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"Bringing people together to serve humanity"

A Highlighted Glimpse into the Opioid Crisis for African American and Latinos: A Community-Focused, Church Imperative for a Culturally-Responsive Approach

> "One day I received a call from an African American male who was in crisis and needed some type of services. I proceeded to ask him about what type of services he needed. He responded, "I am addict and that I was hooked on pain killers." The gentleman continued to tell me that "he was middle-class and that he felt ashamed of his situation." He also shared with me that "he could not tell his wife, his colleagues, or his pastor." I felt really helpless about the gentleman's situation because the phone call came to me during the height of the COVID crisis. The gentleman further shared with me that he "kept going back to my doctor for refills and he never refused to fulfill the prescription. And now, I am in crisis." I had prayer with him and suggested that he take the COVID vaccine and sit in the emergency room until he received services…We never heard back from him." -*Reverend Anthony Evans, NBCI President; 2020 Phone Dialogue*

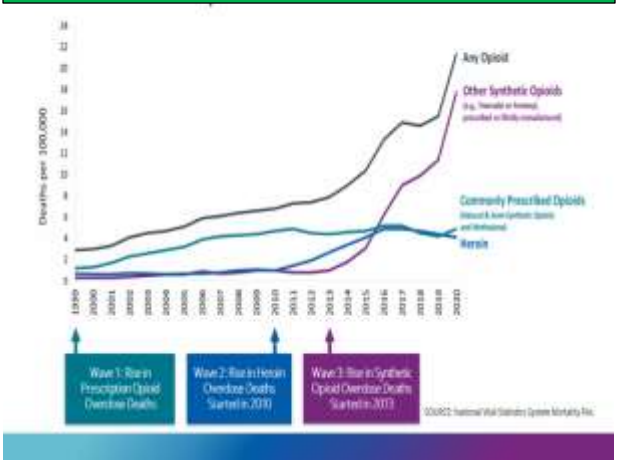
In my leadership role as president of The National Black Church Initiative, a coalition of 150,000 African American and Latino churches working to eradicate racial disparities in healthcare, technology, education, housing, and the environment, I receive all types of phone calls or messages daily from both known and unknown persons across the country who are experiencing some type of crisis. Unlike other calls, what was different about this call in 2020 was not only that it occurred during COVID-19, but through the frantic and desperation tone of his voice, what I recall mainly was the unspoken anticipation and unapologetic expectation he, as an unnamed gentleman to me, had from me, as a named gentlemen to him, to do something about his situation. Out of everyone the unnamed gentleman could have called, even to this day, I have often wondered why did he call me? What about me and/or the work at the National Black Church Initiative made him want to reach out to me?

And, as I further reflect upon the call, I am reminded of how the spoken and unspoken issues for which emerged from the conversation with the unnamed gentleman (i.e. need for help, need for compassion, need for safety, need for alternatives) were ones often missing as part of the public dialogue. I would venture to say that the unnamed gentleman was unaware of the broader persisting challenges African American and Latino communities encounter from opioid addictions, like him, and how those community members who comprise those churches, too, have encountered first-hand dire phenomena of opioid addictions and subsequent crises created. To that end, the unsettling phone call and persisting phenomena generated an urgent need for the National Black Church Initiative to examine the broader context of the opioid crisis in conjunction with governmental, pharmaceutical, and media viewpoints and explore opioid addictions through understanding perspectives, perceptions, and practices within church and community. Such combined insights serve as a community-focused, church imperative to create a culturally-responsive plan to address the opioid crisis for African Americans and Latinos.

Contextualizing the Opioid Crisis and Viewpoints of Governmental, Pharmaceutical, Media, and the Broader Public Arenas

The opioid crisis has impacted the broader American public and the Centers for Disease Control and Prevention (2022) has particularly identified the opioid crisis as occurring within three different waves. Figure 1, as extracted from the Centers for Disease Control and Prevention (2022), has identified those waves as any opioid, other synthetic opioids, and commonly prescribed opioids. What the Center for Disease Control and Prevention (2022)

Figure 1: Three Waves of Opioid Overdose Deaths



indicates in their report, “Three Waves of Opioid Overdose Deaths,” is that the “number of drug overdose deaths increased by nearly 30% from 2019 to 2020 and has quintupled since 1999 and that nearly 75% of the 91,799 drug overdose deaths in 2020 involved an opioid.” The Centers for Disease Control and Prevention (2022) further reports that from 2019 to 2020, “there were significant changes in opioid-involved death rates: 1) Opioid-involved death rates increased by 38%; 2) Prescription opioid-involved death rates increased by 17%; 3) Heroin-involved death rates decreased by 7%; and 4) Synthetic opioid-involved death rates (excluding methadone) increased by 56%.” Such findings show the steady increase of opioid deaths for the American public.

Regarding the origins of the opioid crisis, what has become evident is the commonality of the crisis linkages to the pharmaceutical companies with differences emerging in how those linkages unfolded (CBS News, 2020, U. S. Food and Drug Administration, 2022, American Council on Science and Health, 2018). Following below are highlighted activities across nearly a twenty-year period involving governmental, pharmaceutical, and media arenas. More detailed reports about these activities can be found at the respective websites.

U.S. Food and Drug Administration (2022) (*as extracted directly from the site*)

- 1995. OxyContin (oxycodone controlled-release) approved; first formulation of oxycodone that allowed dosing every 12 hours instead of every 4 to 6 hours.
- Early 2000s. Reports of overdose and death from prescription pain drugs, especially OxyContin, began to rise sharply.
- 2001. OxyContin label was changed to add and strengthen warnings about the drug’s potential for misuse and abuse.
- 2003. FDA issued a Warning Letter External Link Disclaimer (PDF - 149KB) to OxyContin’s manufacturer for misleading advertisements.

- 2009. FDA held several public and stakeholder meetings, including May 27-28 public meeting External Link Disclaimer and December 4 stakeholder meeting External Link Disclaimer, to discuss opioid risks, misuse, and abuse.

- January 2013. On January 9, FDA issued a draft guidance to assist industry in developing new formulations of opioid drugs with abuse-deterrent properties: *Guidance for Industry: Abuse-Deterrent Opioids – Evaluation and Labeling* (PDF - 463KB).

- April 2013: On April 16, FDA took multiple actions related to OxyContin.

- December 2016: On December 16, the FDA approved several safety labeling changes (SLCs) about the serious risks of prescription opioid analgesics and opioids approved for medication assisted treatment (MAT) of opioid addiction including class-wide SLCs for immediate-release (IR) opioid pain medications, SLCs for methadone and buprenorphine products, and class-wide SLCs about the serious risks associated with the combined use of certain opioid medications with benzodiazepines or other central nervous system (CNS) depressants.

