2006). The psychotherapy adaptation and modification framework: Application to asian americans. *American Psychologist*, 61(7), 702-715. doi:10.1037/0003-066X.61.7.702
- Hwang, W. C. (2011). Cultural adaptations: A complex interplay between clinical and cultural issues. *Clinical Psychology: Science and Practice*, 18, 238-241.
- Iguchi, M. Y., Bell, J., Ramchand, R. N., & Fain, T. (2005). How criminal system racial disparities may translate into health disparities. *Journal of Health Care for the Poor and Underserved*, 16(4), 48-56. doi:10.1353/hpu.2005.0114
- Israel, B. A., Schulz, A. J., Parker, E. A., & Becker, A. B. (1998). Review of community-based research: Assessing partnership approaches to improve public health. *Annual Review of Public Health*, 19(1), 173-202.
- Israel, B. A., Lichtenstein, R., Lantz, P., McGranaghan, R., Allen, A., Guzman, R. J., ... Maciak, B. (2001). The Detroit community-academic urban research center: Development, implementation, and evaluation. *Journal of Public Health Management and Practice*, 7(5), 1-19.
- Israel, B. A., Krieger, J., Vlahov, D., Ciske, S., Foley, M., Fortin, P., ... & Tang, G. (2006). Challenges and facilitating factors in sustaining community-based participatory research partnerships: Lessons learned from the Detroit, New York City and Seattle urban research centers. *Journal of Urban Health*, 83(6), 1022-1040.



- Ivey, A. E. (1986). *Developmental therapy: Theory into practice*. San Francisco: Jossey Bass Higher and Adult Education.
- Ivey, A. E. (1991). *Developmental strategies for helpers: Individual, family, and network interventions*. Canton, CT: Microtraining Assoc.
- Ivey, A. E. (2000). *Developmental therapy: Theory into practice*. North Amherst, MA: Microtraining Associates.
- Ivey, A. E., & Ivey, M. B. (2007). *Intentional interviewing and counseling: Facilitating focus group participant development in a multicultural society* (6th ed.). Belmont, CA: Thompson Learning, Inc.
- James, C., Thomas, M., Lillie-Blanton, M., & Garfield, R. (2007). Key facts: Race, ethnicity, and medical care. *Menlo Park: The Henry J. Kaiser Family Foundation*.  
<http://www.kff.org/minorityhealth/6069.cfm>. Accessed 20 August 2008.
- Jenkins, A. H. (2000). The liberating value of constructionism for minorities. *The Humanistic Psychologist*, 28(1-3), 79-87. doi: 10.1080/08873267.2000.9976984
- Jha, A. K., Orav, E. J., Zheng, J., & Epstein, A. M. (2008). Patients' perception of hospital care in the United States. *New England Journal of Medicine*, 359(18), 1921-1931.
- Joffe, H. (2012). Thematic analysis. In D. Harper & A. R. Thompson (Eds.), *Qualitative research methods in mental health and psychotherapy: A guide for students and practitioners* (pp. 209-223). West Sussex, UK: JohnWiley & Sons, Ltd.
- Johnson, M. (1999). Observations on positivism and pseudoscience in qualitative nursing research. *Journal of Advanced Nursing*, 30, 67-73. doi: 10.1046/j.1365-2648.1999.01050.x

- Johnson, J. C., Hayden, U. T., Thomas, N., Groce-Martin, J., Henry, T., Guerra, T., ... & Kumanyika, S. (2009). Building community participatory research coalitions from the ground up: The Philadelphia Area Research Community Coalition. *Progress in community health partnerships: research, education, and action*, 3(1), 61-72.
- Johnson, R. L., Roter, D., Powe, N. R., & Cooper, L. A. (2004). Patient race/ethnicity and quality of patient-physician communication during medical visits. *American Journal of Public Health*, 94(12), 2084-2090.
- Johnson, R. L., Saha, S., Arbelaez, J. J., Beach, M. C., & Cooper, L. A. (2004). Racial and ethnic differences in patient perceptions of bias and cultural competence in health care. *Journal of General Internal Medicine*, 19(2), 101-110.
- Johnston, F. (2000). *Social representation of psychology and the psychologist* (Unpublished doctoral dissertation). University College London, London, UK.
- Jones, M. L. (2007). Hofstede-culturally questionable? Proceedings from *Oxford Business & Economics Conference*. Oxford, UK.
- Kilbourne, A. M., Neumann, M. S., Pincus, H. A., Bauer, M. S., & Stall, R. (2007). Implementing evidence-based interventions in health care: application of the replicating effective programs framework. *Implementation Science*, 2(1), 42-52. doi:10.1186/1748-5908-2-42
- Korcha, R. A., Cherpitel, C. J., Moskalewicz, J., Swiatkiewicz, G., Bond, J., & Ye, Y. (2012). Readiness to change, drinking, and negative consequences among Polish SBIRT patients. *Addictive behaviors*, 37(3), 287-292.

- Krefting, L. (1999). Rigor in qualitative research: The assessment of trustworthiness. In A. K. Milinki (Ed.). *Cases in qualitative research*, (pp. 173-181). Los Angeles, CA: Pyrczak Publishing.
- Kumpfer, K. L., Alvarado, R., Smith, P., & Bellamy, N. (2002). Cultural sensitivity and adaptation in family-based prevention interventions. *Prevention Science*, 3(3), 241-246.
- Kumpfer, K. L., Pinyuchon, M., de Melo, A. T., & Whiteside, H. O. (2008). Cultural adaptation process for international dissemination of the Strengthening Families Program. *Evaluation & the Health Professions*, 31(2), 226-239.
- Krueger, R. A., & Casey, M. A. (2000). *Focus groups: A practical guide for applied research* (3rd ed.). Thousand Oaks, CA: Sage Publications, Inc.
- La Roche, M., & Christopher, M. S. (2008). Culture and empirically supported treatments: On the road to a collision? *Culture & Psychology*, 14(3), 333-356.
- Lau, A. S. (2006). Making the case for selective and directed cultural adaptations of evidence-based treatments: Examples from parent training. *Clinical Psychology: Science and Practice*, 13(4), 295-310. doi:10.1111/j.1468-2850.2006.00042.x
- Leventhal, H., Weinman, J., Leventhal, E. A., & Phillips, L. A. (2008). Health psychology: The search for pathways between behavior and health. *Annual Review of Psychology*, 59, 477-505.
- Levine, D. M., Becker, D. M., Bone, L. R., Hill, M. N., Tuggle, M. B., & Zeger, S. L. (1994). Community-academic health center partnerships for underserved minority populations: one solution to a national crisis. *The Journal of the American Medical Association*, 272(4), 309-311.

- Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic inquiry*. Beverly Hills, CA: Sage.
- Lingard, L., Albert, M., & Levinson, W. (2008). Grounded theory, mixed methods, and action research. *BMJ*, 337, 459-461. doi:10.1136/bmj.39602.690162.47
- Liu, N. H., & Satterfield, J. M. (2015). Screening, brief intervention, and referral to treatment (SBIRT) for substance abuse in older populations.
- Lo, C. C., & Cheng, T. C. (2011). Racial/ethnic differences in access to substance abuse treatment. *Journal of Health Care for the Poor and Underserved*, 22(2), 621-637. doi:10.1353/hpu.2011.0054
- Lundgren, L. M., & Rieckmann, T. (2011). Research on implementing evidence based practices in community based addiction treatment programs: Policy and program implications. *Evaluation and Program Planning*, 34(4), 353–355.
- Lurie, N., & Fremont, A. (2006). Looking forward: Cross-cutting issues in the collection and use of racial/ethnic data. *Health services research*, 41(4), 1519-1533.
- Macaulay, A. C., Commanda, L. E., Freeman, W. L., Gibson, N., McCabe, M. L., Robbins, C. M., & Twohig, P. L. (1999). Participatory research maximises community and lay involvement. *BMJ: British Medical Journal*, 319(7212), 774-778.
- MacQueen, K. M., McLellan, E., Kay, K., & Milstein, B. (1998). Codebook development for team-based qualitative analysis. *Cultural anthropology methods*, 10(2), 31-36.

- Maisto, S.A., Galizio, M. & Connors, G.J. (2008). Drug use and abuse (2nd ed.). Thomson and Learning Inc.
- Marsh, J. C., Cao, D., Guerrero, E., & Shin, H. (2009). Need-service matching in substance abuse treatment: Racial/ethnic differences. *Evaluation & Program Planning*, 32(1), 43-51. doi:10.1016/j.evalprogplan.2008.09.003
- Mason, S. E. (2005). Offering African Americans opportunities to participate in clinical trials research: How social workers can help. *Health & Social Work*, 30(4), 296-304.
- McCullough, L., & Anderson, M. (2013). Agency lost and recovered: A social constructionist approach to smoking addiction and recovery. *Addiction Research & Theory*, 21(3), 247-257. doi:10.3109/16066359.2012.709561
- McRee, B. (n.d.). *Screening, brief intervention & referral to treatment (SBIRT): An overview* [PowerPoint slides]. Retrieved from <http://www.ct.gov/dmhas/lib/dmhas/publications/SBIRT-Overview110311.pdf>
- Miller, W., & Rollnick, S. (2002). *Motivational Interviewing* (2nd ed.). New York and London: Guilford Press.
- Miller, W., Simon, P., & Maleque, S. (Eds.). (2009). *Beyond health care: New directions to a healthier America*. Washington, DC: Robert Wood John Robert Wood Johnson Foundation Commission to Build a Healthier America.
- Minkler, M., Blackwell, A.G., Thompson, M., & Tamir, H. (2003). Community-based participatory research: Implications for public health funding. *American Journal of Public Health: Public Health Advocacy Forum*, 93(8), 1210-1213.

- Minkler, M., & Wallerstein, N. (Eds.). (2010). *Community-based participatory research for health: From process to outcomes*. Hoboken, NJ: John Wiley & Sons, Inc.
- Miranda, J., McGuire, T. G., Williams, D. R., & Wang, P. (2008). Mental health in the context of health disparities. *American Journal of Psychiatry*, 165(9), 1102–1108.
- Montgomery, L., Burlew, A. K., Kosinski, A. S., & Forcehimes, A. A. (2011). Motivational enhancement therapy for African American substance users: A randomized clinical trial. *Cultural Diversity and Ethnic Minority Psychology*, 17(4), 357-365. doi: 10.1037/a0025437
- Morse, J. M., Barrett, M., Mayan, M., Olson, K., & Spiers, J. (2002). Verification strategies for establishing reliability and validity in qualitative research. *International Journal of Qualitative Methods*, 1(2), 13-22.
- Mountian, I. (2013). *Cultural ecstasies: Drugs, gender and the social imaginary*. New York, NY: Routledge/Taylor & Francis Group.
- Mulia, N., Ye, Y., Greenfield, T. K., & Zemore, S. E. (2009). Disparities in Alcohol-Related Problems Among White, Black, and Hispanic Americans. *Alcoholism: Clinical and Experimental Research*, 33(4), 654-662.
- Myers, B., Fakier, N., & Louw, J. (2009). Stigma, treatment beliefs, and substance abuse treatment use in historically disadvantaged communities. *African Journal of Psychiatry*, 12(3), 218-222.
- National Institute on Drug Abuse. (2003). *Drug use among racial/ ethnic minorities*. Bethesda, Maryland: U.S. Department of Health and Human Services, National Institutes of Health.

- National Institute on Drug Abuse Minority Health Disparities Work Group. (2011). *Report of the diversity and health disparities council review work group*. Bethesda, Maryland: National Institute on Drug Abuse.
- National Institute of Health. (2001). In NIH policy and guidelines on the Inclusion of women and minorities as subjects in clinical research. Retrieved from [http://grants1.nih.gov/grants/funding/women\\_min/guidelines\\_amended\\_10\\_2001.htm](http://grants1.nih.gov/grants/funding/women_min/guidelines_amended_10_2001.htm)
- National Prevention Council. (2011). *National prevention strategy: America's plans for better health and wellness*. Washington, DC: U.S. Department of Health and Human Services, Office of the Surgeon General.
- Neighbors, H. W., Trierweiler, S. J., Ford, B. C., & Muroff, J. R.. (2003). Racial differences in DSM diagnosis using a semi-structured instrument: The importance of clinical judgment in the diagnosis of African Americans. *Journal of Health and Social Behavior*, 44(3), 237-256
- Neighbors, H. W., Trierweiler, S. J., Munday, C., Thompson, E. E., Jackson, J. S., Binion, V. J., & Gomez, J. (1999). Psychiatric diagnosis of African Americans: Diagnostic divergence in clinician-structured and semistructured interviewing conditions. *Journal of the National Medical Association*, 91(11), 601-612.
- Nelson, T. D., Steele, R. G., & Mize, J. A. (2006). Practitioner attitudes toward evidence-based practice: Themes and challenges. *Administration and Policy in Mental Health and Mental Health Services Research*, 33(3), 398-409.
- Notley, C., Maskrey, V., & Holland, R. (2012). The needs of problematic drug misusers not in structured treatment—a qualitative study of perceived treatment barriers and

recommendations for services. *Drugs: education, prevention and policy*, 19(1), 40-48.

doi:10.3109/09687637.2011.570384

Office of Minority Health. (2001). National standards for culturally and linguistically appropriate services in health care: Final report. [Contract No. 282-99-0039]. Washington, DC: Author.

Patton, M. Q. (1990). *Qualitative research and evaluation methods*. Thousand Oaks, CA: Sage Publications.

Penner, L. A., Albrecht, T. L., Coleman, D. K., & Norton, W. E. (2007). Interpersonal perspectives on Black-White health disparities: Social policy implications. *Social Issues and Policy Review*, 1(1), 63-98.

Petrik, M. L., Billera, M., Kaplan, Y., Matarazzo, B., & Wortzel, H. (2015). Balancing patient care and confidentiality: Considerations in obtaining collateral information. *Journal of Psychiatric Practice*®, 21(3), 220-224.

Pincus, H. A., Page, A. E., Druss, B., Appelbaum, P. S., Gottlieb, G., & England, M. J. (2007). Can psychiatry cross the quality chasm? Improving the quality of health care for mental and substance use conditions. *The American journal of psychiatry*, 164(5), 712-719.

President's New Freedom Commission on Mental Health. (2003). *Achieving the Promise: Transforming Mental Health Care in America. Final Report* (DHHS Pub. No. SMA-03-3832). Rockville, MD: Author.

Redmond, M., Rooney, R., & Bishop, B. (2006). Unipolar depression across cultures: A Delphi analysis of the methodological and conceptual issues confronting the cross-cultural study of depression. *Advances in Mental Health*, 5(2), 113-125.



- Rigazio-DiGilio, S. A. (1994). A co-constructive-developmental approach to ecosystemic treatment. *Journal of Mental Health Counseling*, 16(1), 43-74.
- Rigazio-DiGilio, S. A. (2000). Reconstructing psychological distress and disorder from a relational perspective: A systemic, coconstructive-developmental framework. In R. Neimeyer & J. Raskin (Eds.), *Constructions of disorder* (pp. 309–332). American Psychological Association.
- Rigazio-DiGilio, S. A. (2001). *Postmodern theories of counseling*. In D. C. Locke, J. E. Meyers, & E. L. Herr (Eds.). *The handbook of counseling*. (pp. 197-217). Thousand Oaks, CA: Sage
- Rigazio-DiGilio, S. A. (2014). *Supervising couple and family therapy practitioners*. In C. Watkins and E. Milne (Eds.) *The Wiley international handbook of clinical supervision* (pp. 622-647). London, U.K.: Wiley-Blackwell.
- Rigazio-DiGilio, S. A., Ivey, A. E., Kunkler-Peck, K. P., and Grady, L T. (2005) *Community genograms: Using individual, family and cultural narratives with clients*. New York: Teacher's College Press, Columbia University.
- Rigazio-DiGilio, S. A. & Kang, H. (in press). *The extended family context: Using Community Genograms to position culture and context in the foreground of family counseling*. In M. Stauffer and D. Capuzzi (Eds). *Fundamentals of Couples, Marriage, and Family Counseling*. John Wiley and Sons Publishing Company.
- Riley, T., & Hawe, P. (2005). Researching practice: the methodological case for narrative inquiry. *Health education research*, 20(2), 226-236.
- Roberts, K. T., Robinson, K. M., Topp, R., Newman, J., Smith, F., & Stewart, C. (2008). Community perceptions of mental health needs in an underserved minority

- neighborhood. *Journal of Community Health Nursing*, 25(4), 203-217.  
doi:10.1080/07370010802421202
- Roysircar, G., & Pignatiello, V. (2011). A multicultural-ecological assessment tool: Conceptualization and practice with an Asian Indian immigrant woman. *Journal of Multicultural Counseling and Development*, 39, 167-179.
- Rush, B. (2003). The evaluation of treatment services and systems for substance use disorders. *Revista de Psiquiatria do Rio Grande do Sul*, 25(3), 393-411.
- Satre, D. D., McCance-Katz, E. F., Moreno-John, G., Julian, K. A., O'Sullivan, P. S., & Satterfield, J. M. (2012). Using needs assessment to develop curricula for screening, brief intervention, and referral to treatment (SBIRT) in academic and community health settings. *Substance Abuse*, 33(3), 298-302. doi:10.1080/08897077.2011.640100
- Savino, E. A. (2009). *Placement of sensitive and nonsensitive demographic questions: An empirical study* (Master's thesis). Retrieved from ProQuest, UMI Dissertations Publishing. (1484538)
- Sharma, M., & Atri, A. (2006). Substance Abuse in African Americans: In Search of a Culturally Competent Research Agenda. *Journal of Alcohol and Drug Education*, 50(3), 3-7.
- Shaya, F. T., Gbarayor, C. M., Yang, H. K., Agyeman-Duah, M., & Saunders, E. (2007). A perspective on African American participation in clinical trials. *Contemporary Clinical Trials*, 28, 213-217.
- Shelton, L., Aiuppa, L., & Torda, P. (2004). *Recommendations for improving the quality of physician directory information on the internet*. New York: The Commonwealth Fund.

Shenton, A. K. (2004). Strategies for ensuring trustworthiness in qualitative research projects.

*Education for Information*, 22(2), 63-75.

Smedley, B. E., Stith, A. Y., & Nelson, A. R. (2003). *Unequal treatment: Confronting ethnic and racial disparities in healthcare*. Washington, DC: National Academies Press. Retrieved from <http://www.nap.edu/catalog/10260.html>

Smedley, B., & Syme, S. (2001). Promoting health: Intervention strategies from social and behavioral research... reprinted with permission from Promoting Health: Intervention Strategies from Social and Behavioral Research, 2000. *American Journal Of Health Promotion*, 15(3), 149-166.

Steiker, L., Castro, F. G., Kumpfer, K., Marsiglia, F. F., Coard, S., & Hopson, L. M. (2008). A dialogue regarding cultural adaptation of interventions. *Journal of Social Work Practice in the Addictions*, 8(1), 154-162.

Steinberg, A. G., Sullivan, V. J., & Loew, R. C. (1998). Cultural and linguistic barriers to mental health service access: The deaf consumer's perspective. *American Journal of Psychiatry*, 155(7), 982-984.

Substance Abuse and Mental Health Services Administration. (2010). *Substance use among Black adults* (Publication No. NCJ 233636). Rockville, MD: SAMHSA, Office of Applied Studies.

Substance Abuse and Mental Health Services Administration. (2011). *Leading Change: A Plan for SAMHSA's Roles and Actions 2011-2014* (HHS Publication No. (SMA) 11-4629). Rockville, MD: Substance Abuse and Mental Health Services Administration.

- Substance Abuse and Mental Health Services Administration. (2013). *Results from the 2012 National Survey on Drug Use and Health: Summary of National Findings* (HHS Publication No. (SMA) 13-4795). Rockville, MD: Substance Abuse and Mental Health Services Administration.
- Substance Abuse and Mental Health Services Administration. (2014). *Screening, brief intervention, and referral to treatment (SBIRT)*. Retrieved from <http://beta.samhsa.gov/sbirt>
- Suskie, L. A. (1996). *Questionnaire Survey Research: What Works* (2nd ed.). Florida State University: Association for Institutional Research.
- Teddlie, C., & Tashakkori, A. (Eds.). (2009). *Foundations of mixed methods research: Integrating quantitative and qualitative approaches in the social and behavioral sciences*. Sage Publications Inc.: Chicago.
- Trickett, E. J. (2009). Multilevel community-based culturally situated interventions and community impact: An ecological perspective. *American journal of community psychology*, 43(3-4), 257-266.
- U.S. Census Bureau. (2010). *2010 Census* [Data file]. Retrieved from <http://factfinder2.census.gov/faces/tableservices/jsf/pages/productview.xhtml?src=CF>
- U.S. Department of Health and Human Services. (1999). *Mental Health: A report of the Surgeon General*. Rockville, MD: Author.
- U.S. Department of Health and Human Services. (2001). *Mental health: Culture, race, and ethnicity—A supplement to mental health: A report of the surgeon general*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services.

- U.S. Department of Health and Human Services Office of Minority Health. (2001). *National standards for culturally and linguistically appropriate services in health care: Final report*. Rockville, MD: Author.
- U.S. Department of Health and Human Services. (2006). *Mental health, United States, 2004* (DHHS Publication No. SMA-06-4195). Rockville, MD: Substance Abuse and Mental Health Services Administration, Center for Mental Health Services.
- U.S. Department of Health and Human Services. (2008). *Results from the 2007 national survey on drug use and health: National findings*. Washington, DC: U.S. Department of Health and Human Services.
- U.S. Department of Health and Human Services. (2011). *HHS action plan to reduce racial and care*. Washington, DC: U.S. Department of Health and Human Services.
- Vendetti, J., Gmyrek, A., Damon, D., Singh, M., McRee, B., & Del Boca, F. (2014). *Screening, Brief Intervention and Referral to Treatment (SBIRT): Implementation Barriers, Facilitators and Model Migration*. Manuscript submitted for publication.
- Viswanathan, M., Ammerman, A., Eng, E., Gartlehner, G., Lohr, K. N., Griffith, D., ... Whitener, L. (2004). *Community-based participatory research: Assessing the evidence* (AHRQ Publication No. 04-E022-2). Research Triangle Park, NC: RTI International-University of North Carolina.
- Vygotsky, L. S. (1986). *Thought and language*. Cambridge, MA: MIT Press.
- Wallace, J. M. (1999). The social ecology of addiction: Race, risk, and resilience. *Pediatrics*, 103(2), 1122-1127.

- Wallerstein, N., & Duran, B. (2010). The conceptual, historical, and practical roots of community based participatory research and related participatory traditions. In M. Minkler, & N. Wallerstein. (Eds.), *Community-based participatory research for health: From process to outcomes* (pp. 27-52). Hoboken, NJ: John Wiley & Sons.
- Weiner, J., & McDonald, J. A. (2013). Special issue: Three models of community-based participatory research. *LDI issue brief*, 18(5), 1-8.
- Westfall, J. M., VanVorst, R. F., Main, D. S., & Herbert, C. (2006). Community-based participatory research in practice-based research networks. *The Annals of Family Medicine*, 4(1), 8-14.
- Whetten, K., Leserman, J., Whetten, R., Ostermann, J., Thielman, N., Swartz, M., & Stangl, D. (2006). Exploring lack of trust in care providers and the government as a barrier to health service use. *American Journal of Public Health*, 96(4), 716-721.
- Williams, D. R., & Mohammed, S. A. (2013). Racism and health I: Pathways and scientific evidence. *The American Behavioral Scientist*, 57(8), 10.1177/0002764213487340. doi:10.1177/0002764213487340
- Windsor, L. C., & Murugan, V. (2012). From the individual to the community: Perspectives about substance abuse services. *Journal of Social Work Practice in the Addictions*, 12(4), 412-433. doi:10.1080/1533256X.2012.728115
- World Health Organization. (2010a). *The alcohol, smoking and substance involvement screening test (ASSIST): Manual for use in primary care*. Geneva, Switzerland: WHO Press, World Health Organization.

World Health Organization. (2010b). *The ASSIST-linked brief intervention for hazardous and harmful substance use: Manual for use in primary care*. Geneva, Switzerland: WHO Press, World Health Organization.

World Health Organization. (2012). *Risks to mental health: An overview of vulnerabilities and risk factors*. Geneva, Switzerland: Author.

Yancey, A. K., Ortega, A. N., & Kumanyika, S. K. (2006). Effective recruitment and retention of minority research participants. *Annual Review Public Health*, 27, 1-28. doi: 10.1146/annurev.publhealth.27.021405.102113

Table 1

*Number of Stakeholder Group Member by Data Collection Method*

Stakeholder Group	Community Member Stakeholder Group			Community Leader Stakeholder Group			Service Provider Stakeholder Group					
							Hartford Community			Other Community		
Data Collection Method	N	Group %	Sample %	N	Group %	Sample %	N	Group %	Sample %	N	Group %	Sample %
Focus Group and Survey	10	28.6	11.8	8	32.0	9.4	2	8.0	2.4	5	20.0	5.9
Survey Only	25	71.4	29.4	17	68.0	20.0	13	52.0	15.3	5	20.0	5.9
Phase Two	10	28.6	11.8	8	32.0	9.4	5	20.0	5.9	1	4.0	1.2

N: The total number of participants in each respective stakeholder group

Group %: The percentage of participants represented in the respective stakeholder group

Sample %: The percentage of participants represented in the total participant sample



Table 2

## Codebook

DOMAINS		Question 1		
COMBINED CODES		Self-reflection / problems / disparities		
CODES	Inductive	Deductive	Theoretical	
	Self-reflection	problems	disparities	
BRIEF DEFINITIONS	When someone reflects on their personal situation or their family	<u>Perceived effect of substance use or abuse on self, home, neighborhood, and/or the community</u>	The increasing awareness of the on-going disparities and <u>current indicators of disparities</u> (especially if it is an inference).	
FULL DEFINITION OF INCLUSION CRITERIA		(1)An explanation or example of the social problems that are happening in the Hartford area because of drug use, alcohol, or tobacco use; (2)the challenges and the socioeconomic and community factors that contribute to health outcomes.	(1)The risk factors for substance abuse that span across a range of individual (i.e.personality characteristics), interpersonal (i.e. use among family and friends), and contextual (i.e. availability of substances and community socioeconomics) factors (Wallace, 1999); (2) <u>A description of how the experience of being a racial/ethnic minority person influence the etiology and onset of substance abuse and dependence (Castro &amp; Alarcon, 2002).</u>	
EXAMPLE OF INCLUDED DATA	"If you're gonna drink, don't do it around no kids or I suggest don't drink at all."	"There are too many liquor stores in residential areas and near schools."	"There aren't that many positive things for young people in my neighborhood, and that's why a lot of people turn to drugs."	

Question 2	Question 2
<p><b>Deductive</b></p> <p>services</p> <p>Perceived effectiveness &amp; relevance of SU/A services &amp; resources currently available</p>	<p><b>Theoretical</b></p> <p>accessibility concern</p> <p>Any indication that the larger community and healthcare systems inhibit Black individuals in their ability to initiate seeking help (Achara-Abrahams, Evans, Ortiz, Villegas, O'Dell, Ali, &amp; Hawkins, 2012).</p>
<p>(1)Responses related to who assists or should assist with obtaining services and <u>how do professionals initially respond to a person in need</u>; (2)<u>where do they go or perceive a person should go for these services</u>; (3)<u>how services are used or the reason why they are not used</u>.</p>	<p>(1)Any descriptive information that coincides with the evidence that indicates that minorities experience more barriers to care and are further disabled by their unmet health and mental health care needs (DHHS, 2001); or (2)A description of how is the experience of being a racial/ethnic minority person related to specific health service needs (Castro &amp; Alarcon, 2002); (3) <u>Any descriptions related to the dissemination of health-related information for the identified community</u>; (4) <u>Any description of the challenges finding or the lack of existing culturally appropriate services (Jones, Hopson, &amp; Gomes, 2012)</u>.</p>
<p>"You can't trust people you just met with your personal problems."</p>	<p>"You should see flyers on the street telling people where to go for help treating a substance use issue."</p> <p>"In suburban towns, their top concerns for their kids are different then our concerns."</p>
<p><b>Deductive</b></p> <p>exchange</p> <p>Perceptions and perceived comfort of patient-provider exchange before the ASSIST is administered</p>	<p><b>Deductive</b></p> <p>engagement</p> <p>Perceptions and perceived comfort of patient-provider exchange before the ASSIST is administered</p>

Question 3	Question
<p><b>Theoretical</b></p> <p>distrust</p>	<p><b>Deductive</b></p> <p>evaluate ASSIST</p>
<p>Attitudinal barriers (i.e. the attitudes representative of societal viewpoints) that exist due to community distrust for healthcare systems, which is also known to deter individuals from seeking help (Hall, 2001).</p>	<p>Assessment of the relevance of the ASSIST &amp; the feedback report card overall experience</p>
<p><u>(1)Any description of the attitudinal barriers that contribute to the stigma associated with seeking health and mental health services (DHHS, 2006; Lau, 2006);</u></p> <p>(2)Any indications that challenges were specific to the medical professionals (i.e. negative provider attitudes, <b>time constraints</b>, concerns for dishonesty among patients reporting their use) (J. Vendetti, F. Del Boca, &amp; B. McRee, personal communication, July 8, 2014).</p>	<p><u>(1)Perceived comfort level participating in the any aspect of the assessment procedures;</u></p> <p><u>(2)Provider's efforts to gauge the patient's comfort level and alter based on this perception.</u></p>
<p>"I can't talk to the men in my family about their drinking. I can't even get them to see a doctor."</p>	<p>"I would be okay with it if I received this assessment." "I would want to know why they were asking me so many questions."</p>
	<p>usability</p>
	<p><u>utilization of health care services by the Black community</u></p>
	<p>(1) Any indications that the barriers to implementing SBI were related to the medical setting (Babor et al., 2007); <b>or...</b> (2) the lack of dissemination of information about services that are relevant to African Americans throughout urban communities (Roberts et al., 2008).</p>
	<p>"I don't feel welcomed from the moment I enter into the waiting room."</p>

ion 4

### ASSIST suggestions / Patient-centered care / cultural adaptations

Deductive	Theoretical	Deductive
ASSIST suggestions	ASSIST adaptations changed to Patient-Centered Care	BI exchange
Suggestions for improving the ASSIST & the feedback report card overall experience	Incorporating the voices and input of the community (Hall, 2001) regarding the ASSIST. Care that attends to or neglect patient values and preferences	Perceived comfort and relevance of patient-provider exchange
<u>(1)Advice on how to make any part of the assessment procedures more relevant for the Black community;</u> (2)With the constant consideration of the original theoretical framework, these statements should highlight limitations, change mechanisms, and other constructs specific to these communities (Steiker et al., 2008).	<u>Description of any aspect of the assessment procedures that are relevant to the community's concerns</u> (Weiner & McDonald, 2013)	<u>(1)Perceived comfort level participating in the BI;</u> (2) <u>the impact of demographic differences on interactions throughout the BI;</u> (3) <u>Expressed desires for the health care professionals to develop cultural awareness and competency.</u>
"It would be helpful if I could have seen the health educator sometime before this assessment, so he or she would seem familiar to me."	"I want to know how to get my partner to seek help for his drinking problem."	"Its important for medical providers to know things about the community they serve."

## Question 5

Theoretical	Deductive	Theoretical
working alliance	BI relevance	Responsiveness
Any evidence that the connection between the patient and provider helps to illicit change (Davis, Ancis, & Ashby, 2015).	<u>Provide opportunities for patients to understand / reflect on their substance use / abuse</u>	Provide input on the cultural responsiveness of the program before and throughout the implementation of the program (Simmons et al., 2008). (2) <u>Provides a description of the interactions or dynamics that exist between a individuals, families, and community members influence or aim to influence behaviors associated with substance use.</u>
(1)Any form of community-based approaches or ideas that place emphasis on strengthening the relationship between community and healthcare systems (Israel, Schulz, Parker, & Becker, 1998); (2)Literature suggests <u>substance abuse treatment involving African Americans should focus on empowerment in addition to personal responsibility, which can be modeled through and further facilitated by an effective working alliance.</u>	Whether or not a specific part of the BI allows the community to speak freely about matters that are relevant to them; (2)responses related to open revelations about substance use or acknowledging the issues developing from substance use; (3) <u>Identifying sources of irrelevancy in BI for the Black community.</u>	Responds to a national call aimed at establishing and extending culturally competent services by (1) collecting data pertaining to the current indicators of disparities, (2) evaluating treatment for effectiveness particularly for producing outcome relevant to the client's objectives, and (3) establishing and maintaining a relationship with the community (President's New Freedom Commission on Mental Health, 2003); <u>(4)Provider's efforts to self-disclose to further connect with patients. (5) patient's desire or provider's assumed ability to communicate an understanding of African-American values (Jones, Hopson, &amp; Gomes, 2012).</u>
"If the doctor mentioned that he grew up in Hartford, then I would feel different about him."	"Asking someone 'what are the good things about their use?' is similar to something I would ask."	"There needs to be more researchers that ask the community for their perspectives on what's needed to address problems in their area."

		Que
ASSIST suggestions / Patient-centered care / cultural adaptations		collaborations / i
Deductive	Theoretical	Deductive
BI suggestions	cultural adaptations	collaborations
<u>Suggestions for improving the BI and suggestions for adaptation to the BI.</u>	Any indications that standard treatments are not as equally powerful when applied to the Black community, thus validating the need for substantial modifications (Huey & Polo, 2008).	Any necessary components for a community partnerships to take place to address cultural sensitivity among healthcare systems
(1) Advice on how to make any part of the BI more relevant for the Black community; (2) With the constant consideration of the original theoretical framework, these statements should highlight limitations, change mechanisms, and other constructs specific to these communities (Steiker et al., 2008).	<u>(1)Any descriptions of risk and resiliency factors that are unique to indentified community;</u> <u>(2)A rationale for adaptation on the basis of observed community disengagement to standard protocols (Lau, 2006);</u> (3)Any adaptations that aim at enhancing engagement (National Institute of Mental Health, 2008); (4)Elements deemed structurally important for the identified community.	(1)Willingness or practicality for participating in additional steps to improving cultural relevancy; <u>(2)Issues that need to be address through collaborations with others;</u> (3)Assumptions and barriers at the institutional and community levels that deter collaborative efforts; <u>(4) Perception / belief that their participation would make a difference among the community</u>
"I don't think there needs to be any changes to the BI. I just think they need to approach people in the community outside the medical settings."	"It has to feel genuine. If you hear a tone that's accusatory, then you won't want to say anything." "Most people don't want to say anything because they don't know what the professional will do with this information."	"Everyone needs to be involved." "I can make a suggestion for someone you need to reach out talk to."

Question 7	Question 6
<p><b>integrative approach</b></p> <p><b>Theoretical</b></p> <p>integrative approach</p> <p>Intra- and inter-organizational communication and collaboration (i.e. cooperation between departments and across agencies) (Vendetti et al., personal communication, July 8, 2014).</p>	<p>Later comparative analyses within and across stakeholder groups [qualitative &amp;</p> <p>Similarities and differences in perceptions across and within each stakeholder group for research questions 1 – 5 and 7</p>

Any description that suggests that community involvement and additional input of trusted voices from within the community can counteract the stigma that often impedes under-represented minorities from seeking treatment (Gearing et al., 2012). (2)Any time a service provider interacts with another service provider

"You need to get all the family centers in Hartford involved, but not all at once. You need to build a relationship with each one."

Table 3

*Phase 1: Identification of Initial Themes*

Identification of initial themes	Code(s)	Illustrative examples of coded text segments
<b>Barriers of accepting services</b>		
Strong assumptions about substance users	Problems	“Like, if I - he’s my family and I care about him, but I feel like if you’re gonna do that [hazardous drug use] you don’t care about yourself, point blank period.” – <i>community leader</i>
Biopsychosocial impact of substance abuse	Disparities	“A lot of times the patients when they screen positive they’ll, they’ll say they’re continuing to use because of the underlying ... in their family culture Hispanics or African Americans you can’t go see somebody from behavioral health, so what do they continue to do? They continue to use.” – <i>service provider</i>
Underutilization of substance abuse services	Accessibility concerns, services	“I only know about AA. That’s all I know about.” – <i>community member</i>
Uninformed about substance abuse treatment	Services	“They don’t know we are there and we can provide some other services at the, at the same visit or connect them to the right, uh, person that can help them with the other issues.” – <i>service provider</i>
<b>Facilitators of following through</b>		
Trust and confidentiality	Distrust, engagement	“And then it’s the privacy, also. Patient confidentiality. So even ... say if the person is AIDS ... positive for AIDS or does drugs, and um, is in the hospital because of detox or whatever, you know, you have to be understanding of that. You can’t be judgmental. I mean, I’ve always understood that, but I never actually seen it in other people.” – <i>community member</i>
Racism/classism/sexism	Engagement, Brief Intervention (BI) exchange	“I think if it was a white person asking the questions and it’s a black, like, patient or whatever, they’re probably not gonna feel comfortable, like, telling that person.” – <i>service provider</i>
Impact of patient centered care on uptake and utilization	Evaluate ASSIST, usability, ASSIST suggestions, patient-centered care	“They [service providers] should know how the community operates so that they can have a better understanding of why a person would choose that abusive path that they did.” – <i>community leader</i>
Patient-centeredness and transparency		
Cooperation	Integrative approach, collaboration, Brief Intervention (BI) suggestion, responsiveness	“If you really have a good team working with you it boosts your self-esteem and your confidence and your ability to be able to, uh, provide the service.” – <i>service provider</i>

*Note:* Initial ideas and concepts do not support all stakeholder groups. Broader themes that remained throughout all phases of theme development are left flushed. Weaker themes that were removed at later phases of theme development are indented.



Table 4

*Phase 2: Themes supported by low frequency coded text segments*

Themes	Illustrative summarized examples of coded text segments
Sustained assumptions about substance users	N/A
Under-utilization of substance abuse services differs from lack of community knowledge	Two service providers mentioned that the community appears open to seek help for physical problems, but not for behavioral health-related issues.
Trust and confidentiality facilitate substance use questions	Two community leaders would questions the need to continue helping someone who keeps using despite the leader's involvement.
Desire for patient-centered care within the provision of high service quality	One community member provided the suggestion: Always give each individual the benefit of the doubt, then ask questions that gauge their readiness to change.
Cooperation with multiple systems	N/A

*Note:* N/A means that there were no meaningful low frequency coded text segments for the theme.

Table 5

*Phase 3: One-sentence member check statements*

<b>Themes</b>	<b>Illustration / Examples</b>
Sustained assumptions about substance users	“Self-medicating with drugs due to underlying emotional problems (i.e., depression, anger, frustration)” – <i>community member</i>
Under-utilization of substance abuse services differs from lack of community knowledge	“Let people talk. Let people tell you their truth.” – <i>community leader</i>
Trust and confidentiality facilitate substance use questions	“In the Black community there is a stigma regarding mental illness and receiving counseling from a psychiatrist. There is also mistrust of health care providers due to past history.” – <i>community member</i>
Desire for patient-centered care within the provision of high service quality	“If the health care provider can relate, it is more important than ‘what do you know about me’.” – <i>community leader</i>
Cooperation with multiple systems	N/A

Table 6

*Percentages by Stakeholder Groups for Demographic Data, N =85*

	Stakeholder groups		
	Comm. Members	Comm. Leaders	Service Providers
	<i>n</i> = 35	<i>n</i> = 25	<i>n</i> = 25
Sex (male)	56.5	50.0	33.3
Age	41.57	23.20	42.54
Range	22 - 70	18 - 45	23 - 60
Ethnicity			
African American	54.5	40.0	38.5
Afro Caribbean Islander	36.4	40.0	0.0
Caucasian/White	9.1	0.0	15.4
Hispanic	0.0	10.0	46.2
Asian/Pacific Islander	0.0	10.0	0.0
Education (high school)	39.1	60.0	7.7

## Appendix A

Introductory items		
Objective: To orient participants		
Community members / consumers	Community leaders / policy makers	Clinicians / health educators
FGQ-1: Give me an example of how drug, alcohol, or tobacco use has negatively affected your home, neighborhood, or the Hartford area in general?	FGQ-1: Give me examples of the problems that are happening in the Hartford area because of drug use, alcoholism, or tobacco use?	FGQ-1: How often do you examine a patient who you believe has a problem with drugs, alcohol, or tobacco?
CSQ-1: Circle each of the following ways in which you SEEN drug, alcohol, or tobacco use negatively affected your home, neighborhood, or the Hartford area in general? (A) health, (B) employment, (C) safety, (D) other_____	CSQ-1: Circle each of the following ways in which you KNOW drug, alcohol, or tobacco use negatively affected the Hartford area in general? (A) health, (B) employment, (C) safety, (D) other_____	CSQ-1: How often do you interact with or come across a family member, friend, or neighbor who you believe has a problem with drugs, alcohol, or tobacco? (A) daily, (B) regularly, but not daily, (C) not often, (D) not at all, (E) not sure
FGQ-2: How often do you interact with or come across a family member, friend, or neighbor who you believe has a problem with drugs, alcohol, or tobacco?	FGQ-2: Are these problems influenced by any other health disparities?  FGQ-3: How often do you interact with or come across a member of your community who you believe has a problem with drugs, alcohol, or tobacco?	FGQ-2: Give an estimate. What percentage of these patients are part of the local Black community?
CSQ-2: How often do you interact with or come across a family member, friend, or neighbor who you believe has a problem with drugs, alcohol, or tobacco? (A) daily, (B) regularly, but not daily, (C) not often, (D) not at all, (E) not sure	CSQ-2/3: How often do you interact with or come across a family member, friend, or neighbor who you believe has a problem with drugs, alcohol, or tobacco? (A) daily, (B) regularly, but not daily, (C) not often, (D) not at all, (E) not sure	CSQ-2: Give an estimate. What percentage of these patients are part of the local Black community? (A) 10% or less, (B) greater than 10% but less than 50%, (C) about 50%, (D) about 75%, (E) almost 100%
Ways in which substance use /abuse issues are currently addressed		
Objectives: To learn about knowledge of and perceptions about the ways these issues are currently addressed, available services, and effectiveness of available services.		
Community members / consumers	Community leaders / policy makers	Clinicians / health educators
FGQ-1: If you (or someone you know) wanted to receive information about available services to deal with substance abuse / use - who would you / they speak with?	FGQ-1: Do members of your community come to you to receive information about available services to deal with substance abuse / use?	FGQ-1: Do patients from the local Black community ask you (without your broaching the topic first) about available services to deal with substance abuse / use?
CSQ-1: If you (or someone you know) wanted to receive information about available services to deal with substance abuse / use - who would you / they speak with? (A) minister/deacon from church, (B) primary care physician, (C) family	CSQ-1: Do members of your community come to you to receive information about available services to deal with substance abuse / use? (A) regularly, (B) on occasion, (C) rarely, (D) never	CSQ-1: Do patients from the local Black community ask you (without your broaching the topic first) about available services to deal with substance abuse / use? (A) regularly, (B) on occasion, (C) rarely, (D) never

members or friends, (D) social services, (E) other\_\_\_\_, (F) not sure

FGQ-2: What are some of the first questions you think that a person would ask before requesting information about available services?	FGQ-2: If so, what are some of the first questions you ask them when you learn of or suspect that substance use or abuse may be a problem?	FGQ-2: If so, what are some of the first questions you ask them when you learn of or suspect that substance use or abuse may be a problem?
CSQ-2: What is one of the first questions you think that a person would ask before requesting information about available services? (A) cost of service / insurance coverage, (B) location of service, (C) are the services culturally-based, (D) are there consequences to seeking services, (E) other____, (F) not sure	CSQ-2: If so, what is one of the first questions you ask them when you learn of or suspect that substance use or abuse may be a problem? (A) do you think you need help, (B) are you willing to get help, (C) what made you start using, (D) what makes you want to stop, (E) other____, (F) not really sure what to ask	CSQ-2: If so, what is one of the first questions you ask them when you learn of or suspect that substance use or abuse may be a problem? (A) how often have you used in the last 3 months, (B) how often do you experience cravings, (C) how often has your use of (drug) led to health, social, legal or financial problems, (D) other____, (F) not really sure what to ask
FGQ-3: What are some of the reasons why a person might refuse available services or avoid addressing the problem?	FGQ-3: And . . . what types of information / resources do you provide / suggest?	FGQ-3: And . . . what types of information / resources do you provide / suggest?
CSQ-3: What are some of the reasons why a person might refuse available services or avoid addressing the problem? (A) do want to stop using, (B) shame, (C) cost, (D) consequence / might get in trouble (E) other____, (F) not sure	CSQ-3: And . . . what types of information / resources do you provide / suggest? (A) referral to a treatment center, (B) referral to a support group, (C) referral to a social service agency, (D) a self-help brochure, (E) other____, (F) unsure what to suggest / what resources are available	CSQ-3: And . . . what types of information / resources do you provide / suggest? (A) screening and brief intervention, (B) referral to treatment, (C) a self-help brochure, (E) other____, (F) unsure what to suggest / what resources are available
FGQ-4: How do you think you (or someone you know) would respond to the information or resources that might be provided / suggested?	FGQ-4: If you do offer information, how do they generally respond to the information you provide / suggest?	FGQ-4: If you do offer information, how do they generally respond to the information you provide / suggest?
CSQ-4: How do you think you or someone you know) would respond if (you / he / she) was provided information or a referral to an available service for drug, alcohol, or tobacco use. (A) they are receptive & act on the information, (B) they are receptive & say they will think about the information, (C) they are neutral, (D) they are not receptive, (E) other____, (F) not sure	CSQ-4: If you do offer information, how do they generally respond to the information you provide / suggest? (A) they are receptive & act on the information, (B) they are receptive & say they will think about the information, (C) they are neutral, (D) they are not receptive, (E) other, (F) I cannot really tell how they are receiving it	CSQ-4: If you do offer information, how do they generally respond to the information you provide / suggest? (A) they are receptive & act on the information, (B) they are receptive & say they will think about the information, (C) they are neutral, (D) they are not receptive, (E) other, (F) I cannot really tell how they are receiving it
Ways in which substance use /abuse issues are currently addressed in primary health care settings		
Objectives: To learn about knowledge of and perceptions about the ways these issues are currently addressed, available services, and effectiveness of available services in primary health care settings.		
Community members / consumers	Community leaders / policy makers	Clinicians / health educators

FGQ-1: What does it feel like when someone (i.e. health professional) asks you about drug, alcohol, or tobacco use?	FGQ-1: How do members of your local community respond to being asked substance use-related questions during their primary care appointments?	FGQ-1: How do patients from the local Black community respond to your asking them about substance use-related questions during their appointments with you?
CSQ-1: What does it feel like when someone (i.e. health professional) asks you about drug use, alcohol, or tobacco use? (A) uncomfortable, (B) neutral, (C) unexpected but reasonable, (D) expected and reasonable, (E) other_____, (F) a doctor has never asked about substance use.	CSQ-1: How do you think that members of your local community respond to being asked substance use-related questions during their primary care appointments? (A) they will most likely question how this information is used, (B) they will most likely refuse to answer the questions, (C) they will most likely feel more comfortable answering to a health professional, (D) other_____, (E) not sure	CSQ-1: How do patients from the local Black community respond to your asking them about substance use-related questions during their appointments with you? (A) they appear irritated / annoyed, (B) they ask why these questions are asked, (C) they seem okay with these questions, (D) other_____, (E) not sure
FGQ-2: Do you have suggestions for how such questions could be addressed differently / more effectively (if such changes are necessary)?	FGQ-2: What do you think are the most effective ways for health care professionals to ask members of your local community about their drug, alcohol, or tobacco use?	FGQ-2: What do you think are the most effective ways to ask patients from the local Black community about their drug, alcohol, or tobacco use?
CSQ-2: Do you have suggestions for how such questions could be addressed differently / more effectively (if such changes are necessary)? (open-ended response)_____	CSQ-2: What do you think are the most effective ways for health care professionals to ask members of your local community about their drug, alcohol, or tobacco use? (open-ended response)_____	CSQ-2: What do you think are the most effective ways to ask patients from the local Black community about their drug use? (open-ended response)_____
FGQ-3: Would you (or others you know) follow the advice of a doctor or health educator to stop or reduce drug, alcohol, or tobacco use? If so, why? If not, why not?	FGQ-3: Do you think that members of your local community would follow the advice of a doctor or health care educator during primary care appointments, if the advice is to stop or reduce their use? If so, why? If not, why not?	FGQ-3: Do patients from the local Black community follow your advice or recommendations to address substance abuse issues? If so, why? If not, why not?
CSQ-3: Would you (or others you know) follow the advice of a doctor or health educator to stop or reduce drug, alcohol, or tobacco use? If so, why? If not, why not? (A) yes, (B) no, (C) unsure If so, why? (open-ended response)_____ If not, why not? (open-ended response) _____	CSQ-3: Do you think that members of your local community would follow the advice of a doctor or health care educator during primary care appointments, if the advice is to stop or reduce their use? (A) yes, (B) no, (C) unsure If so, why? (open-ended response) _____ If not, why not? (open-ended response) _____	CSQ-3: Do patients from the local Black community follow your advice or recommendations to address substance abuse issues? (a) yes, (B) no, (C) unsure If so, why? (open-ended response) _____ If not, why not? (open-ended response) _____
FGQ-4: If not, what do they need to do or what do you need to see in order for you to feel that their advice is more relevant to you or others you know?	FGQ-4: If not, what would you recommend that health care educators do to increase the effectiveness / relevance of the recommendations / resources they provide?	FGQ-4:

CSQ-4: If not, what do they need to do or what do you need to see in order for you to feel that their advice is more relevant to you or others you know? (open-ended response) _____	CSQ-4: If not, what would you recommend that health care educators do to increase the effectiveness / relevance of the recommendations / resources they provide? (open-ended response) _____	CSQ-4:
FGQ-5: What types of questions or concerns do you think you or they might have about receiving substance use services in primary health care settings?	FGQ-5: What are some of the common concerns or complaints you could hear from people in the community about receiving substance use services in primary health care settings?	FGQ-5: What are some of the common concerns or complaints you hear from patients from the local Black community you speak to about receiving substance use services in primary health care settings?
CSQ-5: What is one of the questions or concerns you think you or they might have about receiving substance use services in primary health care settings? (A) less focus on other health concerns, (B) could affect their relationship with the doctor or health educator, (C) duration of the appointment, (D) other_____, (F) not sure	CSQ-5: What is one of the common concerns or complaints you could hear from people in the community about receiving substance use services in primary health care settings? (A) less focus on other health concerns, (B) could affect their relationship with the doctor or health educator, (C) duration of the appointment, (D) other_____, (F) not sure	CSQ-5: What is one of the common questions / concerns / complaints you hear from patients from the local Black community you speak to about receiving substance use services in primary health care settings? (A) less focus on other health concerns, (B) could affect their relationship with the doctor or health educator, (C) duration of the appointment, (D) other_____, (F) not sure
Knowledge about SBIRT protocol before reviewing the tape and for survey only participants		
Objectives: To learn what is known about protocol and, if known, where did stakeholders learn about the protocol.		
Community members / consumers	Community leaders / policy makers	Clinicians / health educators
FGQ-1: What do you know about the SBIRT program?	FGQ-1: What do you know about the SBIRT program?	FGQ-1: What do you know about the SBIRT program?
CSQ-1: Have you ever heard about the SBIRT program? (A) yes, (B) no, (C)other_____, (F) not sure	CSQ-1: Have you ever heard about the SBIRT program? (A) yes, (B) no, (C)other_____, (F) not sure	CSQ-1: Have you ever heard about the SBIRT program? (A) yes, (B) no, (C)other_____, (F) not sure
FGQ-2: How did you hear about the SBIRT program?	FGQ-2: How do you know about the SBIRT program?	FGQ-2: How are you affiliated with the SBIRT program?
CSQ-2: If so, how did you hear about the SBIRT program? (A) I'm hearing about it for the first time through this study, (B) I received it during a previous health appointment, (C) someone else described it to me, (D)other_____, (F) not sure if I heard about it before.	CSQ-2: If so, how have you previously been affiliated with SBIRT program? (A) I'm hearing about it for the first time through this study, (B) I have referred people to health centers that use it, (C) I have heard about it from other health professionals, (D) I have gathered information about SBIRT on my own, (E) other_____, (F) not sure if I heard about it before.	CSQ-2: If so, how are you affiliated with the SBIRT program? (A) I fully utilize SBIRT with patients, (B) I have utilize parts of SBIRT with patients, (C) I have heard about it from other health professionals, (D) I have previously been provided with information about SBIRT, (E) other_____, (F) not sure if I heard about it before.
Baseline knowledge of and thoughts about the SBIRT protocol after reviewing tape (For focus groups and interviews only.)		
Objectives: To learn about what is known about protocol, thoughts about current effectiveness, and thoughts about		

ways to increase relevance / effectiveness of protocol.

Community members / consumers	Community leaders / policy makers	Clinicians / health educators
<p>FGQ-1: Have you ever participated in this brief screening procedure as part of a scheduled visit with your primary health care provider?</p> <p>If yes, how did you feel going through this procedure?</p> <p>What was helpful about this procedure?</p> <p>What was not helpful about this procedure?</p>	<p>FGQ-1: Have you or any member(s) of your community (that you know of) ever received this brief screening procedure as part of a scheduled visit with your primary health care provider?</p> <p>If yes, how did you or members of your community feel going through this?</p> <p>What did you / they see as helpful?</p> <p>What did you / they see as not helpful?</p>	<p>FGQ-1: Have you ever provided this brief screening procedure in your work with patients from the local Black community as part of a scheduled visit with them?</p> <p>If yes, what did they share with you about / how do you think they felt about participating in this procedure as part of a scheduled visit you?</p> <p>Do you believe they saw it as helpful?</p> <p>If no, what do you believe they saw as not helpful?</p>
<p>FGQ-2: If not, now that you have seen this brief training tape, how do you think you would feel if you participated in this procedure?</p> <p>What seems helpful about this procedure?</p> <p>What seems not helpful about this procedure?</p>	<p>FGQ-2: If not, now that you have seen this brief training tape, how do you think member(s) of your community would feel if they participated in this procedure as part of a scheduled visit with their primary health care provider?</p> <p>What do you think they would see as helpful about this procedure?</p> <p>What do you think they would see as not helpful about this procedure?</p>	<p>FGQ-2: If not, now that you have seen this brief training tape, how do you think patients from the local Black community would feel if they participated in this procedure as part of a scheduled visit with you?</p> <p>What do you think they would see as helpful about this procedure?</p> <p>What do you think they would see as not helpful about this procedure?</p>
FGQ-3:	<p>FGQ-3: When / if you talk to member(s) of your community that you think need to address substance use / abuse problems, do you ask questions that are similar to those seen in the tape?</p> <p>If so, why do these questions seem relevant to you?</p>	<p>FGQ-3: If you screen for and talk with patients from the local Black community about substance use / abuse, do you ask questions similar to those seen in the tape?</p> <p>If so, why do these questions seem relevant to you?</p>
FGQ-4:	<p>FGQ-4: When / if you talk to member(s) of your community that you think need to address substance use / abuse problems, do you ask questions that are different from those seen in the tape?</p> <p>If so, for what reasons?</p>	<p>FGQ-4: When / if you talk to patients from the local Black community that you think need to address substance use / abuse problems, do you ask questions that are different from those seen in the tape?</p> <p>If so, for what reasons?</p>
FGQ-5:	FGQ-5:	<p>FGQ-5: If you have administered the SBIRT protocol before with patients from the local Black community:</p> <p>How would you describe your comfort level with administering this</p>



procedure in a primary care setting?  
How would you evaluate the effectiveness of this procedure?

What is your evaluation based on?

Review and evaluation of the ASSIST v3 and the ASSIST v3 feedback report card  
(After reviewing both)

Objectives: To learn about what is known about instruments, thoughts about current effectiveness, and thoughts about ways to increase relevance / effectiveness of instruments.

Community members / consumers	Community leaders / policy makers	Clinicians / health educators
FGQ-1: After you had a chance to look over these tools, can you let me know if you have been asked to complete these during visits with your primary health care providers?	FGQ-1: After you had a chance to look over these tools, would you personally feel comfortable completing these with your healthcare provider?	FGQ-1: After you had a chance to look over these tools, can you let me know if you generally use these with patients from the local Black community?
If yes, were you comfortable completing these with your healthcare provider?	If yes, were you comfortable completing these with your healthcare provider?	If yes, why?
If not, would you personally feel comfortable completing these with your healthcare provider?	If not, would you personally feel comfortable completing these with your healthcare provider?	If no, why?
CSQ-1: After you had a chance to look over these tools, can you let me know if you have been asked to use these during visits with your primary health care providers? (A) yes, (B) no, (C) not sure	CSQ-1: After you had a chance to look over these tools, can you let me know if you have been asked to use these during visits with your primary health care providers? (A) yes, (B) no, (C) not sure	CSQ-1: After you had a chance to look over these tools, can you let me know if you generally use these with patients from the local Black community? (A) yes, (B) no, (C) do not recall
If yes, were you comfortable completing these with your healthcare provider? (A) yes, (B) no, (C) not sure	If yes, were you comfortable completing these with your healthcare provider? (A) yes, (B) no, (C) not sure	If yes, why? (A) I use it with all my patients equally, (B) I believe it's the best way to gather information and discuss substance use, (C) My place of employment requires that I use it, (D) other _____
If not, would you personally feel comfortable completing these with your healthcare provider? (A) yes, (B) no, (C) not sure	If not, would you personally feel comfortable completing these with your healthcare provider? (A) yes, (B) no, (C) not sure	If no, why? (A) my patients do not seem comfortable with these, (B) I have other tools that I used to assess substance use, (C) My place of employment never requested that I use these, (D) other _____
Please provide any additional thoughts or comments about your comfort level completing these tools. (open-ended response) _____	Please provide any additional thoughts or comments about your comfort level completing these tools. (open-ended response) _____	
FGQ-2:	FGQ-2: Can you let me know if members of your community talked to you about using these tools during visits with their primary health care providers?	FGQ-2: How comfortable are you / would you be using these with patients from the local Black community? First indicate if you have use these in the past.
CSQ-2:	CSQ-2: Can you let me know if members of your community talked to you about using these tools during	CSQ-2: How would you describe your comfort level using these with patients from the local Black community?

	visits with their primary health care providers? (A) yes, (B) no, (C) do not recall	(A) very comfortable, (B) comfortable, (C) neutral, (D) uncomfortable, (E) very uncomfortable.
FGQ-3: Can you review the ASSIST questions and the feedback report card once again, and tell me if there are any questions in the ASSIST or items on the report card that need to be explained better?	FGQ-3: Can you review the ASSIST questions and the feedback report card once again, and tell me if there are any questions in the ASSIST or items on the report card that need to be explained better?	FGQ-3: Can you review the ASSIST questions and the feedback report card once again, and tell me if there are any questions in the ASSIST or items on the report card that need to be explained better?
If so, which ones?	If so, which ones?	If so, which ones?
CSQ-3: Can you review the ASSIST questions and the feedback report card once again, and tell me if there are any questions in the ASSIST or items on the report card that need to be explained better? (A) yes, (B) no, (C) not sure	CSQ-3: Can you review the ASSIST questions and the feedback report card once again, and tell me if there are any questions in the ASSIST or items on the report card that need to be explained better? (A) yes, (B) no, (C) not sure	CSQ-3: Can you review the ASSIST questions and the feedback report card once again, and tell me if there are any questions in the ASSIST or items on the report card that need to be explained better? (A) yes, (B) no, (C) not sure
If so, use the space below indicate which one(s) Fill in the blank _____	If so, use the space below indicate which one(s) Fill in the blank _____	If so, use the space below indicate which one(s) Fill in the blank _____
FGQ-4:	FGQ-4: How do you imagine members of your local community would feel / what their comfort level would be when going through the questions and reviewing the report card?	FGQ-4: How do you imagine patients from the local Black community would feel / what their comfort level would be going through the questions and reviewing the report card?
CSQ-4:	CSQ-4: How do you imagine members of your local community would feel / what their comfort level would be when going through the questions and reviewing the report card? (A) very comfortable, (B) mostly comfortable, (C) mostly uncomfortable (D) very uncomfortable	CSQ-4: How do you imagine patients from the local Black community would feel / what their comfort level would be going through the questions and reviewing the report card? (A) very comfortable, (B) mostly comfortable, (C) mostly uncomfortable (D) very uncomfortable
FGQ-5: What suggestions do you have to modify the questions and report card so that answering the questions and reviewing the report card could be a more comfortable or helpful process for you or others you know?	FGQ-5: What suggestions do you have to modify the questions and report card so that answering the questions and reviewing the report card could be a more comfortable or helpful process for members of your local community and for the service providers who will provide assessments and referrals?	FGQ-5: What suggestions do you have about how the questions and report card could be modified so that answering the questions and reviewing the report card could be a more comfortable process that is relevant and helpful for patients from the local Black community and for you - as the provider who will be making assessments and referrals?
CSQ-5: What suggestions do you have to modify the questions and report card so that answering the questions and reviewing the report card could be a more comfortable or	CSQ-5: What suggestions do you have to modify the questions and report card so that answering the questions and reviewing the report card could be a more comfortable or	CSQ-5: What suggestions do you have about how the questions and report card could be modified so that answering the questions and reviewing the report card could be a more

helpful process for you or others you know? Fill in the blank _____	helpful process for members of your local community and for the service providers who will provide assessments and referrals? Fill in the blank _____	comfortable process that is relevant and helpful for patients from the local Black community and for you - as the provider who will be making assessments and referrals? Fill in the blank _____
FGQ-6: Are there any questions in the ASSIST v3 that you feel would be best to ask you or someone you know about their substance use, and in what ways?	FGQ-6: Are there any questions in the ASSIST v3 that you feel would be best to ask members of your local community about their substance use, and in what ways?	FGQ-6: Do you feel that all the questions in the ASSIST v3 are appropriate to ask patients from the local Black community about their substance use, and in what ways?
CSQ-6: Which questions in the ASSIST v3 do you feel would be best to ask you or someone you know about their substance use, and in what ways? Circle all that apply: (list of questions), (F) all are appropriate Explain why: _____	CSQ-6: Which questions in the ASSIST v3 do you feel would be best to ask members of your local community about their substance use, and in what ways? Circle all that apply: (list of questions), (F) all are appropriate Explain why: _____	CSQ-6: Which questions in the ASSIST v3 do you feel are appropriate to ask patients from the local Black community about their substance use, and in what ways? Circle all that apply: (list of questions), (F) all are appropriate Explain why: _____
FGQ-7: Are there any questions in the Assist v3 that you feel may NOT be best to ask you or someone you know about their substance use, and in what ways?	FGQ-7: Are there any questions in the ASSIST that you feel may NOT be best to ask members of your local community about their substance use, and why?	FGQ-7: Are there any questions in the ASSiST v3 that you feel are NOT appropriate to ask patients from the local Black community about their substance use, and in what ways?
CSQ-7: What questions in the ASSIST v3 do you feel may NOT be best to ask you or someone you know about their substance use, and why? Circle all that apply: (list of questions), (F) none of the above Explain why: _____	CSQ-7: What questions in the ASSIST v3 do you feel may NOT be best to ask members of your local Black community about their substance use, and why? Circle all that apply: (list of questions), (F) none of the above Explain why: _____	CSQ-7: What questions in the ASSIST v3 do you feel are NOT appropriate to ask patients from the local Black community about their substance use, and in what ways? Circle all that apply: (LIST OF QUESTIONS), (F) none of the above Explain why: _____
FGQ-8: Which questions allow you to speak freely about matters that are relevant to you and that you believe would assist the primary care provider to best understand your circumstances?	FGQ-8: Which questions do you feel would allow members of your local community to speak freely about matters that are relevant to them and that you believe would assist the primary care provider to best understand their circumstances?	FGQ-8: Which questions do you feel would allow patients from the local Black community to speak freely about matters that are relevant to them and that you believe would assist you to best understand their circumstances?
CSQ-8: Which questions allow you to speak freely about matters that are relevant to you and that you believe would assist the primary care provider to best understand your circumstances? Circle all that apply: (list of questions), (F) all the above	CSQ-8: Which questions do you feel would allow members of your local community to speak freely about matters that are relevant to them and that you believe would assist the primary care provider to best understand their circumstances? Circle all that apply: (list of questions), (F) all the above	CSQ-8: Which questions do you feel would allow patients from the local Black community to speak freely about matters that are relevant to them and that you believe would assist you to best understand their circumstances? circle all that apply: (list of questions), (F) all the above
FGQ-9: Are there any questions that PREVENT you from speaking freely about matters that are relevant to you, and that you believe would PREVENT the primary care	FGQ-9: Are there any questions that you feel PREVENT members of your local community from speaking freely about matters that are relevant to them, and that you believe would	FGQ-9: Are there any questions that you feel PREVENT patients from the local Black community from speaking freely about matters that are relevant to them, and PREVENT you from

provider from understanding your circumstances?	PREVENT the primary care provider from understanding their circumstances?	understanding their circumstances?
CSQ-9: Which questions PREVENT you from speaking freely about matters that are relevant to you, and that you believe would PREVENT the primary care provider from understanding your circumstances? Circle all that apply: (list of questions), (F) none of the above	CSQ-9: Which questions do you feel PREVENT members of your local community from speaking freely about matters that are relevant to them and that you believe would PREVENT the primary care provider from understanding their circumstances? circle all that apply: (list of questions), (F) none of the above	CSQ-9: Which questions do you feel PREVENT patients from the local Black community from speaking freely about matters that are relevant to them, and that you believe would PREVENT you from understanding their circumstances? circle all that apply: (list of questions), (F) none of the above
FGQ-10: What are some of the questions that you expect someone who cares about you to ask upon learning about your substance use problems? Which questions from the ASSIST v3 are close to those same types of questions?	FGQ-10: What are some of the questions that you or members of your local community would ask upon learning that someone you / they care about has a substance use / abuse problem? Which questions from the ASSIST v3 are close to those same types of questions?	FGQ-10: What are some of the questions that you (or that you expect a patient from the local Black community) would ask upon learning that someone you / they care about has a substance use / abuse problem? Which questions from the ASSIST v3 are close to those same types of questions?
CSQ-10: What is one of the questions that you expect someone who cares about you to ask upon learning about your substance use problems? Fill in the blank_____	CSQ-10: What is one of the questions that you or members of your local community would ask upon learning that someone they care about has a substance use / abuse problem? Fill in the blank_____	CSQ-10: What is one of the questions that you (or that you expect a patient from the local Black community) would ask upon learning that someone you / they care about has a substance use / abuse problem? Fill in the blank_____
Which questions from the ASSIST v3 are close to those same types of questions? Circle all that apply: (list of questions), (F) none of the above	Which questions from the ASSIST v3 are close to those same types of questions? Circle all that apply: (list of questions), (F) none of the above	Which questions from the ASSIST v3 are close to those same types of questions? Circle all that apply: (list of questions), (F) none of the above
Review and evaluation of the ten-step ASSIST-linked brief intervention (After reviewing this intervention)		
Objectives: To learn about what is known about intervention, thoughts about current effectiveness, and thoughts about ways to increase relevance/effectiveness of intervention.		
Community members / consumers	Community leaders / policy makers	Clinicians / health educators
FGQ-1: After you had a chance to look over the sheet containing the steps of the Brief Intervention (BI), can you let me know if you had a discussion with your primary health care provider that followed these steps?	FGQ-1: After you had a chance to look over the sheet containing the steps of the Brief Intervention (BI), can you let me know if you personally had a discussion with your primary health care provider that followed these steps?	FGQ-1: After you had a chance to look over the sheet containing the steps of the Brief Intervention (BI), can you let me know if you generally use this protocol with patients from the local Black community?
If yes, were you comfortable responding to your healthcare provider's efforts to follow this protocol?	If yes, were you comfortable responding to your healthcare provider's efforts to follow this protocol?	If yes, why?  If no, why?

<p>If not, would you personally feel comfortable responding to your healthcare provider's efforts to follow this protocol?</p>	<p>If not, would you personally feel comfortable responding to your healthcare provider's efforts to follow this protocol?</p>	
<p>CSQ-1: After you had a chance to look over the sheet containing the steps of the BI, can you let me know if you had a discussion with your primary health care provider that followed these steps? (A) yes, (B) no, (C) not sure</p>	<p>CSQ-1: After you had a chance to look over the sheet containing the steps of the BI, can you let me know if you personally had a discussion with your primary health care provider that followed these steps? (A) yes, (B) no, (C) not sure</p>	<p>CSQ-1: After you had a chance to look over the sheet containing the steps of the BI, can you let me know if you generally use this protocol with patients from the local Black community? (A) yes, (B) no, (C) do not recall</p>
<p>If yes, were you comfortable responding to your healthcare provider's efforts to follow this protocol? (A) yes, (B) no, (C) not sure</p>	<p>If yes, were you comfortable responding to your healthcare provider's efforts to follow this protocol? (A) yes, (B) no, (C) not sure</p>	<p>If yes, why? (A) I use it with all my patients equally, (B) I believe it's the best way to gather information and discuss substance use, (C) My place of employment requires that I use it, (D) other_____</p>
<p>If not, would you personally feel comfortable responding to your healthcare provider's efforts to follow this protocol? (A) yes, (B) no, (C) not sure</p>	<p>If not, would you personally feel comfortable responding to your healthcare provider's efforts to follow this protocol? (A) yes, (B) no, (C) not sure</p>	<p>If no, why? (A) my patients do not seem comfortable with it, (B) I have other ways to gather information and discuss substance use, (C) My place of employment never requested that I use it, (D) other_____</p>
<p>Please provide any additional thoughts or comments about your comfort level responding to your healthcare provider's efforts to follow this protocol. (open-ended response) _____</p>	<p>Please provide any additional thoughts or comments about your comfort level responding to your healthcare provider's efforts to follow this protocol. (open-ended response) _____</p>	
<p>FGQ-2:</p>	<p>FGQ-2: Can you let me know if any members of your community mentioned to you that they had a discussion with their primary health care provider that followed these steps?</p>	<p>FGQ-2:</p>
<p>CSQ-2:</p>	<p>CSQ-2: Can you let me know if any members of your community mentioned to you that they had a discussion with their primary health care provider that followed these steps? (A) yes, (B) no, (C) do not recall</p>	<p>CSQ-2:</p>
<p>FGQ-3:</p>	<p>FGQ-3:</p>	<p>FGQ-3: How comfortable are you / would you be using this BI protocol with patients from the local Black community? First indicate if you have use these in the past.</p>
<p>CSQ-3:</p>	<p>CSQ-3:</p>	<p>CSQ-3: How would you describe your comfort level using this BI protocol with patients from the local Black community? (A) very comfortable, (B) comfortable,</p>

(C) neutral, (D) uncomfortable, (E) very uncomfortable.

FGQ-4: Can you review the BI protocol once again, and tell me if there are any questions that you would find difficult to answer or procedures that you would find difficult to understand? If so, which ones?	FGQ-4: Can you review the BI protocol once again, and tell me if there are any questions that you would find difficult to answer or procedures that you would find difficult to understand? If so, which ones?	FGQ-4: Can you review the BI protocol once again, and tell me if there are any questions that you would find difficult to answer or procedures that you would find difficult to understand? If so, which ones?
CSQ-4: Can you review the BI protocol once again, and tell me if there are any questions that you would find difficult to answer or procedures that you would find difficult to understand? (A) yes, (B) no, (C) not sure If so, use the space below indicate which one(s) Fill in the blank: _____	CSQ-4: Can you review the BI protocol once again, and tell me if there are any questions that you would find difficult to answer or procedures that you would find difficult to understand? (A) yes, (B) no, (C) not sure If so, use the space below indicate which one(s) Fill in the blank: _____	CSQ-4: Can you review the BI protocol once again, and tell me if there are any questions that you would find difficult to answer or procedures that you would find difficult to understand? (A) yes, (B) no, (C) not sure If so, use the space below indicate which one(s) Fill in the blank: _____
FGQ-5:	FGQ-5: How do you imagine members of your local community would feel (what their comfort level would be) when going through the BI protocol?	FGQ-5: How do you imagine patients from the local Black community would feel (what their comfort level would be) going through the BI protocol with you?
CSQ-5:	CSQ-5: How do you imagine members of your local community would feel / what their comfort level would be when going through the BI protocol? (A) very comfortable, (B) mostly comfortable, (C) mostly uncomfortable (D) very uncomfortable	CSQ-5: How do you imagine patients from the local Black community would feel (what their comfort level would be) going through the BI protocol with you? (A) very comfortable, (B) mostly comfortable, (C) mostly uncomfortable (D) very uncomfortable
FGQ-6: What suggestions do you have to modify the BI protocol so that responding to the health care provider could be more comfortable or helpful for you or others you know?	FGQ-6: What suggestions do you have to modify the BI protocol so that it can be more comfortable or helpful for members of your local community?	FGQ-6: What suggestions do you have to modify the BI protocol so that it could be more comfortable or helpful for patients from the local Black community and for you - as the provider who will be making assessments and referrals?
CSQ-6: What suggestions do you have to modify the BI protocol so that responding to the health care provider could be more comfortable or helpful for you or others you know? Fill in the blank: _____	CSQ-6: What suggestions do you have to modify the BI protocol so that it can be more comfortable or helpful for members of your local community? Fill in the blank: _____	CSQ-6: What suggestions do you have to modify the BI protocol so that it could be more comfortable or helpful for patients from the local Black community and for you - as the provider who will be making assessments and referrals? Fill in the blank: _____
FGQ-7: Are there any steps in the BI protocol that you feel would be best to use when asking you or someone you know about substance use, and in what ways?	FGQ-7: Are there any steps in the BI protocol that you feel would be best to use when asking members of your local community about their substance use, and in what ways?	FGQ-7: Do you feel that all the steps in the BI protocol are appropriate to use when asking patients from the local Black community about their substance use, and in what ways?