- June 2017. On June 8, FDA requested that Endo Pharmaceuticals remove its opioid pain medication, reformulated Opana ER (oxymorphone hydrochloride), from the market based on its concern that the benefits of the drug may no longer outweigh its risks.

- January 2018. On January 11, FDA Commissioner, Scott Gottlieb, M.D., announced the 2018 Strategic Policy Roadmap, which provides an overview of some of the key priorities the agency will pursue advance FDA's public health mission. Part of the Roadmap is reducing misuse and abuse of opioid drugs.

- February 2019. On February 12, FDA announced ongoing efforts to stop the spread of illicit opioids, further secure the U.S. drug supply chain and forcefully confront opioid epidemic.

- March 2019: On March 19, FDA took action against marketer of unapproved products claiming to treat addiction, chronic pain and other serious conditions.

- March 2019: On March 27, FDA announced new steps to strengthen agency's safety requirements aimed at mitigating risks associated with transmucosal immediate-release fentanyl products.

- February 2021**:** On February 16, the FDA issued a warning letter to AcelRx Pharmaceuticals, Inc. for the false and misleading promotion of Dsuvia (sufentanil sublingual tablet), a potent opioid analgesic.

- April 2022: On April 20, FDA published a Federal Register notice seeking public comment on a potential change that would require opioid analgesics used in outpatient

settings to be dispensed with prepaid mail-back envelopes and that pharmacists provide patient education on safe disposal of opioids.

- September 2022: On September 22, the FDA published the immediately-in-effect guidance, Exemption and Exclusion from Certain Requirements of the Drug Supply Chain Security Act (DSCSA) for the Distribution of FDA-Approved Naloxone Products During the Opioid Public Health Emergency, which is intended to clarify the scope of the public health emergency (PHE) exclusion and exemption under the DSCSA as they apply to the distribution of FDA-approved naloxone products to harm reduction programs during the opioid PHE. This guidance supports the FDA Overdose Prevention Framework.

American Council on Science and Health (2018) (*as extracted directly from the site*):

- #1. In 1995, Purdue Pharma received approval for OxyContin, a powerful opioid. Many patients got hooked and began doctor shopping. More importantly, some people began abusing OxyContin, by crushing and injecting it.

- #2. In 2007, Purdue paid a $634-million fine for lying about OxyContin, which they claimed was less addictive than other opioids.

- #3. Prescriptions for opioids tripled between 1991 and 2011. This was probably due to some doctors over-prescribing the drugs, for instance by giving a one-month supply of drugs for a pain issue that might last for only a week. As a result, a lot of opioids flooded the market, and they fell into the wrong hands, such as drug dealers, addicts, and teenagers. In response, the government decided to crack down on opioid prescriptions.

- #4. In 2010, Purdue released an abuse-resistant formulation of OxyContin. If a drug abuser tried to crush it for injection, it would turn into an unusable gummy mess. Simultaneously, doctors became reluctant to give opioids to patients, so prescriptions began to decrease.

- #5. This marked the beginning of the heroin epidemic. Despite all the good intentions in #4, addicts and other recreational drug users -- who could no longer get easy access to OxyContin, Vicodin, or other opioids -- turned to heroin. As a result, *opioid-related deaths have continued to increase.*

- #6. Deaths from prescription opioids alone are rare. The reason so many people, usually recreational drug users, overdose is because they are mixing opioids with other drugs, such as alcohol or benzodiazepines. This is a lethal cocktail. Additionally, heroin is often adulterated with illegal fentanyl, a drug that is 50 times more potent than morphine. (A lethal dose of fentanyl looks like a few grains of table salt.) Fentanyl is largely coming into the country from China via Mexico.

CBS News (2022) (*as extracted directly from the site*):

- The opioid epidemic, which started around 2005 and began to peak around 2010, was created by pharmaceutical executives that hail from companies like Cardinal Health, Cephalon Pharmaceuticals, Insys Therapeutics, McKesson Pharmaceuticals, Mallinckrodt Pharmaceuticals, and Purdue Pharmaceuticals.

- Although it is impossible to pinpoint which human being or company thought of it first, the inspiration behind the opioid crisis was to sell drugs that would soon sell themselves to addicted human beings and bring a lot of income to pharmaceutical companies. No one cared what kind of toll this took on human health.

- First, the drug companies had to sell the idea to their staffs and their distributors, and try to rearrange both their thinking and their characters. "I was taught to forget the patient, to not think about the patient, take the human aspect out of it," former Insys senior vice president of sales Alec Burlakoff told Bill Whitaker of the TV show 60 Minutes. "It's like selling widgets. The less of a conscience you had, the better."

- In January of 2020, a jury found five Insys executives guilty of racketeering and fraud for recklessly and illegally conspiring to boost profits from the opioid painkiller Subsys. While Insys CEO John Kapoor was sentenced to five and a half years in prison, the victims of the opioid epidemic, 19,416 of whom died in the first three months of 2020 alone (CDC and NIDA), have been sentenced to a lifetime of suffering and struggle. The COVID-19 pandemic has made things even worse.

- Between March 2019 and March 2020, approximately 75,500 people overdosed, a 10% increase over the same period between 2018 and 2019.

What becomes evident in the highlighted activities are the pursuit of policy and public buy-in efforts that governmental, pharmaceutical, and media arenas sought to accomplish. Each arena utilized the depth and breadth of its platform to advocate positions unique to constituencies served.

Perspectives Matter on the Church involving African Americans and Latinos and the Opioid Crisis

Perspectives surrounding the role of the church, as a faith-based community, and the broader community surrounding the church are critical, yet somewhat, underutilized components in efforts toward combatting the opioid addiction. Burdette et.al (2018) report that church attendance was connected with the reduction in the risk of illicit drug use and not connected with

prescription drug misuse. Another study indicated that opioid misuse may be considered as more socially acceptable than illicit drug use. Consequently, there might be an underlying belief that there are less legal consequences (Inciardi et.al, 2009; Mui et.al, 2014). A remaining study, as conducted by Ransome et.al (2019) revealed that church attendance was linked to a reduced likelihood of fulfilling any of the criteria for opioid use disorder. All of these studies indicate the influence of the opioids within the faith-based community.

With regards to the opioid crisis, often times individuals experience challenges with mental health given the emotional needs that are a result of addiction. Lukacho, Myer, and Hankerson (2015) highlight how the cultural background of individuals dealing with mental health indicate that "professional mental health care may clash with sociocultural religious norms" (p. 578). Hechanova and Waelde (2017) identify five areas for which mental health professionals need to be concerned: 1) emotional expression; 2) shame; 3) power distance; 4) collectivism; and 5) spirituality and religion. The focus on spirituality and religion particularly highlights how individuals access spirituality and religion in such a manner that is transferable into coping skills of mental health and the challenges therein (i.e. depression, anxiety). More specifically, within the Ellison in the Nashville Stress and Health Study (2017), as it relates to the Black Church, assert the following:

> Church-based social support may be particularly important for African Americans. On average, they tend to exchange instrumental and socioemotional aid informally with fellow church members more often than Whites from comparable backgrounds (Krause 2002, 2008). Several studies report that such congregational support, particularly socioemotional assistance, is linked with health and well-being among African Americans (Chatters et al. 2011, 2015; Ellison, Musick, and Henderson 2008; Head and

> Thompson 2017; Hope et al. 2017), perhaps more so than among Whites (Krause 2003, 2008a). Among African Americans, church-based support often augments and complements – rather than replicates the support that is available from family members and other non-kin ties (Nguyen, Chatters, and Taylor 2016).

The aforementioned perspectives of the Ellison in the Nashville Stress and Health Study (2017) indicate the intricate role of the church within the mental health affairs. African Americans tend to gravitate toward the church as a source of inspiration and comfort to respond to the varying pressures. More specifically, with Latinos, Caplan (2019) reports the following:

> "Among the Hispanic/Latino faith-based communities in this study, mental illness and depression were culturally defined and often perceived to be a spiritual problem rather than a "sickness." This non-biomedical interpretation of illness is consistent with the findings of Breslau et al. (2017), indicating that Hispanics/Latinos (particularly Spanish-speaking individuals) have very low perceived need for mental health services irrespective of severity of illness. The importance of religion and religious coping as a means of treating of depression, as well as *Familismo*, or the necessity of family and community support, illustrate the cultural and religious values of many Latinos in the United States (Dalencour et al., 2017; Moreno, & Cardemil, 2013)."

Findings from Caplan (2019) show how Latinos rely upon churches as a critical reliance of support for social, educational, and spiritual resources. Cultural values among Latinos are identified as a source of strength, but also serves as a contributor as a stigma. Within the faith-based community for Latinos, there is need for mental health literacy and anti-stigma interventions. Understanding what we know from broader and specific trends on mental health,

particularly as it relates to opioid addiction, becomes critically important for contextualizing the role of the religious community to respond in intentional and relevant ways.

Earls (2019) from Lifeway Research reports the implications of the opioid crisis for the church and the impending need for focused outreach. Based upon a phone survey of 1,000 Protestant Pastors, the interviews were conducted with the senior pastor, minister, or priest of the particular church. In the article, "Half of Pastors Say the Opioid Epidemic Has Hit Their Church," offer insightful perspectives about opioid addictions for and within their congregation. Earls (2019) indicate the following:

- Two-thirds of pastors (66%) say a family member of someone in their congregation has been personally affected by opioid abuse.
- More than half (55%) say they or someone in their congregation knows a local neighbor suffering through opioid abuse.
- For half of pastors (52%), someone directly in their church is dealing with an opioid addiction.
- Pastors in the Northeast (11%) are least likely to say they don't have any such personal connections.

Such findings offer perspectives that show how church leadership, particularly with pastors, serve as a direct and indirect conduit to the community of those affected by the opioid crisis.

Thus, what becomes particularly evident through the findings is how the majority of the pastors know of someone who is directly involved with opioid addiction. Knowing someone who is facing the opioid crisis is quite telling since according to the U. S. Department of Health and Human Service's Substance Abuse and Mental Health Services Administration (2020), 11.4 million people in the United States, aged 12 and older, experienced some type of opioid misuse

(i.e. 4.2%). And consequently, according to the article, "Larger churches—those with more resources and more personal connections to the crisis-are most likely to say they offer both spiritual and practical help for those with an opioid addiction." The relational dynamics between those affected and not affected with opioid addictions become an important component when considering how to address the opioid addiction.

What also becomes particularly evident is that pastors who are least likely to know of someone experiencing opioid addiction is geographically located within the northeastern region of the country. Data from the U. S. Department of Health and Human Services' Substance Abuse and Mental Health Administration Report (2022) show the top five states with highest percentage of opioid deaths are Ohio, Florida, New York, Pennsylvania, and New Jersey while the top five states with the highest percentage of opioid death rates are West Virginia, Maryland, New Hampshire, and New Jersey. As indicated, New Hampshire ranks as the fourth state with the highest percentage of opioid death rates and is the only state that is identified as having notable percentages about death and death rates for opioid related incidents. To that end, more deliberate and geographically-situated responses are needed to address the opioid crisis.

Earls (2019) further provides perspectives that show next steps for how churches might address those who are dealing with opioid addiction. The article, "Half of Pastors Say the Opioid Epidemic Has Hit Their Church," again, asserts the following:

> "Gallaty said one simple way churches can address the problem is by 'educating our people of the dangers of addition by talking about it publicly and preaching sermons about the topic. Pastors shouldn't shy away from it. As people with addictions come to the attention of the church, however, Gallaty said congregations and leaders must be ready. When people come to our churches as hospitals for healing, pastors should have a

> game plan to help them,' he said." We can stick our heads in the sand and hope the issue dissolves or we can recognize the need and take steps to come alongside those struggling."

The role of church and community leadership is critical toward ensuring those affected by the opioid epidemic are responded to in an impactful way. Leaders must be strategic in their approach, yet courage is required by those persons in positions of access and opportunity to advocate meaningfully for these vulnerable populations.

Notwithstanding, the article by Becker (2017), "*Churches Step Up To Help With Opioid Epidemic, But Spirituality's Role In Treatment Is Controversial*," shows how the demonstration of spirituality to be a reflection of principles of outreach and connection. Rev. Janice Ford, one of the article respondents who serves as an episcopal pastor, states the following:

> We're not looking to convert folks. That's not what this is about. Ford said. When you provide spiritual care, you're trying to find, where is God in their addiction? Where is God in their life? That's lived spirituality means. Lived spirituality, Ford tells the group, could mean many things such as providing informational resources at the church about addiction and treatment or connecting congregants with others. Mostly, she says, it's letting people know that the church might be able to help.

Lived spirituality shows the importance of putting into practice the beliefs that are held as well as the recognition of an unfolding, individual journey of life. Being able to offer information or experiences that speak to the life phases of those involved becomes a critical component of what is needed to ensure needs are fulfilled. In this case, with opioid crisis, how to ensure both conventional or convenient needs (i.e., physical resources) and non-conventional or inconvenient

needs (i.e., emotional and mental support) are being addressed of individuals and their respective families is important and extended responsibility of the church.

To that end, the members of the church and broader community have to reckon with the following (Lance Dodes in Becker, 2017):

> What does spirituality or morality or a good feeling toward others have to do with addiction? Zero. Addiction isn't about that. Addiction is a psychological symptom to help you get through feelings of being overwhelmed.