<p>CSQ-7: Which steps in the BI protocol do you feel would be best to use when asking you or someone you know about substance use, and in what ways? Circle all that apply: (list of steps), (F) all are appropriate Explain why: _____</p>	<p>CSQ-7: Which steps in the BI protocol do you feel would be best to use when asking members of your local Black community about their substance use, and in what ways? Circle all that apply: (list of questions), (F) all are appropriate Explain why: _____</p>	<p>CSQ-7: Which steps in the BI protocol do you feel are appropriate to use when asking patients from the local Black community about their substance use, and in what ways? Circle all that apply: (list of questions), (F) all are appropriate Explain why: _____</p>
<p>FGQ-8: Are there any steps in the BI protocol that you feel may NOT be best to use when asking you or someone you know about substance use, and in what ways?</p>	<p>FGQ-8: Are there any steps in the BI protocol that you feel may NOT be best to use when asking members of your local Black community about their substance use, and why?</p>	<p>FGQ-8: Are there any steps in the BI protocol that you feel may NOT be best to use when asking patients from the local Black community about their substance use, and in what ways?</p>
<p>CSQ-8: Which steps in the BI protocol do you feel may NOT be best to use when asking you or someone you know about substance use, and in what ways? Circle all that apply: (list of steps), (F) none of the above Explain why: _____</p>	<p>CSQ-8: Which steps in the BI protocol do you feel may NOT be best to use when asking members of the local Black community about their substance use, and why? Circle all that apply: (list of steps), (F) none of the above Explain why: _____</p>	<p>CSQ-8: Which steps in the BI protocol do you feel may NOT be best to use when asking patients from the local Black community about their substance use, and in what ways? Circle all that apply: (list of steps), (F) none of the above Explain why: _____</p>
<p>FGQ-9: Which steps allow you to speak freely about matters that are relevant to you and that you believe would assist the primary care provider to best understand your circumstances?</p>	<p>FGQ-9: Which steps do you feel would allow members of your local community to speak freely about matters that are relevant to them and that you believe would assist the primary care provider to best understand their circumstances?</p>	<p>FGQ-9: Which steps do you feel would allow patients from the local Black community to speak freely about matters that are relevant to them, and that you believe would assist you to best understand their circumstances?</p>
<p>CSQ-9: Which steps allow you to speak freely about matters that are relevant to you and that you believe would assist the primary care provider to best understand your circumstances? Circle all that apply: (list of steps), (F) all the above</p>	<p>CSQ-9: Which steps do you feel would allow members of your local community to speak freely about matters that are relevant to them and that you believe would assist the primary care provider to best understand their circumstances? Circle all that apply: (list of steps), (F) all the above</p>	<p>CSQ-9: Which steps do you feel would allow patients from the local Black community to speak freely about matters that are relevant to them, and that you believe would assist you to best understand their circumstances? Circle all that apply: (list of steps), (F) all the above</p>
<p>FGQ-10: Are there any steps that PREVENT you from speaking freely about matters that are relevant to you, and that you believe would PREVENT the primary care provider from understanding your circumstances?</p>	<p>FGQ-10: Are there any steps that you feel PREVENT members of your local community from speaking freely about matters that are relevant to them, and that you believe would PREVENT the primary care provider from understanding their circumstances?</p>	<p>FGQ-10: Are there any steps that you feel PREVENT patients from the local Black community from speaking freely about matters that are relevant to them, and that you believe would PREVENT you from understanding their circumstances?</p>
<p>CSQ-10: Which steps PREVENT you from speaking freely about matters that are relevant to you, and that you believe would PREVENT the primary care provider from understanding your circumstances? Circle all that apply: (list of steps), (F) none of the above</p>	<p>CSQ-10: Which steps do you feel PREVENT members of your local community from speaking freely about matters that are relevant to them and that you believe would PREVENT the primary care provider from understanding their circumstances?</p>	<p>CSQ-10: Which questions do you feel PREVENT patients from the local Black community from speaking freely about matters that are relevant to them, and that you believe would PREVENT you from understanding their circumstances? Circle all that apply: (list of steps), (F)</p>

	Circle all that apply: (list of steps), (F) none of the above	none of the above
FGQ-11: Are there any steps in the BI protocol that are close to the same type of questions (or remarks) that you or someone you know would ask upon learning that someone they care about has a substance use / abuse problems?	FGQ-11: Are there any steps in the BI protocol that are close to the same type of questions (or remarks) that you or members of your local community would ask upon learning that someone they care about has a substance use / abuse problem?	FGQ-11: Are there any steps in the BI protocol that are close to the same type of questions (or remarks) that you expect a patient from the local Black community would ask upon learning that someone they care about has a substance use / abuse problem?
CSQ-11: Do any of the following steps in the BI protocol resemble questions (or remarks) that you or someone you know would ask upon learning that someone they care about has a substance use / abuse problems? Circle all that apply: (list of steps), (F) none of the above	CSQ-11: Do any of the following steps in the BI protocol resemble questions (or remarks) that you or members of your local community would ask upon learning that someone they care about has a substance use / abuse problem? Circle all that apply: (list of steps), (F) none of the above	CSQ-11: Do any of the following steps in the BI protocol resemble questions (or remarks) that you expect a patient from the local Black community would ask upon learning that someone they care about has a substance use / abuse problem? Circle all that apply: (list of steps), (F) none of the above
Thoughts / ideas about ways to increase relevance / effectiveness collaboratively		
Objective: To learn about thoughts for the feasibility of joining future efforts to adapt SBIRT to meet the needs of the community		
Community members / consumers	Community leaders / policy makers	Clinicians / health educators
FGQ-1: Are there concerns related to substance use in your community that have not been adequately addressed - that you believe could be addressed in collaboration with others, including healthcare professionals / community leaders / local institutions / community members / etc.? If so, how would you suggest we develop these collaborations?	FGQ-1: Are there concerns related to substance use in your community that you have not been able to address in your role as XX / as a member of XX - that you believe could be addressed in collaboration with others, including healthcare professionals / community leaders / local institutions / community members / etc.? If so, how would you suggest we develop these collaborations?	FGQ-1: Are there concerns related to substance use for the patients that come to your office/agency that you, in your role as XX, have not been able to address - that you believe could be addressed in collaboration with others, including healthcare professionals / community leaders / local institutions / community members / etc.? If so, how would suggest we develop these collaborations?
CSQ-1: Are there concerns related to substance use in your community that have not been adequately addressed - that you believe could be addressed in collaboration with others, including healthcare professionals / community leaders / local institutions / community members / etc.? (A) yes, (B) no, (C) not sure  If so, use the space below indicate your concern Fill in the blank _____  If so, how would you suggest we develop these collaborations? (A) Invite healthcare professionals to community settings, (B) Invite community members to join an action	CSQ-1: Are there concerns related to substance use in your community that you have not been able to address in your role as XX / as a member of XX - that you believe could be addressed in collaboration with others, including healthcare professionals / community leaders / local institutions / community members / etc.? (A) yes, (B) no, (C) not sure  If so, use the space below indicate your concern Fill in the blank _____  If so, how would you suggest we develop these collaborations? (A) Invite healthcare professionals to community settings, (B) Invite	CSQ-1: Are there concerns related to substance use for the patients that come to your office/agency that you, in your role as XX, have not been able to address - that you believe could be addressed in collaboration with others, including healthcare professionals / community leaders / local institutions / community members / etc.? (A) yes, (B) no, (C) not sure  If so, use the space below indicate your concern Fill in the blank _____  If so, how would you suggest we develop these collaborations? (A) Invite healthcare professionals to



---

research team, (C) meet periodically with healthcare professionals and community leaders, (D) other_____	community members to join an action research team, (C) meet periodically with healthcare professionals and community leaders, (D) other_____	community settings, (B) Invite community members to join an action research team, (C) meet periodically with healthcare professionals and community leaders, (D) other_____
----------------------------------------------------------------------------------------------------------------	-------------------------------------------------------------------------------------------------------------------------------------------------------	-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

---

*Note.* FGQ: Focus group questions; CSQ: Corresponding survey questions

## Appendix B

### Focus Group Questions (Community Members Stakeholder Group)

Intro (brief explanation; 7 sections; take approx. 2 amount of time)

1. Give me examples of how drug, alcohol, or tobacco use have negatively affected your home, neighborhood, or the Hartford area in general?
2. How often do you interact with or come across a family member, friend, or neighbor who you believe has a problem with drugs, alcohol, or tobacco?
  - a. Do you ever talk about the drug, alcohol, or tobacco use with these individuals?
  - b. If so, how do the conversations typically go?

**The next set of questions will ask for your perspectives on services available to the Black community in Hartford to address drug, alcohol, or tobacco use.**

3. If you (or someone you know) wanted to receive information about available services to deal with substance abuse / use - who would (you / they) speak with?
4. How do you think you (or someone you know) would respond to any information about available services to reduce tobacco, alcohol, or drug use that might be provided / suggested from a family member, friend, or trust member of the community?
  - a. What about information about available services that might be provided / suggested from a health care provider?
  - b. What if the health care provider was of a different race or class? How would this impact how you (or someone you know) would respond to information about available services?
5. What are some of the reasons why you (or someone you know) might not consider using the available services provided / suggested?

**The following questions will focus on your interactions with medical professionals, and the drug, alcohol, and tobacco use assessment protocol that your opinions and suggestions can help to change.** (Time set aside to watch the first of two brief video clips, which provides a brief introduction and visual of the program)

6. What does it feel like when someone (i.e. health care provider) asks you about drug, alcohol, or tobacco use?
  - a. Does the feeling differ if the health care provider is of the same race or class or a different race or class?
    - i. What comes to mind when a health care provider of another race or class asks you about drug, alcohol, or tobacco use?
  - b. Have you ever experienced discrimination and/or prejudice in a medical setting?
    - i. If so, can you give me an example of what happened and how you responded?

- ii. If not, how do you believe such an experience would affect how you respond to the health care provider?
  - iii. Additional prompts (if needed): African Americans felt they were victimized because of stereotypes from health care professionals such as the following:
    - African Americans and other minorities are not able to pay for medical services.
    - African Americans over utilize the emergency room for primary care.
    - Young African-American mothers are unmarried
  - iv. Do you think your cultural background or class have influenced how people have treated you in a medical setting? If so, in what ways?
- c. What does a health care provider need to understand about your culture, beliefs, neighborhood, or environment before you respond to substance use related questions?
- d. What suggestions do you have for how health care providers should initiate asking members of the Black community in Hartford questions about drug, alcohol, or tobacco use?
  - i. Additional Prompts (if needed): (1) Address patients by their formal name, not by their first name, especially for elderly patients. (2) Make direct eye contact. (3) Explain reason for obtaining information since there may be reluctance to engage in personal disclosure. (4) Be cognizant of basic distrust of health professionals by many African Americans.
- 7. What types of questions, comments, thoughts, or concerns do you think you or someone you know might have about responding to substance use questions, or receiving substance use services in primary health care settings?
  - a. What are your thoughts about the idea of introducing the reason for obtaining information about substance use before the questions are asked?
    - i. Additional prompt (if needed): Would it reduce the concerns?

**Please take a moment to review the documents titled the ASSIST v.3 and the ASSIST feedback report card.**

- 8. Now that you have reviewed the questions, how do you think you would feel if you participated in this procedure?
  - a. Would you personally feel comfortable using these tools with your health care provider?
  - b. If so, can you say a bit about why?
  - c. If not, what suggestions do you have about what would be needed for you to feel comfortable using these tools?

**Please take a moment to review the document titled the Ten-Step ASSIST-linked Brief Intervention (BI). After completing the ASSIST, health care providers use several therapeutic procedures that proceed in the following steps.** (Time set aside to watch another brief video clip)

9. Can those of you who have ever had a discussion with a health care provider that followed these steps raise your hands?
  - a. Can those of you who raised your hands say a bit about your experience – what it was like for you when you were responding to a health care provider's efforts to follow this protocol?
  - b. Can those of you who did not raise your hands say a bit about what you think it would be like for you to respond to a health care provider's efforts to follow this protocol?
10. Can you take a moment to review the BI protocol once again, and look for any questions that you found / would find difficult to answer or any procedures that you found / would find difficult to understand? If yes, which ones?
11. Do you ever feel that any differences in race and class between you and a health care provider might have an effect on how you would respond to the BI?
12. Previously, I asked about your thoughts on the ways differences in race or class might influence meetings with health care providers. Here – I want to ask more specifically – about your thoughts on this. That is:
  - a. Can those of you who have had a discussion with a health care provider that followed these steps let me know if you believe your experience and your responses were influenced by differences in race and class – and – if so – in what ways? And – if not – in what ways?
  - b. Also, can those of you who have not had a discussion with a health care provider that followed these steps let me know if you believe such an experience would be influenced by differences in race and class – and – if so – in what ways? And – if not – in what ways?

**Now that we have heard one another's thoughts, experiences, and suggestions, I would like to shift the discussion so that I can learn more about your ideas and suggestions regarding ways to make this protocol more relevant (comfortable / useful / beneficial) to you or those you know. Given your knowledge of the community, your feedback regarding the next set of questions will help to tailor the BI to the local Black community.**

13. Do you have any suggestions about ways to modify the BI protocol so that responding to a health care provider could be more comfortable or helpful for you or others you know?
14. Which steps would allow you or others you know to speak most freely about matters that are relevant to you / them and that you believe would assist a health care provider to best understand your or their circumstances?
15. Are there any steps that you can identify that would PREVENT you or others you know from speaking freely about matters that are relevant, and that you believe would PREVENT a health care provider from understanding your or their circumstances?

16. Are there any steps in the BI protocol that are close to the same type of questions (or remarks) that you or someone you know would ask upon learning that someone they care about has a substance use / abuse problems?
17. Would you (or others you know) follow the advice of a health care provider to reduce drug, alcohol, or tobacco use? If yes, why? If no, why not?
  - a. If not, what do health care providers need to do, or what do you (or others you know) need to see, in order for you / them to feel that their advice is more relevant to you or others you know?
18. Is there anything that is not discussed or offered in the BI that you believe would be helpful if it was included?

**These final questions will ask for your opinion on who needs to be involved in any future plans to address substance use / abuse among the Black community in Hartford.**

19. Are there concerns related to substance use in your community that have not been adequately addressed - that you believe could be addressed in collaboration with others, including health care professionals / community leaders / local institutions / community members / etc.?
  - a. If so, how would you suggest we develop these collaborations?

## Appendix C

### Focus Group Questions (Community Leaders Stakeholder Group)

**Intro (brief explanation; 7 sections; take approx. 2 amount of time)**

1. Give me examples of the social problems that are happening in the Hartford area because of drug use, alcoholism, or tobacco use?

**The next set of questions will ask for your perspective on services available in Hartford to address drug, alcohol, or tobacco use, specifically for the Black community. As community leaders, your perspective is important even if you feel that others may not initially reach out to you for substance-related concerns.** (Each question is addressed to “your community”, but this phrase also refers to the “Black community”).

2. Do individuals of your community come to you to receive information about available services to deal with substance abuse / use?
  - a. If so, how often do you receive such requests?
  - b. Can you say a bit about the types of conversations you have when this occurs?
3. For all of you, with or without experiences like these, do you feel that your responses to such requests are (or would be) influenced by similarities or differences in race or class that may exist between you?
  - a. If so, in what ways?
4. What are (or could be) some of the first questions you ask an individual from your community when you learn of or suspect that substance use or abuse may be a problem?
  - a. After these initial questions, how would you approach the situation?
5. What types of information / resources (do you / would you) provide / suggest?
  - a. If you have offered information, how do those requesting your assistance generally respond to the information you provide / suggest?

**The next set of questions will focus on interactions between patients and providers, and the drug, alcohol, and tobacco use assessment protocol that your opinions and suggestions can help to change.** (Time set aside to watch the first of two brief video clips, which provides a brief introduction and visual of the program)

6. What do you think (or what have you heard about) how individuals in your local community would or might generally respond to being asked substance use-related questions during a medical appointment?

It may be that many of you have experienced being asked such questions as part of your own medical appointments, or that, you can imagine being asked such questions if you went to a medical setting that used this protocol as part of an overall medical assessment. You can respond based on what you feel, or how you imagine someone in your community would feel.

7. With this in mind, it would be good to learn a little about what it has felt like (or what you think it might feel like) when someone (i.e. a health care provider) asks you about drug, alcohol, or tobacco use?
  - e. Does the feeling you remember or imagine differ if the health care provider is of the same race or class or a different race or class?
    - i. What comes to mind when you remember –or try to imagine - a health care provider of another race or class asking you about drug, alcohol, or tobacco use?
  - f. Have you experienced discrimination and/or prejudice in a medical setting?
    - i. If so, can you give an example of what happened and how you responded?
    - ii. If not, can you say a bit about how you believe such an experience would affect how you would respond to the health care provider?
    - iii. Additional prompts (if needed): African Americans felt they were victimized because of stereotypes from health care professionals such as the following:
      - African Americans and other minorities are not able to pay for medical services.
      - African Americans over utilize the emergency room for primary care.
      - Young African-American mothers are unmarried
  - g. Do you think your cultural background or class have influenced how you (or individuals from the Black community) are treated in a medical setting?
    - i. If so, in what ways?
  - h. What does a health care provider need to understand about the culture, beliefs or neighborhood or environment in the Black community before they ask substance use related questions?
8. Do you have suggestions for how health care providers should initiate asking individuals from Black community in Hartford questions about drug, alcohol, or tobacco use?
  - a. Additionally, can you share any thoughts you may have about ways/approaches you believe could help create a connection between patients from the Black community and their health care provider before the screening instrument is introduced as part of the medical assessment?
    - i. Additional Prompts (if needed): Which of the following approaches do you feel that health care providers should readily use with clients from the Black community: (1) Address patients by their formal name, not by their first name, especially for elderly patients. (2) Make direct eye contact. (3) Explain reason for obtaining information since there may be reluctance to engage in personal disclosure. (4) Be cognizant of basic distrust of health professionals by many African Americans.
9. What are some of the common issues, comments, concerns, or complaints you have heard from people in the community – or perhaps from peers / colleagues or others - about responding to substance use questions, or about receiving substance use services in primary health care settings? (If you have heard any)

- a. What are your thoughts about the idea of introducing the reason for obtaining information about substance use before the questions are asked?

**Please take a moment to review the documents titled the ASSIST v.3 and the ASSIST feedback report card.**

10. Now that you have reviewed the questions, how do you think you would feel if you participated in this procedure?
  - a. Would you personally feel comfortable completing this brief screening with your healthcare provider?
    - i. If so, could you say a bit about why? If not, could you say a bit about why not?
  - b. How do you think individuals from your community would feel about using these tools with a health care provider?
    - i. What do you feel would need to be in place for them to feel more comfortable using these tools?

**Please take a moment to review the document titled the Ten-Step ASSIST-linked Brief Intervention (BI). After completing the ASSIST, health care providers use several therapeutic procedures that proceed in the following steps.** (Time set aside to watch another brief video clip)

11. Can those of you who have ever had a discussion with a health care provider that followed these steps raise your hands?
  - a. Can those of you who raised your hands say a bit about your experience – what it was like for you when you were responding to the health care provider's efforts to follow this protocol?
  - b. Can those of you who did not raise your hands say a bit about what you think it would be like for you to respond to a health care provider's efforts to follow this protocol?
12. Can you take a moment to review the BI protocol once again, and look for any questions that you found / would find difficult to answer or any procedures that you would find difficult to understand?
  - a. If yes, which ones?
13. Do you feel that any differences in race and class between individuals from your community and health care providers might have an effect on how members of your community would respond to the BI?
  - a. Can you explain?
14. How do you imagine members of your local community would feel when going through the BI protocol?
  - a. What suggestions do you have to modify the BI protocol so that it can be more comfortable or helpful for members of your community?



**Now that we have heard one another's thoughts, experiences, and suggestions, I would like to shift the discussion so that I can learn more about your ideas and suggestions regarding ways to make this protocol more relevant (comfortable / useful / beneficial) to you or those you know. Given your knowledge of the community, your feedback regarding the next set of questions will help to tailor the BI to the local Black community.**

15. Which steps do you feel would allow members of your local community to speak most freely about matters that are relevant to them and that you believe would assist the health care provider to best understand their circumstances?
16. Are there any steps that you can identify in the BI protocol that you feel might PREVENT members of your local community from speaking freely about matters that are relevant to them, and / or that you believe would PREVENT the health care provider from understanding their circumstances?
15. Are there any steps that you can identify in the BI protocol that are close to the same type of questions that you have asked or believe you would ask if a member of your community was in need of substance use services?
  - a. And, can you share your thoughts about any additional questions, comments, procedures, or other things that, if made part of this overall protocol, would be beneficial?
17. Do you believe that individuals from your community have or would follow the advice of a health care provider to reduce drug, alcohol, or tobacco use? If yes, why? If no, why not?
  - a. If not, what do health care providers need to do, or what do you need to see, in order for you to feel that their advice is more relevant to members of your local community?
18. Is there anything that is not discussed or offered in the BI– that my questions and this discussion have not provided space to share - that you believe would be helpful if it was included?

**These final questions will ask for your opinion on who needs to be involved in any future plans to address substance use / abuse among the Black community in Hartford.**

19. Are there concerns related to substance use in your community that you have not been able to address in your position, and you believe could be addressed in collaboration with others (i.e., healthcare professionals / community leaders / local institutions / community members / etc.)?
  - a. If yes, how would you suggest we develop these collaborations?

## Appendix D

### Focus Group Questions (Service Provider Stakeholder Group)

**Intro (brief explanation; 5 sections; take approx. 2 amount of time)**

1. How would you describe the health, mental health, and social problems specific to drug, alcohol, and tobacco use within the local Black community in your service area?
2. How often do you work with patients, who you believe have a problem with drugs, alcohol, or tobacco?
  - a. What percentage of these patients are part of the local Black community?
3. Has it been your experience that it is the same, easier, or more difficult to understand and communicate with patients from the local Black community as it is with patients from other backgrounds in your service area?
  - a. Can you explain?

**The following questions will focus on your interactions with patients before you introduce the ASSIST screening instrument, and your experiences with them after you administer the ASSIST. (No video clip required)**

4. What are your thoughts about the need to explain to patients you serve the reason for obtaining information about substance use before administering the ASSIST?
5. Do you think that the differences and/or similarities in race and class that exist between you and those you serve influence how you introduce the ASSIST?
  - a. If yes, in what ways?
  - b. If not, can you explain?
6. Switching now to a specific focus on your work with patients from the local Black community in your service area, what are your initial thoughts as you prepare to ask patients from this community questions about tobacco, alcohol, and drug use?
7. Have you ever asked a patient from the Black community in your service area if they have any concerns or questions before you start the assessment?
  - a. If so, what was your experience of the impact this had on your interaction (i.e. your rapport) with the patient and the patient's response to you?
  - b. If not, what are your thoughts about how this kind of inquiry would impact your interaction with the patient and the patient's response to you?
8. What do you think are the most effective ways to initiate asking patients from the local Black community in your service area about their drug, alcohol, or tobacco use?
9. How do patients from the local Black community initially respond to you asking substance use-related questions during their appointments?
  - a. Are there any common issues or questions?
10. If you have administered the ASSIST before with patients from the local Black community, how would you describe your level of comfort / confidence / impact when administering this procedure in a primary care setting?