Such question, as posed by Lance Dodes in Becker (2017), demonstrates the need to ensure addiction is being addressed within the context of what it is and what it is not. For example, the opioid crisis and the emerging addiction may be viewed to some within faith-based as a result of sin. And while that might be part of a broader theological debate, the question put forth by Lance Dodes in Becker (2017) situates addiction in a particular place of being a 'psychological symptom' and encourages others to focus on addiction within that manner. Such approach prioritizes directly what is important in the opioid crisis.

Lastly, Mike Clark in Becker (2017) highlights how addiction requires honesty on both parts of those who are addicted and those who are trying to serve the addicted. To the extent that type of honesty is accomplished is the extent to which the help provided is success. The article indicates the following:

> In my experience, there are as many active alcoholics and addicts upstairs in churches as there are recovering alcoholics and addicts downstairs," Clark said. "But the ability to be honest about and seek help unfortunately is a challenge for most people. So we've approached it here as not only trying to offer support to folks in the congregation, but

> also trying to find some appropriate ways for two very separate communities, historically, to say, actually, we might have some things in common."

The level of interest, participation, and engagement required by both communities (i.e. those who are addicted, those who are trying to serve the addicted), again, is critical to cultivate success. Being able to establish commonality between those communities allows for transparency to be assumed and aligning motivations to be achieved. Consequently, what gets known about the perspectives of church matters and the opioid crisis involve a need to be responsive to an expanded view of mental health and spirituality as a community-focused endeavor.

More specifically, Christensen, Berkley-Patton, and Bauer (2020) examines how the population of African Americans, as predominant church goers, are influenced by the opioid crisis. The study focused on understanding factors related to opioid use among midwestern church-affiliated African Americans to inform what future faith-based interventions might be. Christensen, Berkley-Patton, and Bauer (2020) assert the following:

> African Americans in the Midwest are more likely to die from an opioid overdose compared to Whites, despite lower rates of use…African Americans have the highest rate of church attendance among all racial/ethnic groups and the black church may be an appropriate setting for prevention efforts…Participants were predominantly female (71%) and church members (74%) with an average age of 47…The Black Church is a highly influential, trusted institution in African American communities that could play an important role in responding to this call. Also, African Americans have the highest rate of church attendance among all racial/ethnic groups, with greatest attendance in the Midwest and South (Pew Research Center, 2014).

The study highlighted the particular influence of the church on the African American community. Within this study, African American women were a significant part of the study. The work of Christensen, Berkley-Patton, and Bauer (2020) resulted in the following findings:

- 53% of the participants had prescription opioid use at some point in their lifetime;
- Opioid use was higher in this sample than the general population which is surprising given that African Americans are less likely to be prescribed prescription opioids than white counterparts (Santoro & Santora, 2018). This may be due to medical indications, such as increased sensitivity to pain among African Americans (Ostrom et. al, 2017) and well-established disparities in cancer incidence (Singh & Jemal, 2017). Opioid prescribing rates are also typically higher in middle-aged/older adults and females (Center for Disease Control, 2019a), a population that is typically highly concentrated in African American churches (Bauer, Berkley-Patton, Bowe Thompson, & Christensen, 2018; Christensen et al, 2020).
- Given the possible high overlap amongst substances among church-affiliated African Americans, interventions may benefit from educating African Americans on substance use generally, discussing healthy coping strategies, and providing community referrals when appropriate.
- Discussion of coping strategies may be particularly salient given that African Americans are less likely to see mental health care than Whites (Cook et al, 2014) and misuse of substances may be means of coping with emotional distress and racial stressors (Gerrard et al, 2012; Pittman, Brooks, Kaur, & Obasi, 2019).

Consequently, the work of Christensen, Berkley-Patton, and Bauer (2020) suggests the importance of focusing on holistic approaches to opioid additions and addictive behaviors. The

physical, emotional, mental, and spiritual needs of the person who is being treated for addictions and addictive behaviors cannot utilize a cookie cutter or one-size fits all approach, but instead, a more intentional and specialized approach is needed for those involved. Christensen, Berkley-Patton, and Bauer (2020), additionally, indicates the need to have more African Americans educated on the type of opioids that have higher incidences of addition. Having the appropriate knowledge and information can provide the necessary insight toward identifying the prescriptions that are least addictive in accordance with body disposition.

The article, "A collaborative culturally-centered and community-driven faith-based opioid recover initiative: The Imani Breakthough Project," as authored by Bellamy et. al (2021), offers practical, solutions-oriented approaches for African Americans and Latinos dealing with opioid addictions. The church is considered as an influential force within African American and Latino communities and thereby becomes a place of refuge for any of their needs that may or may not be spiritual. Bellamy et. al (2021) asserts the following:

> "…religion and spirituality play important roles in the lives of Black and Latinx people, and the church exists as a prominent fixture in both communities, historically serving those in need (Blank, Mahmood, Fox, & Guterbock, 2002; Taylor, Ellison, Chatters, Levin, & Lincoln, 2000). In a national survey of religious beliefs and practices, a higher proportion for Black and Latinx people indicated attended weekly religious services and an absolute belief in God, when compared to White people (Oxhandler, Edward, & Achenbaum, 2018; Pew Research Center 2014). Given the high cultural importance of religion and spirituality, Blacks and Latinx individuals may perceive their mental illness or addiction a as problem in need of a spiritual solution, reinforcing the help seeking behavioral pattern of engaging with clergy or attending church services instead of (or in

addition to) exploring formal treatment options (Ayalon & Young, 2005). Continued education and outreach to faith-based institutions may provide a viable path to improve access to substance use treatment for these historically excluded populations" (p. 560). Bellamy et. al (2021) pinpoint the various roles for which the church has historically assumed. While the church appears to more likely link addiction to something that is not being fulfilled spiritually, the church still maintains a disposition of having an open-armed approach to addressing the needs of those it serves. Bellamy et. al (2021) also pinpoint the level of church engagement for which African Americans and Latinos have within the church. Being able to engagement in the church in this capacity shows a clear understanding of the meaning the church assumes within their respective lives. The church is fundamental to the lives and livelihoods of these two communities.

Moreover, when considering the practical, solutions-oriented approach put forth by Bellamy et. al (2021), what becomes evident is how the Imani program responded to the presence of opioid addiction as requiring a broader approach to addressing their needs. Bellamy et. al (2021) state the following:

> The findings showed many aspects of how the program helped participants improve their lives such as building goals, being recognized as productive and valued members of society, connecting with others, and having a positive relationship with their loved ones and their community. Eight main themes emerged from these focus groups. They reflect the collective view of participants such as: Empowerment and decision making; relationships and self-reflective; autonomy and freedom; spirituality and belief; choice and trust; and options and engagement. The voices and perspectives of participants reflected the thoughts shared by the facilitators about their perceptions of the program.

The emerging eight themes show the interdependence of internal and external components required for the successful identification and implementation of a programmatic approach to opioid addiction. For example, empowerment contributes to the types of choices and decision that get or does not get made and, consequently, without empowerment, the quality choices and decisions are minimized. Quality relationships, too, are a critical component because quality relationships cultivate healthy engagement and, consequently, without relationship, the level of options and trust get compromised. Being able to implement programmatic endeavors for opioid addictions that are interdependent provides more sustainable, long-term approaches.

Perceptions Matter in the Demographic Intersections of Race, Age, Money, and Location

Perceptions matter for those involved in the opioid crisis as they are often viewed through the lens of who they are, what they do, and where they are from. Ascunce (2020) offers a unique perspective about how opioid crisis gets problematized or not, humanized or not, and under what circumstances either as a problem or as a human condition within the broader society. The manner in which the opioid addiction is problematized or humanized becomes based upon racialized, genderized, and economicalized perspectives. Ascunce (2020) asserts the following:

> For decades, the opioid crisis has made the headlines of U.S. news. Yet whether it was in its first wave or in its most recent one, there has always been a common factor in the opioid crisis in America: its portrayal as solely a white problem. Regardless of data to the contrary, testimonials, op-eds, and academic research continue to depict the crisis as one-sided, portraying how hardworking white men and women have "fallen" into addiction.

The characterization of opioid addiction as inclusive of individuals who have fallen into addiction appears to abdicate any level of personal responsibility, systemic practices, bias consciousness, and/or related inequitable or unequal treatment for persons of a certain race and

gender. The characterization of opioid addition as indicative of individuals who are hardworking appears to suggest only persons who are not perceived as hardworking are the ones who fall into addition and not those who are in positions of privilege, power, and prestige. The characterization of opioid addiction as commonly considered as a 'white problem' diminishes the harsh reality and shared human experiences of the opioid addition of those individuals and their respective families. Thus, consideration of the multi-dimensional roles of race, gender, and class as influencing perceptions of those involved in the opioid crisis is unfortunate given the widespread impact caused.

What becomes evident is the need to view the opioid crisis and the experiences of individuals and families within and across different groups. Such culturally-relevant approach offers the opportunity for considering the broader and subsequent implications of this dreadful occurrence. To that end, broader and subsequent implications of the opioid crisis involve matters beyond the addiction itself and redirects focus on how perceptions of those within the crisis receive attention. Ascunce (2020) further asserts:

> The humanity afforded to the opioid-dependent white person stands in stark contrast to the disproportionate incarceration of and lack of treatment available to Black and Latinx people with the same substance use disorder. Latinx people, in particular, encounter obstacles — implicit biases, language barriers, and immigration statuses, for example — that bar them from seeking and receiving proper treatment to counter their opioid addiction. As a result, between 2014 and 2017, the number of opioid deaths per year nearly doubled for Latinx people. With poverty rates at 19 percent in 2018, over double that of whites, the Latinx community is also more prone to being underinsured or uninsured. Despite all the statistics revealing this population's vulnerability, the Latinx

voice in the opioid crisis has not been heard. If the opioid crisis in America is to be addressed, it must include all communities affected and adjust to these communities' respective needs.

The racialized, genderized, and economicalized viewpoints of the opioid crisis do not have to be addressed from a culturally-deficit position. Viewing the opioid crisis in this manner relegates the issue to something less than what it is intended to be. And while there are shared experiences irrespective of who is involved as part of the opioid crisis, there is a need to recognize how individuals and their respective families experience the opioid in a culturally-different manner. Thus, by looking at the opioid crisis in a culturally-different manner and not a culturally-deficit manner, the integrity and dignity for those involved is maintained through the perceptions that are held as either real or imagined. At minimum, those who are addicted deserve this type of response.

Table 1. Number and age-adjusted rates[a] of drug overdose deaths[b] involving selected drugs by race/ethnicity—United States, 2017

	Drug overdose deaths,[b] overall		Drug overdose deaths involving: Any opioid[c]		Natural and semi-synthetic opioids[d]		Synthetic opioids other than methadone[e]		Prescription opioids[f]		Heroin[g]	
Race/Ethnicity	Deaths	Rate	Deaths	Rate	Deaths	Rate	Deaths	Rate	Deaths	Rate	Deaths	Rate
Total	70,237	21.7	47,600	14.9	14,495	4.4	28,466	9.0	17,029	5.2	15,482	4.9
non-Hispanic White	53,516	27.5	37,113	19.4	11,921	5.9	21,956	11.9	13,000	6.9	11,293	6.1
non-Hispanic Black	8,852	20.6	5,515	12.9	1,247	2.9	3,832	9.0	1,508	3.5	2,140	4.9
non-Hispanic Asian/Pacific Islander	756	3.5	388	1.6	117	0.5	189	0.8	130	0.6	119	0.5
non-Hispanic American Indian/Alaska Native	672	25.7	408	15.7	147	5.7	171	6.5	187	7.2	136	5.2
Hispanic	5,988	10.6	3,932	6.8	996	1.8	2,152	3.7	1,211	2.1	1,668	2.9

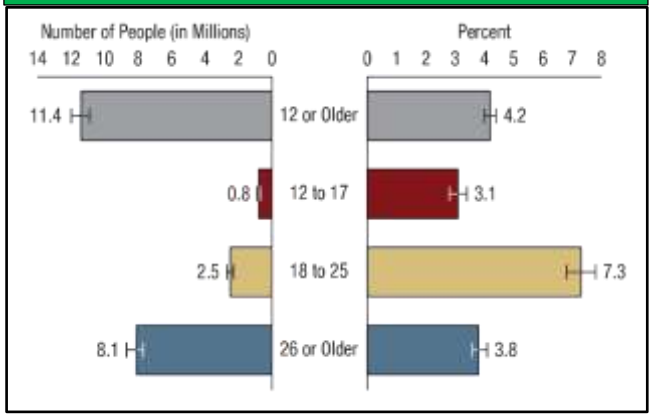
Source: National Vital Statistics System, Mortality File.
[a]Rate per 100,000 population age-adjusted to the 2000 U.S. standard population using the vintage year population of the data year. Rates are suppressed where based on <20 deaths.
[b]Deaths are classified using the International Classification of Diseases, Tenth Revision (ICD–10). Drug overdose deaths are identified using underlying cause-of-death codes X40-X44 (unintentional), X60-X64 (suicide), X85 (homicide), and Y10-Y14 (undetermined). Because deaths might involve more than one drug, some deaths are included in more than one category. On death certificates, the specificity of drugs involved with deaths varies over time. In 2015, approximately 15% of drug overdose deaths did not include information on the specific type of drug(s) involved.
[c]Drug overdose deaths, as defined using ICD-10 codes, that involve opium (T40.0), heroin (T40.1), natural and semi-synthetic opioids (T40.2), methadone (T40.3), synthetic opioids other than methadone (T40.4) and other and unspecified narcotics (T40.6).
[d]Drug overdose deaths, as defined, that involve natural and semi-synthetic opioids (T40.2).
[e]Drug overdose deaths, as defined, that involve synthetic opioids other than methadone (T40.4).
[f]Drug overdose deaths, as defined, that involve natural and semi-synthetic opioids (T40.2) and methadone (T40.3).
[g]Drug overdose deaths, as defined, that involve heroin (T40.1).