11. What ways/approaches have you found to be most helpful and efficient in creating an effective connection with patients from the Black community before you introduce the screening instrument?
  - a. Additional Prompts (if needed): Which of the following approaches do you feel you readily use with clients from the Black community: (1) Address patients by their formal name, not by their first name, especially for elderly patients. (2) Make direct eye contact. (3) Explain reason for obtaining information since there may be reluctance to engage in personal disclosure. (4) Be cognizant of basic distrust of health professionals by many African Americans.
12. In general, how do you perceive / imagine patients from the local Black community feel (comfort level / openness / trust / sense of relevance) while going through the questions and reviewing the report card with you?
13. Do you believe that patients from the local Black community follow your advice or recommendations to address substance use issues? If so, why? If not, why not?

**Please take a moment to review the document titled the Ten-Step ASSIST-linked Brief Intervention (BI). (No video clip required)**

14. I would first like to ask those of you who have used the BI with the Black community to say a bit about your experience – what it was / has been like for to use the BI protocol with this community?
  - i. Additional prompt (if needed): comfort level / confidence / effectiveness
  - b. Can those of you who have not used the BI protocol with the Black community say a bit about what you think it would be like for you to use the BI protocol with this community?
15. Can you review the BI protocol once again, and look for any questions that you –as a patient - would find difficult to answer or any procedures you would find difficult to understand?
  - a. If you identified a question or procedure, can you explain your reasons you see these as difficult?
16. Switching back to the patient population we are focusing on, how do you imagine patients from the local Black community in your service area might feel going through the BI protocol with you?
  - i. Additional prompt (if needed): comfort level / confidence / effectiveness
17. Do you ever feel that any differences in race or class between you and patients from the Black community in your service area might have an effect on the position you hold throughout the BI?
  - i. Additional prompt (if needed): how you perceive your position of power while implementing the BI, or (2) how they would respond to the BI

18. What suggestions do you have to modify the BI protocol so that it could be more comfortable or helpful for patients from the local Black community in your service area and more useful / effective protocol for you – in your work as a health care provider?

**Now that we have heard one another's thoughts, experiences, and suggestions, I would like to shift the discussion so that I can learn more about your ideas and suggestions. As experts using this protocol, your feedback regarding the next set of questions will help to tailor the BI to the local Black community.**

19. Has it been your experience / or do you anticipate that particular procedures in the BI protocol have been or could be difficult for you to introduce / implement with patients from the local Black community?
- a. If so, which ones and in what ways?
20. From your actual experience using the BI protocol, or from what you have learned and we have discussed today, can we take a moment to speak about any questions or procedures in the overall BI protocol that you see as providing opportunities for patients from the local Black community to speak freely about matters that are relevant to them, and that you believe would assist you to best understand their circumstances?
- i. Additional prompt: Tracking questions will be used to obtain further details as necessary
21. As important for us to learn about, I would appreciate it if you could take a moment to speak about any questions or procedures in the overall BI protocol that you believe might PREVENT patients from the local Black community from speaking freely about matters that are relevant to them, and that you believe would PREVENT you from understanding their circumstances?
- i. Additional prompt: Tracking questions will be used to obtain further details as necessary
22. From your actual experience using the BI protocol, or from what you have learned and we have discussed today, can we take a moment to speak about how you have addressed or imagine addressing circumstances where you suspect that a patient's race or class is impacting his/her expressions of distress and understanding of its cause?
- i. Additional prompt: Tracking questions will be used to obtain further details as necessary
23. I also know that there may be questions I did not ask or issues we did not discuss that you may feel are important, so is there anything that my questions and this discussion have not provided space to share - that you believe would be helpful if it was included?

**These final questions will ask for your opinion on who needs to be involved in any future plans to address substance use / abuse among the Black community in Hartford.**

24. Are there concerns related to substance use for the patients that come to your office/agency that you have not been able to address in your position, and you believe could be addressed in collaboration with others (i.e., healthcare professionals / community leaders / local institutions / community members / etc.)?
- a. If yes, how would you suggest we develop these collaborations?

## Appendix E

### ATTENDING PROBES

#### Eliciting Participant Sharing of Experiences and Perspectives

While any probes will influence a participant, attending probes are considered the least directive and are intended to:

1. Reduce interviewer talk time
2. Discover how participants present their experiences and perceptions with minimal intrusion from the interviewer
3. Indicate the interviewer is listening, which helps to facilitate the interview process

Skill	Description	Function in Focus Groups
<b>Attending Probes</b>	<ul style="list-style-type: none"> <li>• Individually and culturally appropriate vocals and verbal cues</li> <li>• Expressions of interest and wanting to know more</li> <li>• Respectful silence</li> <li>• Minimal encouragers</li> </ul>	<ul style="list-style-type: none"> <li>• Acknowledges the participant</li> <li>• Sets comfortable tone</li> <li>• Reduces interviewer influence</li> <li>• Allows space for participants to share experiences and perceptions from their own worldview</li> <li>• Allows participants time to process what they have been saying</li> </ul>

<b>Representative Attending Probes</b>	
All attending probes have one goal in common: to reduce interviewer talk-time while providing participants with opportunities to share experiences and perspectives from their own cultural and contextual worldview, and with minimal interference from the interviewer.	
<b>Vocal Qualities</b>	Appropriate modifications in pitch, volume, speech rate, tone, attending to cultural and idiosyncratic preferences.
<b>Useful Silence</b>	Appropriate use of silence – taking cues from participant's preference for silence to think things through without interruption.
<b>Verbal Underlining</b>	Appropriate volume / vocal emphasis to certain words and short phrases to convey what aspects of the participant's words the interviewer is relating to, and to open pathways for clarification, should the interviewer be emphasizing aspects of the participant's words differently than they mean to convey.
<b>Verbal Tracking</b>	Staying with participant's topics and encouraging elaboration from their own worldview or point of reference.
<b>Selective Attention</b>	Remaining alert to intentional versus less intentional preferences in what the consulting interviewer and participant attend to.

## TRACKING PROBES

### Elaborating Participant Sharing of Experiences and Perspectives

Tracking probes encourage participants to elaborate on experiences and perspectives by drawing out additional information from various vantage points *within* their worldview. The intentions of tracking probes are to:

1. Circumvent unrecognized ways interviewers work within their own frame.
2. Facilitate interviewer's focus on participant's actual words and on tracking these words for clarification or elaboration in ways that do not extend beyond participant's worldview.
3. Invite participants to elaborate descriptive accountings interpretive responses.
4. Clarify details to be sure the interviewer understands what is being shared, to show that the interviewer is listening, to obtain clarification, and to facilitate the continued exchange.

Skill	Description	Function in Focus Groups
<b>Open Questions</b>	<ul style="list-style-type: none"> <li>• Could: general picture</li> <li>• How: process / feelings</li> <li>• What: facts</li> <li>• Why: reasons / reflection</li> <li>• Consider: review</li> </ul>	<ul style="list-style-type: none"> <li>• Facilitates full descriptions of experiences and perceptions from various vantage points within the participant's worldview.</li> </ul>
<b>Closed Questions</b>	<ul style="list-style-type: none"> <li>• Do</li> <li>• Is</li> <li>• Are</li> </ul>	<ul style="list-style-type: none"> <li>• Quickly obtains specific data</li> <li>• Focuses participants</li> <li>• Ends lengthy/repetitive speech</li> </ul>
<b>Encouragers</b>	<ul style="list-style-type: none"> <li>• Restating participant's key words, sometimes with a questioning tone</li> </ul>	<ul style="list-style-type: none"> <li>• Encourages elaboration of experiences and perceptions</li> </ul>

Representative Tracking Questioning Strategies	
Tracking probes help direct the interview, open areas for discussion, assist in pinpointing and clarifying issues, and aid in participant exploration.	
<b>Open Questions</b>	Open questions cannot be answered in a few words, facilitate open discussion, and encourage participants to provide maximum information. Typically, open questions begin with <i>what</i> , <i>how</i> , <i>why</i> , or <i>could</i> .
<b>Closed Questions</b>	Closed questions can be answered in a few words or sentences and have the advantage of focusing the interview and obtaining information, but the burden of guiding the talk remains on the interviewer. Closed questions often begin with <i>is</i> , <i>are</i> , or <i>do</i> . Used judiciously, they help obtain important specifics.
<b>Tracking Questions</b>	Tracking questions are a combination of open and closed questions that help draw out a story beyond its usual beginning and ending. Some examples include: What happened first? What happened next? What was the result?
<b>Encouragers</b>	Encouragers invite participants to continue talking. These include a repetition of keywords stated by the participant.

## ACTIVE LISTENING PROBES

### Organizing the Participants Experiences and Perspectives

Active-listening probes help interviewers organize the main elements of participant experiences and perspectives to be sure they have heard correctly, and to help keep the interview focused. These probes are intended to: (1) clarify what the participant has shared; (2) check on the accuracy of what the interviewer has heard; (3) facilitate further exchange; and, (4) summarize one phase of an interview and move to the next.

Skill	Description	Function in Focus Groups
<b>Paraphrasing</b>	<ul style="list-style-type: none"> <li>Repeat essence of what is shared</li> <li>Shorten/clarify what is shared</li> </ul>	<ul style="list-style-type: none"> <li>Participant feels heard</li> <li>Facilitates self-exploration</li> <li>Offers new point of departure</li> </ul>
<b>Summarizing</b>	<ul style="list-style-type: none"> <li>Feedback experiences and perspectives in an organized form</li> </ul>	<ul style="list-style-type: none"> <li>Beginning: Offers framework</li> <li>Ongoing: Clarifies path of interview</li> <li>Transitions from one topic to another</li> <li>Closing: Summarizes experience</li> </ul>
<b>Reflecting</b>	<ul style="list-style-type: none"> <li>Reflect feelings/reactions shared to show participant has been heard and to check for accuracy</li> </ul>	<ul style="list-style-type: none"> <li>Normalizes affect</li> <li>Sorts out complex experiences and perceptions</li> </ul>
<b>Synthesizing</b>	<ul style="list-style-type: none"> <li>Bring together experiences and perceptions shared</li> </ul>	<ul style="list-style-type: none"> <li>Clarifies how interviewer understands and facilitates further exchange</li> </ul>
<b>Checking Perceptions</b>	<ul style="list-style-type: none"> <li>Finding out if interpretations and perceptions are valid and accurate</li> </ul>	<ul style="list-style-type: none"> <li>Requests information about accuracy of interviewer's understanding and facilitates further exchange</li> </ul>

<b>Representative Active Listening Probes</b>	
Active listening probes help interviewers distill, shorten, and clarify what participants share to show they are listening and to clarify if they accurately heard what was shared.	
<b>Paraphrase</b>	Shorten and clarify what has been shared, using: <ul style="list-style-type: none"> <li>Sentence stems such as "I think what I just took from what you shared is ..."</li> <li>Participant's key words that capture experiences and perceptions shared</li> <li>Clarifying statements to that organize complex explanations</li> <li>Checks for accuracy, such as "Am I hearing you correctly?"</li> </ul>
<b>Summarize</b>	Clarify and distill what has been shared over a long period of time restating key concepts, and asking for feedback on accuracy
<b>Reflect</b>	Reflecting includes: <ul style="list-style-type: none"> <li>Sentence stems about feelings shared</li> <li>Feeling labels or words to capture what participants are experiencing</li> <li>Checks for accuracy, such as "Did I capture what you were feeling?"</li> </ul>
<b>Synthesize</b>	Synthesizing brings together multiple experiences and perceptions shared, and checks for accuracy.
<b>Check Perceptions</b>	Checking how the interviewer is understanding, interpreting, and organizing what is being shared (this probe that should be used throughout the interview).



---

## **Semi-Structured Focus Group Probes**

© Sandra A. Rigazio-DiGilio, 2007

Adapted from Ivey, A. E., and Bradford Ivey, M. (2007) *Intentional interviewing and counseling: Facilitating participant development in a multicultural society* (6th Edition). Belmont, CA: Thomson Learning Inc.

**Appendix F**

Code # \_\_\_\_\_

**Community Member Stakeholder Group Questionnaire**

**The first set of questions will ask for your perspectives on drug, alcohol, or tobacco use among the Black community in Hartford.**

7. Circle each of the following ways in which you SEEN drug, alcohol, or tobacco use negatively affected your home, neighborhood, or the Hartford area in general?

- (A) health      (B) employment      (C) safety      (D) other: \_\_\_\_\_

8. How often do you interact with or come across a family member, friend, or neighbor who you believe has a problem with drugs, alcohol, or tobacco?

- (A) Daily      (C) Not often      (E) Not sure  
(B) Regularly, but not daily      (D) Not at all

**The next set of questions will ask for your perspective on services available to the Black community in Hartford to address drug, alcohol, or tobacco use?**

9. If you (or someone you know) wanted to receive information about available services to deal with substance abuse / use - who would (you / they) speak with?

- (A) Minister/deacon from church      (D) Social services  
(B) Primary care physician      (E) Other: \_\_\_\_\_  
(C) Family members or friends      (F) Not sure

10. How do you think you (or someone you know) would respond to any information about available services to reduce tobacco, alcohol, or drug use that might be provided / suggested from a **health care provider**?

- (A) Receptive & they will act on the information      (D) They are not receptive  
(B) Receptive & say they will think about the information      (E) Other: \_\_\_\_\_  
\_\_\_\_\_  
(C) They are neutral      (F) Not sure

11. If the health care provider was of a different race or class, would this impact how you (or someone you know) would respond to information about available services? (circle all that apply)

- (A) yes, if of a different race  
(B) yes, if of a different class  
(C) no, if of a different race  
(D) no, if of a different class

12. What are some of the reasons why you (or someone you know) might not consider using the available services provided / suggested?

- (A) Don't want to stop using  
(B) Shame  
(D) Consequence / might get in trouble  
(E) Other:

- \_\_\_\_\_  
(C) Cost  
(F) Not sure

**The following questions will focus on your interactions with medical professionals, and the drug, alcohol, and tobacco use assessment protocol that your opinions and suggestions can help to change. (Please take a moment to view a brief video clip through the following link: <https://www.youtube.com/watch?v=gdlT9rbIq4g> ; the portion you need to review lasts four minutes, starting at 2:08 and ending at 6:08).**

13. What does it feel like when someone (i.e. health care professional) asks you about drug use, alcohol, or tobacco use?

- (A) Uncomfortable  
(B) Neutral  
(C) Unexpected but reasonable  
(D) Expected and reasonable  
(E) Other: \_\_\_\_\_  
(F) A doctor has never asked about substance use

14. Does the feeling differ if the health care provider is of the same race or class or a different race or class?

- (A) Yes  
(B) no  
(C) unsure

15. What comes to mind when you remember – or try to imagine - a health care provider of another race or class asking you about drug, alcohol, or tobacco use? (Please provide a response in the space below)

---

---

---

---

16. Have you ever experienced discrimination and/or prejudice in a medical setting?

- (A) Yes  
(B) no  
(C) unsure

17. Do you believe that such an experience (i.e. feeling discrimination in a medical setting) would affect how you respond to the health care provider?

- |                                                       |                   |
|-------------------------------------------------------|-------------------|
| (A) Yes, and I would say or do something about it.    | (C) No            |
| (B) Yes, but I would not say or do anything about it. | (D) I don't know. |

18. What does a health care provider need to understand about your culture, beliefs, neighborhood, or environment before you respond to substance use related questions? (Please provide a response in the space below)

---

---

---

---

19. What suggestions do you have for how health care providers should initiate asking members of the Black community in Hartford questions about drug, alcohol, or tobacco use? (circle all that apply)

- (A) Address patients by their formal name, not by their first name, especially for elderly patients.
- (B) Make direct eye contact.
- (C) Explain reason for obtaining information
- (D)

Other: \_\_\_\_\_

20. What is one of the questions or issues you think you or someone you know might have about responding to substance use questions, or receiving substance use services in primary health care settings?

- |                                                       |                       |
|-------------------------------------------------------|-----------------------|
| (A) Less focus on other health concerns               | (D) Other:            |
| _____                                                 |                       |
| (B) Could affect their relationship with the doctor   |                       |
| _____                                                 |                       |
| (C) Duration of the appointment questions or concerns | (E) I do not have any |

**Please take a moment to review the documents titled the ASSIST v.3 (section A) and the ASSIST feedback report card (section C). The ASSIST is**

**a substance use assessment form that a health care provider may use to ask patients about tobacco, alcohol, and drug use in a medical setting.**

21. After you had a chance to review the question, can you indicate if you would personally feel comfortable responding to this assessment and reviewing the report card with a health care provider?

(A) yes      (B) no      (C) not sure

22. Please provide any additional thoughts or comments about your comfort level completing these tools. (Please provide a response in the space below)

---

---

---

**Please take a moment to review the document titled the Ten-Step ASSIST-linked Brief Intervention (BI). After completing the ASSIST, health care providers may use several therapeutic procedures that proceed in the following steps (i.e., the Ten-Step ASSIST-linked BI) to guide the conversation.**

(Please take a moment to view a brief video clip through the following link: <https://www.youtube.com/watch?v=ltVKYSKHnW4&feature=youtu.be> ; please review up to the first nine minutes of the video clip, starting at the beginning and ending at 9:15).

23. After you had a chance to look over the sheet containing the steps of the BI, can you let me know if you ever had a discussion with a health care provider that followed these steps?

(A) yes      (B) no      (C) not sure

If yes, were you comfortable responding to a health care provider's efforts to follow this protocol?

(A) yes      (B) no      (C) not sure

If not, would you personally feel comfortable responding to a health care provider's efforts to follow this protocol?

(A) yes      (B) no      (C) not sure

24. Please provide any additional thoughts or comments about your comfort level responding to a health care provider's efforts to follow this protocol.

---

---

---

25. Can you review the BI protocol once again, and look for any questions that you found / would find difficult to answer or procedures that you would find difficult to understand?

(A) yes      (B) no      (C) not sure

If yes, circle which one(s) below?

(A) Step 1	(D) Step 4	(G) Step 7	(J) Step 10
(B) Step 2	(E) Step 5	(H) Step 8	(K) none of the
above			
(C) Step 3	(F) Step 6	(I) Step 9	

26. Do you feel that any differences in race and class between you and a health care provider might have an effect on how you would respond to the BI?

(A) yes      (B) no      (C) not sure

Please explain why:

---

---

---

**Given you knowledge of the community, your feedback regarding the next set of questions will help to tailor the BI to the Black community in Hartford.**

27. What suggestions do you have to modify the BI protocol so that responding to a health care provider could be more comfortable or helpful for you or others you know?

---

---

28. Which steps allow you to speak most freely about matters that are relevant to you and that you believe would assist a health care provider to best understand your circumstances? (Circle all that apply)

- |       |        |     |        |     |        |     |            |
|-------|--------|-----|--------|-----|--------|-----|------------|
| (A)   | Step 1 | (D) | Step 4 | (G) | Step 7 | (J) | Step 10    |
| (B)   | Step 2 | (E) | Step 5 | (H) | Step 8 | (K) | all of the |
| above |        |     |        |     |        |     |            |
| (C)   | Step 3 | (F) | Step 6 | (I) | Step 9 |     |            |

Please explain why:

---

---

---

29. Which steps PREVENT you from speaking freely about matters that are relevant to you, and that you believe would PREVENT a health care provider from understanding your circumstances? (Circle all that apply)

- |       |        |     |        |     |        |     |             |
|-------|--------|-----|--------|-----|--------|-----|-------------|
| (A)   | Step 1 | (D) | Step 4 | (G) | Step 7 | (J) | Step 10     |
| (B)   | Step 2 | (E) | Step 5 | (H) | Step 8 | (K) | none of the |
| above |        |     |        |     |        |     |             |
| (C)   | Step 3 | (F) | Step 6 | (I) | Step 9 |     |             |

Please explain why:

---

---

---

30. Do any of the following steps in the BI protocol resemble questions (or remarks) that you or someone you know would ask upon learning that someone they care about has a substance use / abuse problems?

- |       |            |            |            |                 |
|-------|------------|------------|------------|-----------------|
|       | (A) Step 1 | (D) Step 4 | (G) Step 7 | (J) Step 10     |
|       | (B) Step 2 | (E) Step 5 | (H) Step 8 | (K) none of the |
| above | (C) Step 3 | (F) Step 6 | (I) Step 9 |                 |

Please explain why:

---



---



---

31. Would you (or others you know) follow the advice of a health care provider to reduce drug, alcohol, or tobacco use? If yes, why? If no, why not?

- (A) yes      (B) no      (C) not sure

If no, what do health care providers need to do, or what do you (or others you know) need to see, in order for (them / you) to feel that their advice is more relevant to you or others you know? (Please use the space below to respond)

---



---



---

32. Is there anything that is not discussed or offered in the BI that you believe would be helpful if it was included?

(Please provide a response in the space below)

---



---



---



**These final questions will ask for your opinion on who needs to be involved in any future plans to address substance use / abuse among the Black community in Hartford.**

33. Are there concerns related to substance use in your community that have not been adequately addressed - that you believe could be addressed in collaboration with others, including health care professionals / community leaders / local institutions / community members / etc.?

(B) yes      (B) no      (C) not sure

If yes, use the space below to indicate your concern.

---

---

---

If yes, how would you suggest we develop these collaborations?

- (A) Invite health care professionals to community settings
- (B) Invite community members to join an action research team
- (C) Meet periodically with health care professionals and community leaders
- (D) Other: \_\_\_\_\_

Did you skipped or declined to answer any of the questions in this survey? (circle one)

yes  
no

If yes, please explain why:

---

---

---

Thank you for your participation!

**Appendix G**

Code # \_\_\_\_\_

**Community Leader Stakeholder Group Questionnaire**

**The first set of questions will ask for your perspectives on drug, alcohol, or tobacco use in Hartford, specifically for the Black community.**

7. Circle each of the following ways in which you KNOW drug, alcohol, or tobacco use negatively affected the Hartford area in general?

(B) health      (B) employment      (C) safety      (D)  
other: \_\_\_\_\_

Please use the space below to provide any additional details about the impact on the Hartford area.

---

---

---

**The next set of questions will ask for your perspective on services available in Hartford to address drug, alcohol, or tobacco use, specifically for the Black community. As community leaders, your perspective is important even if you feel that others may not initially reach out to you for substance-related concerns. (Each question is addressed to “your community”, but this phrase also refers to the “Black community”).**

8. Do members of your community come to you to receive information about available services to deal with substance abuse / use?

(A) regularly      (B) occasionally      (C) rarely      (D) never

Do you feel that your responses to such requests are (or would be) influenced by similarities or differences in race or class that may exist between you? (circle all the apply)

- (A) Yes, similarities in either race or class has an impact
- (B) Yes, differences in either race or class has an impact
- (C) No, similarities in either race or class does not have an impact

(D) No, differences in either race or class does not have an impact

Please explain why:

---

---

---

9. What (is / could be) one of the first questions you ask them when you learn of or suspect that substance use or abuse may be a problem?

- (A) Do you think you need help
- (B) Are you willing to get help
- (C) What made you start using
- (D) What makes you want to stop
- (E)

Other: \_\_\_\_\_

- \_\_\_\_\_ (F) Not really sure what to ask

10. What types of information / resources (do you / would you) provide / suggest?

- (A) Referral to a treatment center
- (B) Referral to a support group or ministry
- (C) Referral to a social service agency
- (D) A self-help brochure
- (E) Other: \_\_\_\_\_
- (F) Unsure what to suggest / what resources are available

11. If you have offered information, how do those requesting your assistance generally respond to the information you provide / suggest?