As extracted from the *Opioid Crisis and the Black/African American Population: An Urgent Issue*, as published in 2020 by the U.S. Department of Health and Human Services' Substance Abuse and Mental Health Services Administration Office of Behavioral Health Equity, Table 1 highlights important findings about the drug overdose deaths and death rates. Such findings are inclusive of racial and ethnic groups as well as age adjusted rates which indicates the rates would have existed if the population under study had the same age distribution as the standard population. Of the various racial/ethnic groups,

Table 1 indicates Blacks/African Americans as having 8,832 deaths which was the second highest among other reported racial/ethnic groups. With regards to any type of opioid, Table 1 also shows Blacks/African Americans as having 5,513 deaths which, too, ranked as the second highest among other reported racial/ethnic groups. The remaining figures in Table 1 further depicts the deaths of Blacks/African Americans from specific types of opioid drugs (i.e. natural and semi-synthetic opioids, synthetic opioids, prescription opioid, heroine). When compared to non-Hispanic Whites, the largest racial group within our country, Blacks/African American lead in overall opioid deaths and death rates with Hispanics following closely behind.

When focusing on the age grouping within the context of the broader population, Figure 2, as extracted from the 2017 Substance Abuse and Mental Health Administration, 11.4 million people in the United States, aged 12 and older, experienced some type of opioid misuse (i.e. 4.2%). Figure 1 highlights how the percentage of usage of those between the ages of 12 to 17 is slightly behind those between the ages of 26 or older. Figure 1 shows how those between the ages 18 to 25 is almost double each of those within the age groups of 12 to 17 and 26 or older. Thus, while the type of drug use or misuse might have varied, those who are within the age group of 18 to 25 are experiencing drug misuse or use more prevalently than others within the identified age categories.

Figure 2: Past Year Opioid Misuse Among People Aged 12 or older: 2017



More specifically, when considering the data from the Substance Abuse and Mental Health Services Administration Report (2020), *The Opioid Crisis and the Black/African American Population: An Urgent Issue*, as based upon using two indicators of measurements, death rate and absolute number, made compelling cases about the areas in which opioid overdoses and subsequent deaths are occurring. Table 2, as extracted from the U. S. Department of Health and Human Services' Substance Abuse and Mental Health Services Administration Report (2020) and age-adjusted per 100,000, shows West Virginia and Delaware as the top two states with the highest percentage of opioid overdose death rates and, for non-Hispanic Black, West Virginia, Washington, DC, Missouri, Maryland, and Illinois had the second, third, fourth, and fifth highest percentage of opioid-related overdose death rates. With that said, the death rates of non-Hispanic Blacks were disproportionately higher compared to the general populations within all 50 states. Additionally, what Table 2 shows is that West Virginia and Maryland appear in both percentage groups for the general population among non-Hispanic Blacks for percentages of opioid-related overdose death rates.

Table 2. Opioid Overdose Death Rates (age-adjusted per 100,000), Top 5 States and District of Columbia, by Total and non-Hispanic Black Populations, 2018

	Total			non-Hispanic Black	
1.	WV	42.4	1.	WV	58.2
2.	DE	39.3	2.	DC	47.7
3.	MD	33.7	3.	MO	40.5
4.	NH	33.1	4.	MD	34.3
5.	NJ	29.7	5.	IL	31.3

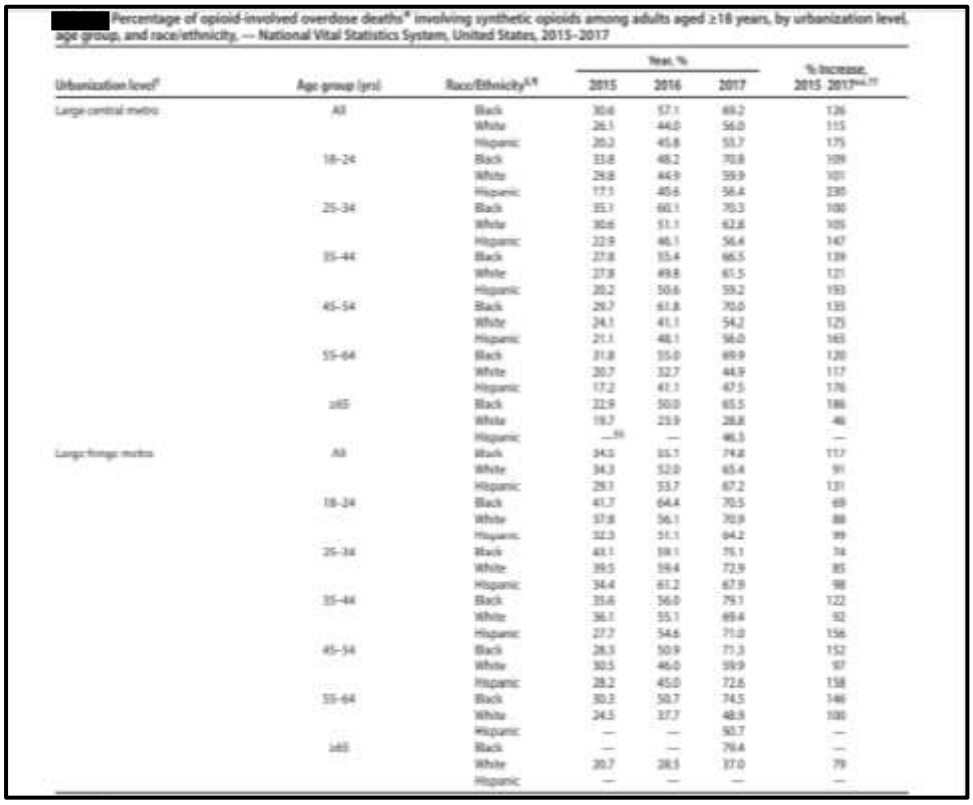
Table 3, as extracted from the U. S. Department of Health and Human Services' Substance Abuse and Mental Health Services Administration Report (2020) as based upon 2018 data, Ohio, Florida, New York, Pennsylvania, and New Jersey had the highest,

Table 3. Number of Opioid Overdose Deaths, Top 5 States, by Total and non-Hispanic Black Populations, 2018

	Total			non-Hispanic Black	
1.	OH	3237	1.	MD	709
2.	FL	3189	2.	IL	598
3.	NY	2991	3.	NJ	459
4.	PA	2866	4.	MI	426
5.	NJ	2583	5.	OH	402

second highest, third highest, fourth highest, and fifth highest number of opioid overdose deaths. With regards to non-Hispanic Blacks, Maryland, Illinois, New Jersey, Michigan, and Ohio had the first, second, third, fourth, and fifth highest number of opioid overdose deaths. When considering both sets of data within Table 3, what becomes interesting is how Ohio and New Jersey ranks the highest when considering the general population and the non-Hispanic Black populations regarding the number of opioid overdose deaths. Irrespective of whether it is the number of deaths or the percentage of death rates for both the general population and non-Hispanic Black populations, the impact of opioid addiction is disproportionately occurring within the states of Ohio, New Jersey, West Virginia, and Maryland.

Table 4 provides a summative view of the percentage of opioid deaths within the country. Table 4, formerly Table 2 as extracted from Morbidity and Mortality Weekly Report, as published by Lipphold et. al. (2019) of the U. S. Department of Health and Human Services, Centers for Disease Control and Prevention, the following results have been provided:



[redacted] Percentage of opioid-involved overdose deaths* involving synthetic opioids among adults aged ≥18 years, by urbanization level, age group, and race/ethnicity — National Vital Statistics System, United States, 2015–2017

Urbanization level†	Age group (yrs)	Race/Ethnicity§,¶	Year, %			% Increase, 2015–2017**,††
			2015	2016	2017	
Large central metro	All	Black	30.6	57.1	69.2	126
		White	26.1	44.0	56.0	115
		Hispanic	20.2	45.8	53.7	175
	18–24	Black	33.8	48.2	70.8	109
		White	29.8	44.9	59.9	101
		Hispanic	17.1	40.6	56.4	230
	25–34	Black	35.1	60.1	70.3	100
		White	30.6	51.1	62.8	105
		Hispanic	22.9	46.1	56.4	147
	35–44	Black	27.8	55.4	66.5	139
		White	27.8	49.8	61.5	121
		Hispanic	20.2	50.6	59.2	193
	45–54	Black	29.7	61.8	70.0	135
		White	24.1	41.1	54.2	125
		Hispanic	21.1	48.1	56.0	165
	55–64	Black	31.8	55.0	69.9	120
		White	20.7	32.7	44.9	117
		Hispanic	17.2	41.1	47.5	176
	≥65	Black	22.9	50.0	65.5	186
		White	19.7	25.9	28.8	46
		Hispanic	—§§	—	46.3	—
Large fringe metro	All	Black	34.5	65.1	74.8	117
		White	34.3	52.0	65.4	91
		Hispanic	29.1	53.7	67.2	131
	18–24	Black	41.7	64.4	70.5	69
		White	37.8	56.1	70.9	88
		Hispanic	32.3	51.1	64.2	99
	25–34	Black	43.1	69.1	75.1	74
		White	39.5	59.4	72.9	85
		Hispanic	34.4	61.2	67.9	98
	35–44	Black	35.6	56.0	79.1	122
		White	36.1	55.1	69.4	92
		Hispanic	27.7	54.6	71.0	156
	45–54	Black	28.3	50.9	71.3	152
		White	30.5	46.0	59.9	97
		Hispanic	28.2	45.0	72.6	158
	55–64	Black	30.3	50.7	74.5	146
		White	24.5	37.7	48.9	100
		Hispanic	—	—	50.7	—
	≥65	Black	—	—	78.4	—
		White	20.7	28.5	37.0	79
		Hispanic	—	—	—	—

[redacted] (Continued) Percentage of opioid-involved overdose deaths* involving synthetic opioids among adults aged ≥18 years, by urbanization level, age group, and race/ethnicity. — National Vital Statistics System, United States, 2015–2017

Urbanization level†	Age group (yrs)	Race/Ethnicity§,¶	Year, % 2015	2016	2017	% Increase, 2015–2017**,††
Medium and small metro	All	Black	36.0	49.9	67.4	87
		White	29.0	42.3	57.8	100
		Hispanic	17.9	36.9	47.9	168
	18–24	Black	38.3	47.4	65.1	12
		White	34.3	45.9	66.0	92
		Hispanic	25.6	36.4	53.2	108
	25–34	Black	35.1	54.1	76.2	117
		White	34.0	49.1	66.3	95
		Hispanic	16.8	35.2	53.4	217
	35–44	Black	37.7	51.8	69.7	85
		White	31.0	46.6	62.8	102
		Hispanic	20.1	44.6	51.1	154
	45–34	Black	34.5	50.6	68.0	97
		White	26.1	38.9	53.6	106
		Hispanic	18.2	34.3	43.7	140
	55–64	Black	30.3	47.1	58.8	94
		White	21.6	28.0	43.0	99
		Hispanic	—	31.2	32.3	—
	≥65	Black	—	—	46.9	—
		White	17.2	23.4	22.2	29
		Hispanic	—	—	—	—

* Deaths were classified using the International Classification of Diseases, Tenth Revision (ICD-10). Opioid-involved overdose deaths were identified using underlying cause-of-death codes X40–44, X60–64, X85, and Y10–14. Among deaths with overdose as the underlying cause, the type of drug involved in the overdose death was indicated by the following ICD-10 multiple cause-of-death codes: any opioid (T40.0, T40.1, T40.2, T40.3, T40.4, or T40.6) and synthetic opioids other than methadone (T40.4). Totals for deaths by category might involve more than one drug other than synthetic opioids. The percentage of opioid-involved overdose deaths involving synthetic opioids was calculated by dividing the number of opioid-involved overdose deaths involving synthetic opioids by the number of opioid-involved overdose deaths, then multiplying by 100.

† Based on the 2013 urbanization classification (https://www.cdc.gov/nchs/data_access/urban_rural.htm). Large central metro: counties in metropolitan statistical areas (MSAs) of ≥1 million population that 1) contain the entire population of the largest principal city of the MSA, or 2) have their entire population contained in the largest principal city of the MSA, or 3) contain at least 250,000 inhabitants of any principal city of the MSA. Large fringe metro: counties in the MSAs of ≥1 million population that did not qualify as large central metro counties. Medium metro: counties in MSAs of populations of 250,000–999,999. Small metro: counties in MSAs of populations <250,000. Because of low numbers of deaths and rate suppression for key populations, micropolitan areas (nonmetropolitan counties) and noncore areas (counties that did not qualify as micropolitan) were not included in this analysis.

§ Blacks and whites were non-Hispanic; Hispanics could be of any race.