- (A) They are receptive & act on the information
- (B) They are receptive & say they will think about the information
- (C) They are neutral
- (D) They are not receptive
- (E) Other: \_\_\_\_\_
- (F) I cannot really tell how they are receiving it



15. What comes to mind when you remember – or try to imagine - a health care provider of another race or class asking you about drug, alcohol, or tobacco use? (Please provide a response in the space below)

---

---

---

16. Have you ever experienced discrimination and/or prejudice in a medical setting?

(A) Yes

(B) no

(C) unsure

17. Do you believe that such an experience (i.e. feeling discrimination in a medical setting) would affect how you respond to the health care provider?

(C) Yes, and I would say or do something about it.

(C) No

(D) Yes, but I would not say or do anything about it.

(D) I don't know.

18. What does a health care provider need to understand about the culture, beliefs, neighborhood, or environment in the Black community before you respond to substance use related questions? (Please provide a response in the space below)

---

---

---

19. Do you have suggestions for how health care providers should initiate asking individuals from Black community in Hartford questions about drug, alcohol, or tobacco use? (Please provide a response in the space below)

---

---

---

20. Which of the following approaches do you believe could help create a connection between patients from the Black community and their health care provider before the screening instrument is introduced as part of the medical assessment? (Circle all that apply)

(A) Address patients by their formal name, not by their first name, especially for elderly patients.

- (B) Make direct eye contact.
- (C) Explain reason for obtaining information
- (D)
- Other: \_\_\_\_\_

21. What is one of the common questions or issues you have heard from people in the community – or perhaps from peers / colleagues or others - about responding to substance use questions, or about receiving substance use services in primary health care settings?

- (A) Less focus on other health concerns
- (B) Could affect their relationship with the doctor or health educator
- (C) Duration of the appointment
- (D) Other: \_\_\_\_\_
- (E) Not sure
- (F) I have not heard any complaints

**Please take a moment to review the documents titled the ASSIST v.3 (section A) and the ASSIST feedback report card (section C). The ASSIST is a substance use assessment form that a health care provider may use to ask patients about tobacco, alcohol, and drug use in a medical setting.**

22. Would you personally feel comfortable completing this assessment with your healthcare provider?

- (A) yes      (B) no      (C) not sure

Please provide any additional thoughts or comments about your comfort level completing this assessment.

---

---

---

23. How do you think member(s) of your community would feel if they were giving this assessment as part of a scheduled visit with a health care provider?

- (A) It fits well within a primary care appointment
- (B) It disrupts a primary care appointment
- (C) Other: \_\_\_\_\_

Please provide a response below, if you feel that something would need to be in place for members of your community to feel more comfortable using this assessment?

---

---

**Please take a moment to review the document titled the Ten-Step ASSIST-linked Brief Intervention (BI). After completing the ASSIST, health care providers may use several therapeutic procedures that proceed in the following steps (i.e., the Ten-Step ASSIST-linked BI) to guide the conversation.**

(Please take a moment to view a brief video clip through the following link: <https://www.youtube.com/watch?v=ltVKYSKHnW4&feature=youtu.be> ; please review up to the first nine minutes of the video clip, starting at the beginning and ending at 9:15).

24. After you had a chance to look over the sheet containing the steps of the BI, can you let me know if you ever had a discussion with your primary health care provider that followed these steps?

(A) yes      (B) no      (C) not sure

If yes, were you comfortable responding to your healthcare provider's efforts to follow this protocol?

(A) yes      (B) no      (C) not sure

If not, would you personally feel comfortable responding to your healthcare provider's efforts to follow this protocol?

(A) yes      (B) no      (C) not sure

25. Please provide any additional thoughts or comments about your comfort level responding to your healthcare provider's efforts to follow this protocol.

---

---

26. Can you review the BI protocol once again, and look for any questions that you found / would find difficult to answer or procedures that you would find difficult to understand?

(B) yes      (B) no      (C) not sure

If yes, circle which one(s) below?

- |            |            |            |                 |
|------------|------------|------------|-----------------|
| (D) Step 1 | (D) Step 4 | (G) Step 7 | (J) Step 10     |
| (E) Step 2 | (E) Step 5 | (H) Step 8 | (K) none of the |
| above      |            |            |                 |
| (F) Step 3 | (F) Step 6 | (I) Step 9 |                 |

27. Do you feel that any differences in race and class between individuals from your community and health care providers might have an effect on how members of your community would respond to the BI?

- (B) yes      (B) no      (C) not sure

Please explain why:

---



---



---

28. How do you imagine members of your local community would feel when going through the BI protocol?

- (A) Very comfortable  
 (B) Mostly comfortable  
 (C) Mostly uncomfortable  
 (D) Very uncomfortable

29. What suggestions do you have to modify the BI protocol so that it can be more comfortable or helpful for members of your local community?

---



---



---

**Given you knowledge of the community, your feedback regarding the next set of questions will help to tailor the BI to the Black community in Hartford.**



30. Which steps do you feel would allow members of your local community to speak freely most about matters that are relevant to them and that you believe would assist the primary care provider to best understand their circumstances?

- |       |        |     |        |     |        |     |         |
|-------|--------|-----|--------|-----|--------|-----|---------|
| (A)   | Step 1 | (D) | Step 4 | (G) | Step 7 | (J) | Step 10 |
| (B)   | Step 2 | (E) | Step 5 | (H) | Step 8 | (K) | All the |
| above |        |     |        |     |        |     |         |
| (C)   | Step 3 | (F) | Step 6 | (I) | Step 9 |     |         |

Please explain why:

---



---



---

31. Which steps do you feel PREVENT members of your local community from speaking freely about matters that are relevant to them and that you believe would PREVENT the primary care provider from understanding their circumstances?

- |           |        |     |        |     |        |     |         |
|-----------|--------|-----|--------|-----|--------|-----|---------|
| (A)       | Step 1 | (D) | Step 4 | (G) | Step 7 | (J) | Step 10 |
| (B)       | Step 2 | (E) | Step 5 | (H) | Step 8 | (K) | None of |
| the above |        |     |        |     |        |     |         |
| (C)       | Step 3 | (F) | Step 6 | (I) | Step 9 |     |         |

Please explain why:

---



---



---

32. Do any of the following steps in the BI protocol resemble the same type of questions (or procedure) that you have asked or believe you would ask if a member of your community was in need of substance use services?

- |           |        |     |        |     |        |     |         |
|-----------|--------|-----|--------|-----|--------|-----|---------|
| (A)       | Step 1 | (D) | Step 4 | (G) | Step 7 | (J) | Step 10 |
| (B)       | Step 2 | (E) | Step 5 | (H) | Step 8 | (K) | None of |
| the above |        |     |        |     |        |     |         |
| (C)       | Step 3 | (F) | Step 6 | (I) | Step 9 |     |         |

33. Do you believe that members from your local community have or would follow the advice of a health care provider to reduce drug, alcohol, or tobacco use?

(A) yes      (B) no      (C) unsure

If not, what would you recommend that health care providers do, or what do you need to see, in order for you to feel that their advice is more relevant to members of your local community? (Please use the space below to respond)

---

---

---

34. Is there anything that is not discussed or offered in the BI that you believe would be helpful if it was included?

(Please provide a response in the space below)

---

---

---

**These final questions will ask for your opinion on who needs to be involved in any future plans to address substance use / abuse among the Black community in Hartford.**

35. Are there concerns related to substance use in your community that you have not been able to address in your position, and you believe could be addressed in collaboration with others (i.e., healthcare professionals / community leaders / local institutions / community members / etc.)?

(A) yes      (B) no      (C) not sure

If yes, use the space below indicate your concern.

---

---

---

If yes, how would you suggest we develop these collaborations?

(A) Invite healthcare professionals to community settings

- (B) Invite community members to join an action research team
  - (C) Meet periodically with healthcare professionals and community leaders
  - (D) Other:
- 

Did you skipped or declined to answer any of the questions in this survey? (circle one)

- (A) yes
- (B) no

If yes, please explain why:

---

Thank you for your participation!

**Appendix H**

Code # \_\_\_\_\_

**Service Provider Stakeholder Group Questionnaire**

**The first set of questions will ask for your perspectives on drug, alcohol, or tobacco use in your service area, specifically for the Black community.**

7. How would you describe the health, mental health, and social problems specific to drug, alcohol, and tobacco use within the local Black community in your service area?

(A) These problems seem to impact the Black community more than other populations.

(B) These problems seem to impact the Black community just as much as other populations.

(C) These problems seem to impact the Black community less than other populations.

(D) The health, mental health, and social problems that I have observed among the Black community does not seem to be directly linked to drug, alcohol, or tobacco use.

(E)

Other: \_\_\_\_\_

8. How often do you interact with patients who you believe have a problem with drugs, alcohol, or tobacco?

(A) Daily

(B) Regularly, but not daily

(C) Not often

(D) Not at all

(E) Not sure

9. **If you interact with patients**, give an estimate. What percentage of these patients are part of the local Black community?

(A) 10% or less

(B) Greater than 10% but less than 50%

(C) About 50%

(D) About 75%

(E) Almost 100%

(F) I do NOT interact with patients

10. Has it been your experience that it is the same, easier, or more difficult to understand and communicate with patients from the local Black community as it is with patients from other backgrounds in your service area?

(A) Same

(B) Easier

(C) More difficult

Please explain why:

---

---

---

**The following questions will focus on your interactions with patients before you introduce the ASSIST screening instrument, and your experiences with them after you administer the ASSIST.**

11. What are your thoughts about the need to explain to patients you serve the reason for obtaining information about substance use before administering the ASSIST? (Circle all the apply)

(A) It could be helpful

(B) It could affect the duration of the appointment

(C) I incorporate explanations for those who need it on a case by case basis

(D) It may not make any significant difference

(E) Other: \_\_\_\_\_

12. Do you think that the differences and/or similarities in race and class that exist between you and those you serve influence how you introduce the ASSIST? (circle all the apply)

(E) Yes, similarities in either race or class has an impact

(F) Yes, differences in either race or class has an impact

(G) No, similarities in either race or class does not have an impact

(H) No, differences in either race or class does not have an impact

Please explain:

---

---

---

13. Switching now to a specific focus on your work with patients from the local Black community in your service area, what are your initial thoughts as you prepare to ask patients from this community questions about tobacco, alcohol, and drug use? (Please provide a response in the space below)

---

---

---

---

14. Have you ever asked a patient from the Black community in your service area if they have any concerns or questions before you start the assessment?

(A) Yes      (B) No      (C) I have yet to see patients from the Black community

Please describe below your experience – or how you would imagine your experience would be - of the impact this had on your interaction (i.e. your rapport) with the patient, and the patient's response to you?

---

---

---

---

15. How do patients from the local Black community initially respond to you asking substance use-related questions during their appointments with you?

- (A) They appear irritated / annoyed
- (B) They inquire about why these questions are asked
- (C) They seem okay with these questions
- (D) Other:

---

(E) Not sure

16. What is one of the common issues you have heard from patients from the local Black community (and other populations) about receiving substance use services in primary health care settings?

- (A) Less focus on other health concerns
- (B) Could affect their relationship with the doctor or health educator
- (C) Duration of the appointment
- (D) Other: \_\_\_\_\_
- (E) Not sure
- (F) No one as ever expressed an issue to me

17. If you have administered the ASSIST before with patients from the local Black community, how would you describe your level of comfort / confidence / impact when administering this procedure in a primary care setting?

- (A) Very good
- (B) Good
- (C) Neutral
- (D) Poor
- (E) Very poor

18. What ways/approaches have you found to be most helpful and efficient in creating an effective connection with patients from the Black community before you introduce the screening instrument? (circle all that apply)

- (A) Address patients by their formal name, not by their first name, especially for elderly patients.
- (B) Make direct eye contact.
- (C) Explain reason for obtaining information
- (D)

Other: \_\_\_\_\_

19. In general, how do you perceive / imagine patients from the local Black community feel (i.e. level of comfort / openness / trust / sense of relevance) while going through the questions and reviewing the report card with you?

- (F) Very good
- (G) Good
- (H) Neutral
- (I) Poor
- (J) Very poor

20. Do you believe that patients from the local Black community follow your advice or recommendations to address substance abuse issues?

(A) yes

(B) no

(C) unsure

Please explain why:

---

---

---

**Please take a moment to review the document titled the Ten-Step ASSIST-linked Brief Intervention (BI).**

21. How would you describe your comfort level / confidence using this BI protocol with patients from the local Black community?

(A) Very good

(B) Good

(C) Neutral

(D) Poor

(E) Very Poor

22. Switching back to the patient population we are focusing on, how do you imagine patients from the local Black community in your service area might feel going through the BI protocol with you?

(A) Very comfortable

(B) Mostly comfortable

(C) Mostly uncomfortable

(D) Very uncomfortable

23. Do you ever feel that any differences in race or class between you and patients from the Black community in your service area might have an effect on how they would respond to the BI?

(A) yes

(B) no

(C) not sure

Please explain why:

---



---

24. What suggestions do you have to modify the BI protocol so that it could be more helpful for patients from the local Black community in your service area, and more useful / effective protocol for you – in your work as a health care provider?

---



---

**As experts using this protocol, your feedback regarding the next set of questions will help to tailor the BI to the local Black community. Although this document titled ‘What is the Ten-Step ASSIST-linked Brief Intervention?’ does not describe all the techniques you may use to implement this protocol, the following questions will refer to these techniques as “steps” in order to identify each of the main components.**

25. Has it been your experience / or do you anticipate that particular procedures in the BI protocol have been or could be difficult for you to introduce / implement with patients from the local Black community?

(A) yes                      (B) no                      (C) not sure

If yes, circle which one(s) below?

(G) Step 1	(D) Step 4	(G) Step 7	(J) Step 10
(H) Step 2	(E) Step 5	(H) Step 8	(K) none of the
above			
(I) Step 3	(F) Step 6	(I) Step 9	

26. Which steps do you feel would allow patients from the local Black community to speak freely about matters that are relevant to them, and that you believe would assist you to best understand their circumstances? (circle all that apply)

(A) Step 1	(D) Step 4	(G) Step 7	(J) Step 10
(B) Step 2	(E) Step 5	(H) Step 8	(K) All the
above			
(C) Step 3	(F) Step 6	(I) Step 9	

Please explain why:

---



---



---

27. Do you feel that any of the steps PREVENT patients from the local Black community from speaking freely about matters that are relevant to them, and that you believe would PREVENT you from understanding their circumstances?

(A) yes      (B) no      (C) not sure

If yes, circle which one(s) below?

(A) Step 1	(D) Step 4	(G) Step 7	(J) Step 10
(B) Step 2	(E) Step 5	(H) Step 8	(K) None of
the above			
(C) Step 3	(F) Step 6	(I) Step 9	

Please explain why:

---



---



---

28. How have you addressed -or imagine addressing -circumstances where you suspect that a patient's race or class is impacting his/her expressions of distress and understanding of its cause? (Please provide a response in the space below)

---



---



---

29. Is there anything that is not discussed or offered in the BI that you believe would be helpful if it was included? (Please provide a response in the space below)

---

---

---

---

**These final questions will ask for your opinion on who needs to be involved in any future plans to address substance use / abuse among the Black community in your service area.**

30. Are there concerns related to substance use for the patients that come to your office/agency that you have not been able to address in your position, and you believe could be addressed in collaboration with others (i.e., healthcare professionals / community leaders / local institutions / community members / etc.)?

(A) yes      (B) no      (C) not sure

If yes, use the space below indicate your concern.

---

---

---

If yes, how would you suggest we develop these collaborations?

- (A) Invite healthcare professionals to community settings
- (B) Invite community members to join an action research team
- (C) Meet periodically with healthcare professionals and community leaders
- (D) Other:

---

Did you skipped or declined to answer any of the questions in this survey? (circle one)

- (A) yes
- (B) no

If yes, please explain why:

---

---

---

Thank you for your participation!

## Appendix I

### A. WHO - ASSIST V3.0

INTERVIEWER ID	<input type="text"/>	COUNTRY	<input type="text"/>	CLINIC	<input type="text"/>
PATIENT ID	<input type="text"/>	DATE	<input type="text"/>	<input type="text"/>	<input type="text"/>

#### INTRODUCTION (Please read to patient )

Thank you for agreeing to take part in this brief interview about alcohol, tobacco products and other drugs. I am going to ask you some questions about your experience of using these substances across your lifetime and in the past three months. These substances can be smoked, swallowed, snorted, inhaled, injected or taken in the form of pills (show drug card).

Some of the substances listed may be prescribed by a doctor (like amphetamines, sedatives, pain medications). For this interview, we will not record medications that are used as prescribed by your doctor. However, if you have taken such medications for reasons other than prescription, or taken them more frequently or at higher doses than prescribed, please let me know. While we are also interested in knowing about your use of various illicit drugs, please be assured that information on such use will be treated as strictly confidential.

**NOTE: BEFORE ASKING QUESTIONS, GIVE ASSIST RESPONSE CARD TO PATIENT**

#### Question 1

(If completing follow-up please cross check the patient's answers with the answers given for Q1 at baseline. Any differences on this question should be queried)

In your life, which of the following substances have you <u>ever used</u> ? (NON-MEDICAL USE ONLY)	No	Yes
a. Tobacco products (cigarettes, chewing tobacco, cigars, etc.)	0	3
b. Alcoholic beverages (beer, wine, spirits, etc.)	0	3
c. Cannabis (marijuana, pot, grass, hash, etc.)	0	3
d. Cocaine (coke, crack, etc.)	0	3
e. Amphetamine type stimulants (speed, diet pills, ecstasy, etc.)	0	3
f. Inhalants (nitrous, glue, petrol, paint thinner, etc.)	0	3
g. Sedatives or Sleeping Pills (Valium, Serepax, Rohypnol, etc.)	0	3
h. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, etc.)	0	3
i. Opioids (heroin, morphine, methadone, codeine, etc.)	0	3
j. Other - specify:	0	3

Probe if all answers are negative:  
"Not even when you were in school?"

If "No" to all items, stop interview.

If "Yes" to any of these items, ask Question 2 for each substance ever used.

## Question 2

In the <b>past three months</b> , how often have you used the substances you mentioned ( <i>FIRST DRUG, SECOND DRUG, ETC?</i> )	Never	Once or Twice	Monthly	Weekly	Daily or Almost Daily
a. Tobacco products (cigarettes, chewing tobacco, cigars, etc.)	0	2	3	4	6
b. Alcoholic beverages (beer, wine, spirits, etc.)	0	2	3	4	6
c. Cannabis (marijuana, pot, grass, hash, etc.)	0	2	3	4	6
d. Cocaine (coke, crack, etc.)	0	2	3	4	6
e. Amphetamine type stimulants (speed, diet pills, ecstasy, etc.)	0	2	3	4	6
f. Inhalants (nitrous, glue, petrol, paint thinner, etc.)	0	2	3	4	6
g. Sedatives or Sleeping Pills (Valium, Serepax, Rohypnol, etc.)	0	2	3	4	6
h. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, etc.)	0	2	3	4	6
i. Opioids (heroin, morphine, methadone, codeine, etc.)	0	2	3	4	6
j. Other - specify:	0	2	3	4	6

*If "Never" to all items in Question 2, skip to Question 6.*

*If any substances in Question 2 were used in the previous three months, continue with Questions 3, 4 & 5 for each substance used.*

## Question 3

During the <b>past three months</b> , how often have you had a strong desire or urge to use ( <i>FIRST DRUG, SECOND DRUG, ETC?</i> )	Never	Once or Twice	Monthly	Weekly	Daily or Almost Daily
a. Tobacco products (cigarettes, chewing tobacco, cigars, etc.)	0	3	4	5	6
b. Alcoholic beverages (beer, wine, spirits, etc.)	0	3	4	5	6
c. Cannabis (marijuana, pot, grass, hash, etc.)	0	3	4	5	6
d. Cocaine (coke, crack, etc.)	0	3	4	5	6
e. Amphetamine type stimulants (speed, diet pills, ecstasy, etc.)	0	3	4	5	6
f. Inhalants (nitrous, glue, petrol, paint thinner, etc.)	0	3	4	5	6
g. Sedatives or Sleeping Pills (Valium, Serepax, Rohypnol, etc.)	0	3	4	5	6
h. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, etc.)	0	3	4	5	6
i. Opioids (heroin, morphine, methadone, codeine, etc.)	0	3	4	5	6
j. Other - specify:	0	3	4	5	6

## Question 4

During the <b>past three months</b> , how often has your use of ( <i>FIRST DRUG, SECOND DRUG, ETC</i> ) led to health, social, legal or financial problems?	Never	Once or Twice	Monthly	Weekly	Daily or Almost Daily
a. Tobacco products (cigarettes, chewing tobacco, cigars, etc.)	0	4	5	6	7
b. Alcoholic beverages (beer, wine, spirits, etc.)	0	4	5	6	7
c. Cannabis (marijuana, pot, grass, hash, etc.)	0	4	5	6	7
d. Cocaine (coke, crack, etc.)	0	4	5	6	7
e. Amphetamine type stimulants (speed, diet pills, ecstasy, etc.)	0	4	5	6	7
f. Inhalants (nitrous, glue, petrol, paint thinner, etc.)	0	4	5	6	7
g. Sedatives or Sleeping Pills (Valium, Serepax, Rohypnol, etc.)	0	4	5	6	7
h. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, etc.)	0	4	5	6	7
i. Opioids (heroin, morphine, methadone, codeine, etc.)	0	4	5	6	7
j. Other - specify:	0	4	5	6	7

## Question 5

During the <b>past three months</b> , how often have you failed to do what was normally expected of you because of your use of ( <i>FIRST DRUG, SECOND DRUG, ETC</i> )?	Never	Once or Twice	Monthly	Weekly	Daily or Almost Daily
a. Tobacco products					
b. Alcoholic beverages (beer, wine, spirits, etc.)	0	5	6	7	8
c. Cannabis (marijuana, pot, grass, hash, etc.)	0	5	6	7	8
d. Cocaine (coke, crack, etc.)	0	5	6	7	8
e. Amphetamine type stimulants (speed, diet pills, ecstasy, etc.)	0	5	6	7	8
f. Inhalants (nitrous, glue, petrol, paint thinner, etc.)	0	5	6	7	8
g. Sedatives or Sleeping Pills (Valium, Serepax, Rohypnol, etc.)	0	5	6	7	8
h. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, etc.)	0	5	6	7	8
i. Opioids (heroin, morphine, methadone, codeine, etc.)	0	5	6	7	8
j. Other - specify:	0	5	6	7	8

*Ask Questions 6 & 7 for all substances ever used (i.e. those endorsed in Question 1)*

**Question 6**

Has a friend or relative or anyone else <u>ever</u> expressed concern about your use of (FIRST DRUG, SECOND DRUG, ETC.)?	No, Never	Yes, in the past 3 months	Yes, but not in the past 3 months
a. Tobacco products (cigarettes, chewing tobacco, cigars, etc.)	0	6	3
b. Alcoholic beverages (beer, wine, spirits, etc.)	0	6	3
c. Cannabis (marijuana, pot, grass, hash, etc.)	0	6	3
d. Cocaine (coke, crack, etc.)	0	6	3
e. Amphetamine type stimulants (speed, diet pills, ecstasy, etc.)	0	6	3
f. Inhalants (nitrous, glue, petrol, paint thinner, etc.)	0	6	3
g. Sedatives or Sleeping Pills (Valium, Serepax, Rohypnol, etc.)	0	6	3
h. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, etc.)	0	6	3
i. Opioids (heroin, morphine, methadone, codeine, etc.)	0	6	3
j. Other – specify:	0	6	3

**Question 7**

Have you <u>ever</u> tried and failed to control, cut down or stop using (FIRST DRUG, SECOND DRUG, ETC.)?	No, Never	Yes, in the past 3 months	Yes, but not in the past 3 months
a. Tobacco products (cigarettes, chewing tobacco, cigars, etc.)	0	6	3
b. Alcoholic beverages (beer, wine, spirits, etc.)	0	6	3
c. Cannabis (marijuana, pot, grass, hash, etc.)	0	6	3
d. Cocaine (coke, crack, etc.)	0	6	3
e. Amphetamine type stimulants (speed, diet pills, ecstasy, etc.)	0	6	3
f. Inhalants (nitrous, glue, petrol, paint thinner, etc.)	0	6	3
g. Sedatives or Sleeping Pills (Valium, Serepax, Rohypnol, etc.)	0	6	3
h. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, etc.)	0	6	3
i. Opioids (heroin, morphine, methadone, codeine, etc.)	0	6	3
j. Other – specify:	0	6	3



## Question 8

	No, Never	Yes, in the past 3 months	Yes, but not in the past 3 months
Have you <u>ever</u> used any drug by injection? (NON-MEDICAL USE ONLY)	0	2	1

## IMPORTANT NOTE:

Patients who have injected drugs in the last 3 months should be asked about their pattern of injecting during this period, to determine their risk levels and the best course of intervention.

## PATTERN OF INJECTING

Once weekly or less or  
Fewer than 3 days in a row

## INTERVENTION GUIDELINES

Brief Intervention including "risks associated with injecting" card

More than once per week or  
3 or more days in a row

Further assessment and more intensive treatment\*

## HOW TO CALCULATE A SPECIFIC SUBSTANCE INVOLVEMENT SCORE.

For each substance (labelled a. to j.) add up the scores received for questions 2 through 7 inclusive. Do not include the results from either Q1 or Q8 in this score. For example, a score for cannabis would be calculated as: Q2c + Q3c + Q4c + Q5c + Q6c + Q7c

Note that Q5 for tobacco is not coded, and is calculated as: Q2a + Q3a + Q4a + Q6a + Q7a

## THE TYPE OF INTERVENTION IS DETERMINED BY THE PATIENT'S SPECIFIC SUBSTANCE INVOLVEMENT SCORE

	Record specific substance score	no intervention	receive brief intervention	more intensive treatment *
a. tobacco		0 - 3	4 - 26	27+
b. alcohol		0 - 10	11 - 26	27+
c. cannabis		0 - 3	4 - 26	27+
d. cocaine		0 - 3	4 - 26	27+
e. amphetamine		0 - 3	4 - 26	27+
f. inhalants		0 - 3	4 - 26	27+
g. sedatives		0 - 3	4 - 26	27+
h. hallucinogens		0 - 3	4 - 26	27+
i. opioids		0 - 3	4 - 26	27+
j. other drugs		0 - 3	4 - 26	27+

NOTE: \*FURTHER ASSESSMENT AND MORE INTENSIVE TREATMENT may be provided by the health professional(s) within your primary care setting, or, by a specialist drug and alcohol treatment service when available.

### C. ALCOHOL, SMOKING AND SUBSTANCE INVOLVEMENT SCREENING TEST (WHO ASSIST V3.0) FEEDBACK REPORT CARD FOR PATIENTS

Name \_\_\_\_\_ Test Date \_\_\_\_\_

#### Specific Substance Involvement Scores

Substance	Score	Risk Level
a. Tobacco products		0-3 Low 4-26 Moderate 27+ High
b. Alcoholic Beverages		0-10 Low 11-26 Moderate 27+ High
c. Cannabis		0-3 Low 4-26 Moderate 27+ High
d. Cocaine		0-3 Low 4-26 Moderate 27+ High
e. Amphetamine type stimulants		0-3 Low 4-26 Moderate 27+ High
f. Inhalants		0-3 Low 4-26 Moderate 27+ High
g. Sedatives or Sleeping Pills		0-3 Low 4-26 Moderate 27+ High
h. Hallucinogens		0-3 Low 4-26 Moderate 27+ High
i. Opioids		0-3 Low 4-26 Moderate 27+ High
j. Other - specify		0-3 Low 4-26 Moderate 27+ High

#### What do your scores mean?

<b>Low:</b>	You are at low risk of health and other problems from your current pattern of use.
<b>Moderate:</b>	You are at risk of health and other problems from your current pattern of substance use.
<b>High:</b>	You are at high risk of experiencing severe problems (health, social, financial, legal, relationship) as a result of your current pattern of use and are likely to be dependent

Are you concerned about your substance use?

<b>a.</b> <b>tobacco</b>	Your risk of experiencing these harms is:..... <b>Low</b> <input type="checkbox"/> <b>Moderate</b> <input checked="" type="checkbox"/> <b>High</b> <input type="checkbox"/> (tick one)
<b>Regular tobacco smoking is associated with:</b>	
	Premature aging, wrinkling of the skin
	Respiratory infections and asthma
	High blood pressure, diabetes
	Respiratory infections, allergies and asthma in children of smokers
	Miscarriage, premature labour and low birth weight babies for pregnant women
	Kidney disease
	Chronic obstructive airways disease
	Heart disease, stroke, vascular disease
	Cancers

<b>b.</b> <b>alcohol</b>	Your risk of experiencing these harms is:..... <b>Low</b> <input type="checkbox"/> <b>Moderate</b> <input type="checkbox"/> <b>High</b> <input type="checkbox"/> (tick one)
<b>Regular excessive alcohol use is associated with:</b>	
	Hangovers, aggressive and violent behaviour, accidents and injury
	Reduced sexual performance, premature ageing
	Digestive problems, ulcers, inflammation of the pancreas, high blood pressure
	Anxiety and depression, relationship difficulties, financial and work problems
	Difficulty remembering things and solving problems
	Deformities and brain damage in babies of pregnant women
	Stroke, permanent brain injury, muscle and nerve damage
	Liver disease, pancreas disease
	Cancers, suicide

<b>c.</b> <b>cannabis</b>	Your risk of experiencing these harms is:..... <b>Low</b> <input type="checkbox"/> <b>Moderate</b> <input type="checkbox"/> <b>High</b> <input type="checkbox"/> (tick one)
<b>Regular use of cannabis is associated with:</b>	
	Problems with attention and motivation
	Anxiety, paranoia, panic, depression
	Decreased memory and problem solving ability
	High blood pressure
	Asthma, bronchitis
	Psychosis in those with a personal or family history of schizophrenia
	Heart disease and chronic obstructive airways disease
	Cancers

<b>d. cocaine</b>	Your risk of experiencing these harms is:....	Low <input type="checkbox"/>	Moderate <input type="checkbox"/>	High <input type="checkbox"/>
<b>Regular use of cocaine is associated with:</b>				
	Difficulty sleeping, heart racing, headaches, weight loss			
	Numbness, tingling, clammy skin, skin scratching or picking			
	Accidents and injury, financial problems			
	Irrational thoughts			
	Mood swings - anxiety, depression, mania			
	Aggression and paranoia			
	Intense craving, stress from the lifestyle			
	Psychosis after repeated use of high doses			
	Sudden death from heart problems			

<b>e. amphetamine type stimulants</b>	Your risk of experiencing these harms is:.....	Low <input type="checkbox"/>	Moderate <input type="checkbox"/>	High <input type="checkbox"/>
<b>Regular use of amphetamine type stimulants is associated with:</b>				
	Difficulty sleeping, loss of appetite and weight loss, dehydration			
	jaw clenching, headaches, muscle pain			
	Mood swings -anxiety, depression, agitation, mania, panic, paranoia			
	Tremors, irregular heartbeat, shortness of breath			
	Aggressive and violent behaviour			
	Psychosis after repeated use of high doses			
	Permanent damage to brain cells			
	Liver damage, brain haemorrhage, sudden death (ecstasy) in rare situations			

<b>f. inhalants</b>	Your risk of experiencing these harms is:.....	Low <input type="checkbox"/>	Moderate <input type="checkbox"/>	High <input type="checkbox"/>
<b>Regular use of inhalants is associated with:</b>				
	Dizziness and hallucinations, drowsiness, disorientation, blurred vision			
	Flu like symptoms, sinusitis, nosebleeds			
	Indigestion, stomach ulcers			
	Accidents and injury			
	Memory loss, confusion, depression, aggression			
	Coordination difficulties, slowed reactions, hypoxia			
	Delirium, seizures, coma, organ damage (heart, lungs, liver, kidneys)			
	Death from heart failure			

<b>g. sedatives</b>	Your risk of experiencing these harms is: Low <input type="checkbox"/> Moderate <input type="checkbox"/> High <input type="checkbox"/> (tick one)
	<b>Regular use of sedatives is associated with:</b> Drowsiness, dizziness and confusion Difficulty concentrating and remembering things Nausea, headaches, unsteady gait Sleeping problems Anxiety and depression Tolerance and dependence after a short period of use. Severe withdrawal symptoms Overdose and death if used with alcohol, opioids or other depressant drugs.

<b>h. hallucinogens</b>	Your risk of experiencing these harms is:..... Low <input type="checkbox"/> Moderate <input type="checkbox"/> High <input type="checkbox"/> (tick one)
	<b>Regular use of hallucinogens is associated with:</b> Hallucinations (pleasant or unpleasant) – visual, auditory, tactile, olfactory Difficulty sleeping Nausea and vomiting Increased heart rate and blood pressure Mood swings Anxiety, panic, paranoia Flash-backs Increase the effects of mental illnesses such as schizophrenia

<b>i. opioids</b>	Your risk of experiencing these harms is: Low <input type="checkbox"/> Moderate <input type="checkbox"/> High <input type="checkbox"/> (tick one)
	<b>Regular use of opioids is associated with:</b> Itching, nausea and vomiting Drowsiness Constipation, tooth decay Difficulty concentrating and remembering things Reduced sexual desire and sexual performance Relationship difficulties Financial and work problems, violations of law Tolerance and dependence, withdrawal symptoms Overdose and death from respiratory failure

## Appendix J



HO5

### What is the Ten-step ASSIST-linked Brief Intervention?

#### OVERVIEW

1. **Ask** client, "Are you interested in seeing how you scored on the questionnaire you just did?"
2. Give **Feedback about scores** and associated risks using the ASSIST Feedback report card.
3. **Advise** client that they can reduce their risk by reducing their substance use.
4. **Responsibility** – let client know that what they do with the information is up to them.
5. Ask client "Are you **Concerned by your score** for (drug)? How?"
6. Ask client "What are the **Good Things** about using (drug)?"
7. Ask client "What are the **Less Good Things** about using (drug)?"
8. **Summarise** and reflect back client's discussion of their drug use.
9. Ask client "How **Concerned** are you about the **less good things** about using (drug)?"
10. Give client **Take home materials** including Self-Help strategies booklet & Feedback card.

**Appendix K**

Code # \_\_\_\_\_

**Community Member Stakeholder Group Demographic Questionnaire**

Please complete the following information about yourself. The demographic information you provide will be used for research purposes only and will be held in **strictest confidence**.

Please circle the appropriate letter or fill in where requested.

1. Sex: (A) Female (B) Male
2. What is your current age? \_\_\_\_\_ Years
3. What is your ethnic / cultural background?
  - (A) African American (born in USA)
  - (B) Afro Caribbean Islander (not born in USA)
  - (C) African (not born in USA)
  - (D) Caucasian/White
  - (E) Hispanic- or Latino-American
  - (F) Asian/Pacific Islander
  - (G) Native American / Indian American
  - (H) Other: (specify): \_\_\_\_\_

**OR**

Race: \_\_\_\_\_

4. Highest level of education:
  - (A) Some high school or less
  - (B) High school diploma or GED
  - (C) Business or trade school
  - (D) Some college
  - (E) College degree
  - (F) Some graduate school
  - (G) Graduate study

5. Do you live in Hartford?

- (A) Yes
- (B) No

If yes, how long have you lived in Hartford, CT?

- (A) Less than one year
- (B) Between 1 to 3 years
- (C) Between 3 to 6 years
- (D) Longer than 6 years

If no, have you ever lived in Hartford in the past?

- (A) Yes
- (B) No

What city do you currently live in?

\_\_\_\_\_

6. Do you consider yourself to be a member of the Hartford community?

- (A) Yes
- (B) No

If you **do not** consider yourself to be a member of the Hartford community, please indicate below your preferred term of identification with the Hartford community.

\_\_\_\_\_

If you **do not** live in Hartford, what reason(s) make you consider yourself as part of the Hartford community? (circle all that apply)

- (A) I am a member of a church in Hartford.
- (B) I work in Hartford
- (C) I regularly stay or visit with family in Hartford
- (D) I am a member of an organization or community center located in Hartford
- (E) Other: \_\_\_\_\_



**Appendix L**

Code # \_\_\_\_\_

**Community Leader Stakeholder Group Demographic Questionnaire**

Please complete the following information about yourself. The demographic information you provide will be used for research purposes only and will be held in **strictest confidence**.

Please circle the appropriate letter or fill in where requested.

3. Sex: (A) Female (B) Male

4. What is your current age? \_\_\_\_\_ Years

3. What is your ethnic/cultural background?

- (A) African American (born in USA)
- (B) Afro Caribbean Islander (not born in USA)
- (C) African (not born in USA)
- (D) Caucasian/White
- (E) Hispanic- or Latino-American
- (F) Asian/Pacific Islander
- (G) Native American / Indian American
- (H) Other: (specify): \_\_\_\_\_

**OR**

Race: \_\_\_\_\_

4. Highest level of education:

- (A) Some high school or less
- (B) High school diploma or GED
- (C) Business or trade school
- (D) Some college
- (E) College degree
- (F) Some graduate school
- (G) Graduate study

5. If a community leader is defined as a person who works toward improving one or more aspects of the community. Do you consider yourself to be a leader in the Hartford community?

- (A) Yes
- (B) No

If yes, how long have you worked to improve the community?

- (E) Less than one year
- (F) Between 1 to 3 years
- (G) Between 3 to 6 years
- (H) Longer than 6 years

6. Have you ever taken a leadership role to address substance use in the Hartford area?

- (A) Yes
- (B) No

If no, what issue(s) do you have experience addressing in the Hartford area?

**Please circle all that apply.**

- (A) Obesity
- (B) Education
- (C) Income / employment
- (D) Inadequate housing
- (E) Other health disparity. Specify: \_\_\_\_\_
- (F) **Does not apply.** I hold a leadership position within a faith-based community.

**Appendix M**

Code # \_\_\_\_\_

**Service Provider Stakeholder Group Demographic Questionnaire**

Please complete the following information about yourself. The demographic information you provide will be used for research purposes only and will be held in **strictest confidence**.

Please circle the appropriate letter or fill in where requested.

1. Sex: (A) Female (B) Male

2. What is your current age? \_\_\_\_\_ Years

3. What is your ethnic/cultural background?

- (A) African American (born in USA)
- (B) Afro Caribbean Islander (not born in USA)
- (C) African (not born in USA)
- (D) Caucasian/White
- (E) Hispanic- or Latino-American
- (F) Asian/Pacific Islander
- (G) Native American / Indian American
- (H) Other: (specify): \_\_\_\_\_

**OR**

Race: \_\_\_\_\_

4. Highest level of education:

- (A) Some high school or less
- (B) High school diploma or GED
- (C) Business or trade school
- (D) Some college
- (E) College degree
- (F) Some graduate school
- (G) Graduate study

5. Do you work in the Hartford area (including East Hartford)?

- (A) Yes
- (B) No

If yes, how long have you worked in the Hartford area?

- (I) Less than one year
- (J) Between 1 to 3 years
- (K) Between 3 to 6 years
- (L) Longer than 6 years

If no, have you ever worked in the Hartford area in the past?

- (A) Yes
- (B) No

What city do you currently work in?

---

6. In your current position, do you use the Alcohol, Smoking and Substance Involvement Screening Test (ASSIST) as a screening instrument?

- (A) Yes
- (B) No

If yes, how long have you worked in this position?

- (A) Less than one year
- (B) Between 1 to 3 years
- (C) Between 3 to 6 years
- (D) Longer than 6 years

If no, what is your affiliation with SBIRT?

- (A) Health Educator
- (B) Evaluator for SBIRT
- (C) Trainer for SBIRT health educators
- (D) Other: \_\_\_\_\_
- (E) I do not have any affiliation with SBIRT.

## Appendix N



H. Danielle Green M.A.  
Doctoral Student  
University of Connecticut  
Human Development and Family Studies

### **Proposed Project:** Modifying the Screenings, Brief Interventions, and Referral to Treatment (SBIRT) Protocol to Improve the Cultural Relevance for the Black Community

There is a program called **SBIRT** that is used in Community Health Centers across Connecticut. It is an evidence-based treatment protocol designed to briefly ask questions and provide advice to individuals about ways to reduce tobacco, alcohol, or drug use during their regular medical appointments.

### **Some of the existing problems:**

- (a) SBIRT was developed by clinical researchers with limited or no affiliation to the communities being served.
- (b) There is a growing concern that parts of this program do not match the day-to-day living experiences of people in the community, particularly the Black community in Hartford.

### **One proposed solution:**

- (a) Involve the community in the process of redeveloping this program to address the substance use concerns expressed by members of the local community.
- (b) Enlist the help of key **stakeholders**: (1) community members, (2) community leaders, and (3) healthcare professionals at the community health center.

### **My proposed role:**

- (a) To encourage stakeholders within the Hartford community to join an initiative to improve a substance use intervention that is currently disseminated among this and other local communities.
- (b) To conduct focus groups and interviews to understand concerns that are relevant to the Hartford community, and to determine which items of the SBIRT protocol need to be discarded, revised, or added.

- (c) To systematically organize and apply the responses from the community to the development of a culturally relevant version of SBIRT.

**Once approval is obtained from the University, our combined effort will:**

- (a) Allow community health centers to provide a program based on explicit voices of the community.
- (b) Ensure that larger institutions understand how to create programs that can adapt to the changing needs of the local community.

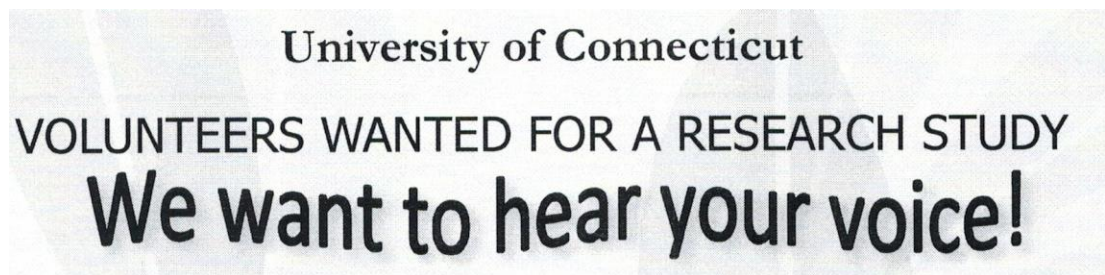
**For more information, please contact:**

H. Danielle Green

Telephone: (302)632-2046

Email: [helena.green@uconn.edu](mailto:helena.green@uconn.edu)

## Appendix O



- We want to change how tobacco, alcohol, and drug use is examined in the community health center in Hartford, Connecticut
  - And we want the input of the Black community to make this change.
- You may be eligible to participate in our study, if you:
  - Are 18 or older
  - Live or work in the Hartford area
  - Have witnessed how substance use has affected your family or the local neighborhoods for the Black community in Hartford
- You will have options for how to participate and provide ideas about how we can improve this community resource.
  - You can either (1) complete a survey, or (2) participate in a 60 – 90 minute focus group and complete a survey
  - You will also have the option to let us know at a later time if we are accurately representing what you shared
- You will receive \$20 for completing each phase.

To learn more, please contact Danielle:

Email: [hdanielleg@comcast.net](mailto:hdanielleg@comcast.net) or call (302)632-2046

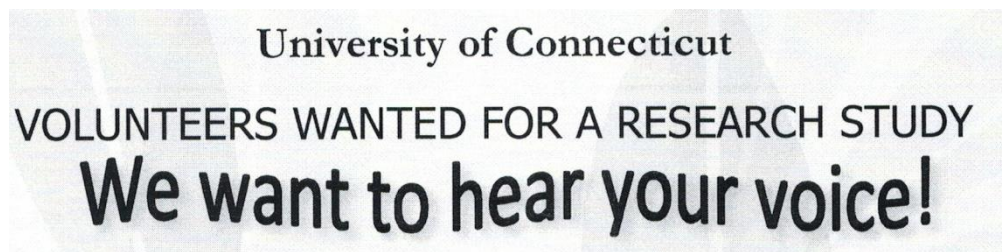
**Principal Investigator:** Sandra Rigazio-DiGilio, PhD

**Student Investigator:** Helena Danielle Green, MA

**Study Title:** Developing a Culturally Relevant Version of SBIRT for the Black Community in Hartford, Connecticut

[illegible]



**Appendix P**

- We want to change how tobacco, alcohol, and drug use is examined in the community health center in Hartford, Connecticut
  - And we want the input of leaders within the Hartford community to make this change.
- You may be eligible to participate in our study, if you:
  - Have been identified as a leader by others in the Black community
  - OR
  - Are affiliated with an agency or organization that is actively addressing disparities for under-represented minorities in the Hartford area
  - AND
  - Have some awareness of the substance use patterns in Hartford, particularly for members of the Black community
- You will have options for how to participate and provide ideas about how we can improve this community resource.
  - You can either (1) complete a survey, or (2) participate in a 60 – 90 minute focus group and complete a survey
  - You will also have the option to let us know at a later time if we are accurately representing what you shared
- For your participation, you will receive a copy of the study outcomes.

To learn more, please contact Danielle:

Email: [hdanielleg@comcast.net](mailto:hdanielleg@comcast.net) or call (302)632-2046

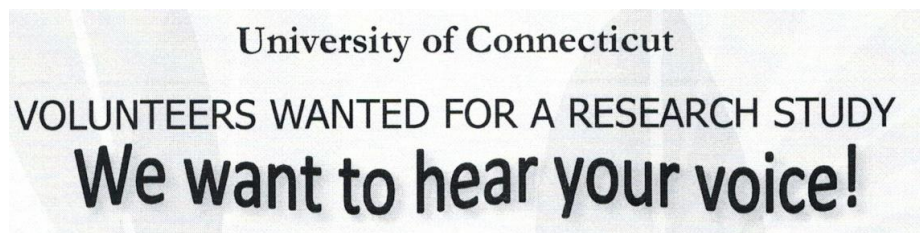
**Principal Investigator:** Sandra Rigazio-DiGilio, PhD

**Student Investigator:** Helena Danielle Green, MA

**Study Title:** Developing a Culturally Relevant Version of SBIRT for the Black Community in Hartford, Connecticut

[illegible]

## Appendix Q



- We want to create a culturally adapted version of SBIRT for use in the community health center in Hartford, Connecticut
  - And we want the input of health educators, brief treatment clinicians, and SBIRT evaluators to make this change.
- You may be eligible to participate in our study, if you:
  - Have administered or evaluated SBIRT for the community health center in Hartford or the surrounding area
  - AND
  - Have experience working with diverse populations or some awareness of the substance use patterns in Hartford, particularly for members of the Black community
- You will have options for how to participate and provide ideas about how we can adapt this resource.
  - You can either (1) complete a survey, or (2) participate in a 60 – 90 minute focus group and complete a survey
  - You will also have the option to let us know at a later time if we are accurately representing what you shared
- For your participation, you will receive a copy of the study outcomes for practical use!

To learn more, please contact Danielle:

Email: [hdanielleg@comcast.net](mailto:hdanielleg@comcast.net) or call (302)632-2046

**Principal Investigator:** Sandra Rigazio-DiGilio, PhD

**Student Investigator:** Helena Danielle Green, MA

**Study Title:** Developing a Culturally Relevant Version of SBIRT for the Black Community in Hartford, Connecticut

[illegible]

## Appendix R

### Community Member - Consent Form for Participation in a Research Study



**Principal Investigator:** Sandra A. Rigazio-DiGilio, Ph.D.

**Student Researcher:** Helena Danielle Green, M.A.

**Study Title:** Developing a Culturally Relevant Version of SBIRT for the Black Community in Hartford, Connecticut

### Introduction

You are invited to participate in a research study because you understand some of the substance use related issues that have developed in Hartford, Connecticut, specifically for the Black community. We are conducting a study that will use your insight and ideas to improve a substance use resource for the community health center in Hartford. Your perspective, along with the perspectives of two other key stakeholder groups, will provide us with a wide range of ideas that may also generalize to adapt this resource for other community health centers throughout Connecticut.

### Why is this study being done?

The purpose of this research is to gather community-based input and feedback that will be used to create a culturally relevant version of a substance use assessment and brief intervention tool, currently used in community health centers across Connecticut. We aim to redesign this community resource by gaining different perspectives of members of / leaders in / and service providers for the local Black community in Hartford, Connecticut. We also want to gain a better understanding of how tobacco, alcohol, and drug use has affected the local families and neighborhoods in Hartford, and how these issues are currently addressed.

### What are the study procedures? What will I be asked to do?

If you agree to participate in this study, you may either: (1) participate in a focus group and fill out a survey, or (2) fill out a survey. This study has two phases and both focus group and survey-only participants will have the option to participate in phase two.

During phase one, the in-person focus group will be audio-taped and follow a semi-structured format. You will be asked to describe how tobacco, alcohol, and drug use has affected local Black families and neighborhoods in Hartford, and how these issues are currently addressed. You will view a ten minute segment of a training video. You will be asked to review the assessment tools and a handout explaining the brief intervention, in order to provide feedback and suggestions for changes. Each focus group will range between 60 and 90 minutes. You will also be asked to complete a brief survey that reiterates the questions asked during the focus group. The survey may take up to 20 minutes to complete. If you elect to participate in a focus

group, you will have the option to complete the survey directly after the focus group ends or take a copy of the survey home. The student researcher will return to the location of the focus group a week later to collect the completed surveys. If you decide to only complete the survey, you will review the assessment tools and a handout explaining the brief intervention, but viewing the training video will be optional.

During phase two, if you choose to participate, you will be able to let the researchers know if they accurately understood all the information your group provided during phase one. If you decide to participate in phase two, we will ask for your phone number below. The student researcher will then contact you after phase one has finished to let you know how you can participate in phase two (i.e., via written feedback or one-on-one interview).

### What are the risks or inconveniences of the study?

There is a minimal risk to participants. However, you might feel uncomfortable responding to some of the questions due to the personal nature of some of the focus group and survey questions asking about substance use in your community. The student researcher will inform you that you need to either keep in mind your own personal experiences, or think about the kind of information other members of your community would share, when responding to questions. You may approach the student researcher with any concerns that come up while you are talking in the focus groups or filling out the survey.

You also may feel inconvenienced by the time it will take to participate in the group(s). However, should you experience any adverse reactions during or after a focus group or following the survey, the student researcher will provide you with the names and contact information of three therapists in your local area. Therefore, you should feel free to contact Danielle Green at 302-632-2046 for such services if necessary. She will contact you within 24 hours.

### What are the benefits of the study?

You may benefit from this study if you decide to seek services at the community health center in Hartford, and would prefer to receive a substance use assessment that is based on your community. You will also be contributing one step towards developing a process that could allow other community health centers to redevelop this resource for the Black community in Hartford and for other underrepresented subgroups in under resourced communities.

### Are there costs to be in the study? Will I receive payment?

There are no costs to you for being in this study. You will receive \$20 when you either: (1) participate in a focus group and fill out a survey, or (2) fill out a survey. If you decide to participate in phase two, you will receive an additional \$20, for a total of \$40.

### How will my personal information be protected?

We will keep your personal information confidential, which means we will not put your name, date of birth, or any other identifying information on our forms. We will keep all surveys and audio recordings locked in a safe place, using code numbers instead of your name. The code numbers will not be used to identify or link your answers from phase one if you decide to participate in phase two. The audio recordings will be kept during the study, but will be destroyed after the study is over. We will use computers to keep track of information we get during this study (these are called data files). We will keep data files safe by using passwords. Only the study team and Verbal Ink (a professional transcription service) will have access to the audio recordings. The audio recordings will be permanently destroyed 14 days after transcription. At the end of this study, we may use the information you give us to create a culturally relevant version of this community resource to be used in the community health center in Hartford, and we may present our findings about your experiences (with identifying data removed), but no one apart from members of the research team will know that you were in this study or will hear the audio recordings of the groups.

You should also know that the UConn Institutional Review Board (IRB) and the Office of Research Compliance might look at study records as part of its program to make sure that we are keeping your information safe and they will not look at your own information. The IRB is a group of people who review studies to protect the rights and welfare of research participants.

### Can I stop being in the study and what are my rights?

You do not have to be in this study if you do not want to be. If you agree to be in the study and change your mind later, you may drop out at any time. There are no penalties or consequences of any kind if you decide that you do not want to be in the study. If there are any questions on the forms that you do not want to answer, you may leave these blank. If you choose to not answer some of the questions or decide not to participate in the study, you will still receive the \$20-\$40.

### Whom do I contact if I have questions about the study?

Take as long as you like before you make a decision. We will be happy to answer any questions you have about this study. Later, if you have more questions about this study, a study-related problem, or any questions or concerns about the questions written on the forms or asked in the groups you may contact the Principal Investigator, Sandra Rigazio-DiGilio at 860-977-1708, or the Student Researcher, Danielle Green, at 302-632-2046. If you have any questions concerning your rights as a research participant, you may contact the University of Connecticut Institutional Review Board (IRB) at 860-486-8802.

### **Documentation of Consent:**

I have read this form and decided that I will participate in this project. What the study is about, what I will do, and possible risks or harm were explained to me. I understand that I can stop at any time. My signature also means that I got a copy of this consent form.

\_\_\_\_\_  
Participant Signature:

\_\_\_\_\_  
Print Name:

\_\_\_\_\_  
Date:

\_\_\_\_\_  
Participant Telephone Number (if participating in phase 2)

\_\_\_\_\_  
Signature of Person  
Obtaining Consent

\_\_\_\_\_  
Print Name:

\_\_\_\_\_  
Date:



## Appendix S

### Community Leader - Consent Form for Participation in a Research Study



**Principal Investigator:** Sandra A. Rigazio-DiGilio, Ph.D.

**Student Researcher:** Helena Danielle Green, M.A.

**Study Title:** Developing a Culturally Relevant Version of SBIRT for the Black Community in Hartford, Connecticut

### Introduction

You are invited to participate in a research study because you understand some of the substance use related issues that have developed in Hartford, Connecticut, specifically for the Black community. We are conducting a study that will use your insight and ideas to improve a substance use resource for the community health center in Hartford. Your perspective, along with the perspectives of two other key stakeholder groups, will provide us with a wide range of ideas that may also generalize to adapt this resource for other community health centers throughout Connecticut.

### Why is this study being done?

The purpose of this research is to gather community-based input and feedback that will be used to create a culturally relevant version of a substance use assessment and brief intervention tool, currently used in community health centers across Connecticut. We aim to redesign this community resource by gaining different perspectives of members of / leaders in / and service providers for the local Black community in Hartford, Connecticut. We also want to gain a better understanding of how tobacco, alcohol, and drug use has affected local families and neighborhoods in Hartford, and how these issues are currently addressed.

### What are the study procedures? What will I be asked to do?

If you agree to participate in this study, you may either: (1) participate in a focus group and fill out a survey, or (2) fill out a survey. This study has two phases and both focus group and survey-only participants will have the option to participate in phase two.

During phase one, the in-person focus group will be audio-taped and follow a semi-structured format. You will be asked to describe how tobacco, alcohol, and drug use has affected Hartford, particularly for the local Black families and neighborhoods, and how these issues are currently addressed. You will view a ten minute segment of a training video. You will be asked to review the assessment tools and a handout explaining the brief intervention, in order to provide feedback and suggestions for changes. Each focus group will range between 60 and 90 minutes. You will also be asked to complete a brief survey that reiterates the questions asked during the focus group. The survey may take up to 20 minutes to complete. If you elect to participate in a focus

group, you will have the option to complete the survey directly after the focus group ends or take a copy of the survey home. The student researcher will return to the location of the focus group a week later to collect the completed surveys. If you decide to only complete the survey, you will review the assessment tools and a handout explaining the brief intervention, but viewing the training video will be optional.

During phase two, if you choose to participate, you will be able to let the researchers know if they accurately understood all the information your group provided during phase one. If you decide to participate in phase two, we will ask for your phone number below. The student researcher will then contact you after phase one has finished to let you know how you can participate in phase two (i.e., via written feedback or one-on-one interview).

### What are the risks or inconveniences of the study?

There is a minimal risk to participants. However, you might feel uncomfortable responding to some of the questions about substance use, the effects of substance use in your community, and assessments and treatments offered within your community. The student researcher will inform you that you need to either keep in mind your own personal experiences, or think about the kind of information other members of your community would share, when responding to questions. You may approach the student researcher with any concerns that come up while you are talking in the focus groups or filling out the survey.

You also may feel inconvenienced by the time it will take to participate in the group(s). However, should you experience any adverse reactions during or after a focus group or following the survey, the student researcher will provide you with the names and contact information of three therapists in your local area. Therefore, you should feel free to contact Danielle Green at 302-632-2046 for such services if necessary. She will contact you within 24 hours.

### What are the benefits of the study?

You may not personally benefit from this study. However, if you have or would like to work towards addressing a health disparity for the Hartford area, then participating in this study allows you to contribute one step towards improving the cultural relevancy of a local substance use resource. You will also be contributing one step towards developing a process that could allow other community health centers to redevelop this resource for the local Black community in Hartford and for other underrepresented subgroups in under resourced communities.

### Are there costs to be in the study? Will I receive payment?

There are no costs to you for being in this study. You will personally receive a copy of suggestions and recommendations (based on the results of the study) for engaging and intervening specifically with the Black community in Hartford for substance use related concerns.

### How will my personal information be protected?

We will keep your personal information confidential, which means we will not put your name, date of birth, or any other identifying information on our forms. We will keep all surveys and audio recordings locked in a safe place, using code numbers instead of your name. The code numbers will not be used to identify or link your answers from phase one if you decide to participate in phase two. The audio recordings will be kept during the study, but will be destroyed after the study is over. We will use computers to keep track of information we get during this study (these are called data files). We will keep data files safe by using passwords. Only the study team and Verbal Ink (a professional transcription service) will have access to the audio recordings. The audio recordings will be permanently destroyed 14 days after transcription. At the end of this study, we may use the information you give us to create a culturally relevant version of this community resource to be used in the community health center in Hartford, and we may present our findings about your experiences (with identifying data removed), but no one apart from members of the research team will know that you were in this study or will hear the audio recordings of the groups.

You should also know that the UConn Institutional Review Board (IRB) and the Office of Research Compliance might look at study records as part of its program to make sure that we are keeping your information safe and they will not look at your own information. The IRB is a group of people who review studies to protect the rights and welfare of research participants.

### Can I stop being in the study and what are my rights?

You do not have to be in this study if you do not want to be. If you agree to be in the study and change your mind later, you may drop out at any time. There are no penalties or consequences of any kind if you decide that you do not want to be in the study. If there are any questions on the forms that you do not want to answer, you may leave these blank. If you choose to not answer some of the questions or decide not to participate in the study, you will still receive a copy of the study outcomes.

### Whom do I contact if I have questions about the study?

Take as long as you like before you make a decision. We will be happy to answer any questions you have about this study. Later, if you have more questions about this study, a study-related problem, or any questions or concerns about the questions written on the forms or asked in the groups you may contact the Principal Investigator, Sandra Rigazio-DiGilio at 860-977-1708, or the Student Researcher, Danielle Green, at 302-632-2046. If you have any questions concerning your rights as a research participant, you may contact the University of Connecticut Institutional Review Board (IRB) at 860-486-8802.

### **Documentation of Consent:**

I have read this form and decided that I will participate in this project. What the study is about, what I will do, and possible risks or harm were explained to me. I understand that I can stop at any time. My signature also means that I got a copy of this consent form.

---

Participant Signature:

---

Print Name:

---

Date:

---

Participant Telephone Number (if participating in phase 2)

---

Signature of Person  
Obtaining Consent

---

Print Name:

---

Date:

## Appendix T

### Service Providers - Consent Form for Participation in a Research Study



**Principal Investigator:** Sandra A. Rigazio-DiGilio, Ph.D.

**Student Researcher:** Helena Danielle Green, M.A.

**Study Title:** Developing a Culturally Relevant Version of SBIRT for the Black Community in Hartford, Connecticut

### Introduction

You are invited to participate in a research study because you understand some of the substance use related issues that have developed in Hartford, Connecticut, specifically for the Black community. We are conducting a study that will use your insight and ideas to improve a substance use resource for the community health center in Hartford. Your perspective, along with the perspectives of two other key stakeholder groups, will provide us with a wide range of ideas that may also generalize to adapt this resource for other community health centers throughout Connecticut.

### Why is this study being done?

The purpose of this research is to gather community-based input and feedback that will be used to create a culturally relevant version of the Screening, Brief Intervention, and Referral to Treatment (SBIRT) for use in the community health center in Hartford. We aim to redesign this community resource by gaining different perspectives of members of / leaders in / and service providers for the local Black community in Hartford, Connecticut. We also want to gain a better understanding of how tobacco, alcohol, and drug use has affected local families and neighborhoods in Hartford, and how these issues are currently addressed.

### What are the study procedures? What will I be asked to do?

If you agree to participate in this study, you may either: (1) participate in a focus group and fill out a survey, or (2) fill out a survey. This study has two phases and both focus group and survey-only participants will have the option to participate in phase two.

During phase one, the in-person focus group will be audio-taped and follow a semi-structured format. You will be asked to describe your experience administering or evaluating SBIRT, and it's fit for diverse populations, specifically the Black community. You will be asked to review the assessment tools and a handout explaining the brief intervention, in order to provide feedback and suggestions for changes. Each focus group will range between 60 and 90 minutes. You will also be asked to complete a brief survey that reiterates the questions asked during the focus group. The survey may take up to 20 minutes to complete. If you elect to participate in a focus group, you will have the option to complete the survey directly after the focus group ends or take

a copy of the survey home. The student researcher will return to the location of the focus group a week later to collect the completed surveys. If you decide to only complete the survey, you will review the assessment tools and a handout explaining the brief intervention.

During phase two, if you choose to participate, you will be able to let the researchers know if they accurately understood all the information your group provided during phase one. If you decide to participate in phase two, we will ask for your phone number below. The student researcher will then contact you after phase one has finished to let you know how you can participate in phase two (i.e., via written feedback or one-on-one interview).

### What are the risks or inconveniences of the study?

There is a minimal risk to participants. However, you might feel uncomfortable responding to some of the questions about substance use, the effects of substance use in the Hartford community, and assessments and treatments offered within the Hartford community. The student researcher will inform you that you need to either keep in mind your own personal experiences, or think about the kind of information other service providers would share, when responding to questions. You may approach the student researcher with any concerns that come up while you are talking in the focus groups or filling out the survey.

You also may feel inconvenienced by the time it will take to participate in the group(s). However, should you experience any adverse reactions during or after a focus group or following the survey, the student researcher will provide you with the names and contact information of three therapists in your local area. Therefore, you should feel free to contact Danielle Green at 302-632-2046 for such services if necessary. She will contact you within 24 hours.

### What are the benefits of the study?

You may benefit from this study if you are interested in working towards applying a culturally adapted version of SBIRT with your patients, or if you are interested in evaluating a culturally adapted version of SBIRT. You will also be contributing one step towards developing a process that could allow other community health centers to redevelop this resource for the local Black community in Hartford and for other underrepresented subgroups in under resourced communities.

### Are there costs to be in the study? Will I receive payment?

There are no costs to you for being in this study. You will personally receive a copy of suggestions and recommendations (based on the results of the study) for engaging and intervening specifically with the Black community in Hartford for substance use related concerns.

### How will my personal information be protected?

We will keep your personal information confidential, which means we will not put your name, date of birth, or any other identifying information on our forms. We will keep all surveys and audio recordings locked in a safe place, using code numbers instead of your name. The code numbers will not be used to identify or link your answers from phase one if you decide to participate in phase two. The audio recordings will be kept during the study, but will be destroyed after the study is over. We will use computers to keep track of information we get during this study (these are called data files). We will keep data files safe by using passwords. Only the study team and Verbal Ink (a professional transcription service) will have access to the audio recordings. The audio recordings will be permanently destroyed 14 days after transcription. At the end of this study, we may use the information you give us to create a culturally adapted version of SBIRT to be used in the community health center in Hartford, and we may present our findings about your experiences (with identifying data removed), but no one apart from members of the research team will know that you were in this study or will hear the audio recordings of the groups.

You should also know that the UConn Institutional Review Board (IRB) and the Office of Research Compliance might look at study records as part of its program to make sure that we are keeping your information safe and they will not look at your own information. The IRB is a group of people who review studies to protect the rights and welfare of research participants.

### Can I stop being in the study and what are my rights?

You do not have to be in this study if you do not want to be. If you agree to be in the study and change your mind later, you may drop out at any time. There are no penalties or consequences of any kind if you decide that you do not want to be in the study. If there are any questions on the forms that you do not want to answer, you may leave these blank. If you choose to not answer some of the questions or decide not to participate in the study, you will still receive a copy of the study outcomes for practical use.

### Whom do I contact if I have questions about the study?

Take as long as you like before you make a decision. We will be happy to answer any question you have about this study. Later, if you have more questions about this study, a study-related problem, or any questions or concerns about the questions written on the forms or asked in the groups you may contact the Principal Investigator, Sandra Rigazio-DiGilio at 860-977-1708, or the Student Researcher, Danielle Green, at 302-632-2046. If you have any questions concerning your rights as a research participant, you may contact the University of Connecticut Institutional Review Board (IRB) at 860-486-8802.

### **Documentation of Consent:**

I have read this form and decided that I will participate in this project. What the study is about, what I will do, and possible risks or harm were explained to me. I understand that I can stop at any time. My signature also means that I got a copy of this consent form.

---

Participant Signature:

---

Print Name:

---

Date:

---

Participant Telephone Number (if participating in phase 2)

---

Signature of Person  
Obtaining Consent

---

Print Name:

---

Date:



## Appendix U

**Study Title:** Developing a Culturally Relevant Version of SBIRT for the Black Community in Hartford, Connecticut

**Student Investigator:** Helena Danielle Green, MA

Thank you again for participating in this University of Connecticut (UConn) research study. The purpose of this study was to incorporate the voices of the community to improve the cultural relevancy of a tobacco, alcohol, and drug use assessment program that is currently used in community health centers. After examining responses from focus groups and surveys, the following themes (i.e., commonly shared experiences, beliefs, and/or values) were expressed:

**We hold assumptions about the people who use substances and the reasons why they use.**

- Every individual is different, but there are common social problems (i.e., the accessibility of drugs, job loss, family disenfranchisement) and beliefs about substance use that continue the cycle of use.

**Many in the Hartford Black community feel that they are uninformed about substance abuse intervention options that are available to the community.**

- Individuals want to be provided information about the different options, in order to feel empowered to pursue the option that is the best fit.
- Some individuals want health care providers to ask them, “Have you ever considered any of these options?” – as a way to initiate this conversation.

**When substance use questions are asked, individuals may feel comfortable answering questions (if there is trust in the healthcare provider), but they still question the confidentiality.**

- Some individuals believe culturally diversity training is needed so that health care providers can be more sensitive to the beliefs and circumstances of the community they serve.
- 61.1% feel that race and class of the health care provider does not matter.
- Some individuals express concern about the consequences to responding to questions truthfully.

**Health care providers need to consider other factors beyond the questions and conversation about substance use, if the aim is to follow a patient-centered approach.**

- Many need to feel welcome into the environment. It helps if the health care providers has a familiarity with the community – i.e., they should know the people and consistently be there
- The lack of service in some medical settings (i.e. the wait times and cleanliness of / restrictions on the amenities) contribute to some of feelings of distrust between the Hartford community and medical professionals.

**Many in the Hartford Black community believe that there are conversations that need to take place among the community, in group settings.**

- This could provide opportunities to share information gained from medical personnel (e.g., Offering take home materials for the individual and another copy to share with someone else in their family or community (i.e., help to translate to the community).
- Some individuals want to learn how to bring up conversation about substance use with family and others so that the problem remains visible ---i.e. To reduce the shame by talking openly with others

## Appendix V

**Study Title:** Developing a Culturally Relevant Version of SBIRT for the Black Community in Hartford, Connecticut

**Student Investigator:** Helena Danielle Green, MA

Thank you again for participating in this University of Connecticut (UConn) research study. The purpose of this study was to incorporate the voices of the community to improve the cultural relevancy of a tobacco, alcohol, and drug use assessment program that is currently used in community health centers. After examining responses from focus groups and surveys, the following themes (i.e., commonly shared experiences, beliefs, and/or values) were expressed:

**We hold assumptions about the people who use substances and the reasons why they use.**

- We generally believe that problems (i.e. unemployment, family stress, gambling) develop from the substance use
- The type of substance can impact how we view an individual's circumstances (i.e., a person who smokes Black and Milds is viewed differently (less negatively) than a person using Angel Dust).
- Our understanding about the severity of the "culturally acceptable" substances is debatable.
- We strongly believe that adults using substances are highly influential to the youth and their behaviors.

**From a community leader perspective, many feel that there is not enough information being distributed about substance abuse intervention options that are available to the community.**

- People in your community typically do not talk to you about problems related to substance use, or go to you to receive information about available services.
- Some feel that there should be better advertisement (i.e., posters and rallies) to inform the community and encourage them to use the available services.

**When substance use questions are asked, individuals generally feel comfortable answering questions (if there is trust in the healthcare provider), and race and class do not matter.**

- Some believe that people in the community need support (i.e., a push) to get help, and its good to ask them questions that show concern:
  - "What initiated your substance use?" or "How can I help?"
- A couple leaders would questions the need to continue helping someone who keeps using despite the leader's involvement.

**Health care providers need to be aware that their own biases could impact how the questions and conversation about substance use are received by the community.**

- Some feel that the community could easily believe that the health care provider is accusing them of using a substance, depending on the approach.
- Some feel it helps if the health care providers has a familiarity with the community (i.e., Understand what is going on in the community or a person's daily life that could factor into why that person uses) –Ask questions:
  - "Is there anything I need to know about you to better understand your circumstance?"
- One suggestion: Always give each individual the benefit of the doubt, then ask questions that gauge their readiness to change.

**Many feel that we need to collaborate with individuals from within and outside the community to address the issue of substance use in the Hartford community.**

- Include the youth, and collaborate with other cities to help and learn from each other.

## Appendix W

**Study Title:** Developing a Culturally Relevant Version of SBIRT for the Black Community

**Student Investigator:** Helena Danielle Green, MA

Thank you again for participating in this University of Connecticut (UConn) research study. The purpose of this study was to incorporate the voices of the community to examine the cultural relevancy of SBIRT. After examining responses from focus groups and surveys, the following themes (i.e., commonly shared experiences, beliefs, and/or values) were expressed:

**Health educators see substance use as a coping mechanism or symptom to larger problems (i.e., mental health issues, homelessness)**

- Some believe that some patients need to resolve other issues (i.e., meet their hierarchy of needs) before actually acting on the behavioral health options.
- Some also believe that cultural background plays a role because they have noticed that certain groups tend to abuse substance while others tend to abstain. Continued use often relates back to the underlying issue that there is a stigma associated with seeking behavioral health services.

**Some health educators question the accessibility of the behavioral health services, given that patients have repeatedly mentioned their difficulties getting appointments**

- This issue is further complicated, given that some providers feel that patients are not always truthful about the problems related to their substance use.
- Two providers mentioned that the community appears open to seek help for physical problems, but not for behavioral health-related issues.
- One mentioned that the community does not know to ask about other services, so they don't know that they can be connected with some other service in the same visit.

**When substance use questions are asked, health educators feel that patients appear comfortable answering questions (if they sense that the patient trusts them), but patients still question the confidentiality or the need to include substance use questions in the appointments.**

- Some providers feel that their own comfort level is dependent on their personal upbringing and whether biases have developed towards certain groups.
- While some feel that race has nothing to do with it because trust is more important. At least one provider feels that the Black community lacks trust in some providers, which creates a barrier and can prevent them from seeing some providers as a resource.
- Health educators feel more confident regardless of the race of the patient, if the doctor or medical assistant is involved in introducing them to patients because it connects them as a medical team.

**Health educators have other factors that they consider that extend beyond the questions and conversation about substance use.**

- Some providers have strategies that they use (i.e., involving the use of humor to probe for additional responses & providing health-related information that may be new to the patients) to create a rapport with patients from the Black community and ease any beliefs that they are being judged.

- Providers are more likely adjust their approach to the age range of the patients (i.e., being more formal with older adult patients), rather than the race or culture.
- Many providers feel that the factor that is most influential to the dynamics in the appointment is the length of the wait time before a patient gets to them.
- Some providers can see that there are cultural differences in the perceived severity and categorization of different substances, but awareness is key because it may require clarifications.

**Many health educators feel encouraged by collaborations within the medical setting, but they make efforts to assist the patients without over extending.**

- Many providers believe that by offering patients take home materials, additional resources, and an opportunity to return when they are ready encourages personal accountability, and alleviates the likelihood that patients will get defensive if they don't want the help.