¶ Data for Hispanic origin should be interpreted with caution; studies comparing Hispanic origin on death certificates and on census surveys have indicated that reporting on Hispanic ethnicity is inconsistent. https://www.cdc.gov/nchs/data/series/sr_02/sr02_172.pdf.

** Percentage increase in opioid-involved overdose deaths involving synthetic opioids was calculated by subtracting the percentage of deaths that involved synthetic opioids in 2017 from the percentage of deaths involving synthetic opioids in 2015, dividing this value by the percentage of deaths involving synthetic opioids in 2015, and then multiplying by 100.

†† Total percent changes were rounded to the nearest whole number.

§§ Dashes indicate that percent change in synthetic opioid involvement in opioid-involved overdose deaths could not be calculated because of unreliable rates or suppression.

Liphold (2019) shows that within the large central metropolitan urban areas, large fringe areas, and medium and small areas from 2015-2017, Hispanics received an overall 175% increase in opioid deaths (large central metropolitan area), 131% increase synthetic opioid deaths (large fringe areas), and 168% increase in synthetic opioid deaths (medium and small areas). The highest percentage increases occurring from 2015-2016 in each of the locational areas within the age group between 18-24.

Practices Matter for Public Relations and Diverse Communities of the Opioid Crisis

Practices matter with regards to how the opioid crisis originated and how it is influencing diverse communities within the broader society. Ascunce (2021), in her report in the *Harvard Political Review*, highlights how the adverse impact of opioid within the Latino communities has not received the level of attention needed to combat the wide-spread impact. As a matter of

public relations, Ascunce (2021) argues that the manner in which the opioid crisis is addressed within communities of color is quite different than communities who do not demographically reflect them. Ascunce (2021) assert the following:

> "This racially-charged dichotomy continues today: while people of color are met with declarations of war, white people are met with declarations of public health emergencies. For example, while members of the Latinx community only represent 17 percent of the U.S. population, 50 percent of federal drug cases are brought against people in this demographic group. Furthermore, from the beginnings of the War on Drugs in 1974 to 2001, the chances of a Hispanic male being incarcerated in his lifetime skyrocketed from 4.0 percent to 17.2 percent. In contrast, in 2019, Health and Human Services announced $1.8 billion in funding to combat the current opioid epidemic by increasing focus on treatment. As this epidemic largely affected white communities, the objective was to treat, not to incarcerate. This would once again cement the government and healthcare system as unjustly skewed toward the needs of white people."

Such perspectives indicate the level of discrimination exercised against socially underserved and financially underprivileged communities faced with opioid additions. Implications of public relations often paints a picture for selected communities that might not be favorable for how they are viewed within the disease of addiction. Clearly, internal challenges associated with opioid additions are difficult (i.e. family dynamics, self-esteem, professional mobility), the external challenges of how opioid additions get treated according to who is and who is not addicted is even more challenging given the subjective nature of the positions taken.

The U. S. Department of Health and Human Services' Substance and Mental Health Services Administration Report (2020), *The opioid crisis and the Black/African American*

population: An urgent issue, have identified five key best practice that can be used to address opioid misuse (pp. 10-18):

1) Implement a comprehensive, holistic approach—"Addition is beyond the neuroreceptor level."
2) Involve the community and develop multi-sectoral, diverse community partnerships—"Community-based organizations are the engines managing crises before they get to the hospital."
3) Increase culturally relevant public awareness—"Campaigns are White-washed and make no sense in Black communities."
4) Employ culturally specific engagement strategies—The opposite of addiction is not abstinence, it's connection.
5) Create culturally relevant and diverse workforce—"[We] have trained Black peers, but not a Black supervisor."

Different best practices that can be used, as identified above, show the need to address addiction from the inside out. How the administrative and program leadership are trained or prepared to address opioid issue is critical and needs to be done in a strategic manner. How the community is trained or prepared to address the needs of this population has to be done in a culturally-responsive or culturally-relevant manner.

Additionally, it important to note that practices of opioid use and substance abuse occurs within urban minority communities, according to Local Youth Risk Behavioral Surveillance System of the Centers for Disease Prevention and Control (2014). The most frequently reported drivers of opioid and other drug use included living in resource poor, unstable homes and neighborhood environments and experiencing and witnessing adverse events (e.g., abuse, assault,

violence) (Linton et al., 2021). These circumstances were characterized as causing mood and anxiety disorders, that when left untreated, caused youth to self-medicate with opioids and other drugs (Linton et al., 2021). Psychosocial theorists argue that young people who are bullied experience depression, low self-esteem, or anxiety and may consequently turn to drug use as a way of coping with victimization (Powers et.al, 1996). Such victimization approach shows the self-imposed ways that practices among young people, particularly black youth, utilize drugs to address their internal and often hidden needs.

According to USA Today, in the article reported by Emerling (2018), "The Opioid Epidemic Hit Black America the Hardest Last Year," recent report, by the Centers for Disease Control and Prevention, shows that African Americans experienced the largest surge in opioid overdose deaths among any racial and ethnic group from 2016 to 2020. The article report that 5,513 blacks died of overdoses involving opioids in 2017 – up 26 percent from 4,374 in 2016 – and the rate of such deaths adjusted for age increased by more than 25 percent. While the number of opioid-involved overdose deaths among whites was far greater at 37,113 in 2017, it represented only an 11 percent increase in both total deaths and death rate over 2016. Emerling (2018) further highlighted these key findings about the epidemic and the practices therein:

- Through 2017, the drug overdose epidemic continues to worsen and evolve, and the involvement of many types of drugs (e.g., opioids, cocaine, and methamphetamine) underscores the urgency to obtain more timely and local data to inform public health and public safety action," the report states.
- Among states assessed, West Virginia had the highest death rate tied to synthetic opioids, at 37.4 per 100,000, while Arizona saw the largest rate increase in that category at 122 percent.

- "Deaths involving (illicitly manufactured fentanyl) have been seen primarily east of the Mississippi River," the report says. "However, recent increases occurred in eight states west of the Mississippi River, including Arizona, California, Colorado, Minnesota, Missouri, Oregon, Texas, and Washington."
- Overall in 2017, the U.S. saw 70,237 drug overdose deaths – up from 63,632 in 2016 – with opioids involved in 47,600 of those fatalities.

What becomes very telling about the report is the number of opioid-related deaths involved particular types of drugs. Such findings are critically important about having certain types of programs that might be geared toward particular communities.

When considering practices involving research, the existing research on barriers to addressing adolescent opioid use and abuse emphasizes: (1) socioeconomic and environmental factors (Ford & Rigg, 2015; Hudgins et al., 2019; Lankenau et al., 2012; McCabe et al., 2013), (2) limited access to medications for opioid use disorder, naloxone for overdose reversal, and behavioral health services, and (3) inability to receive care in the earlier stages of use (Carson, 2019; Wilson et al., 2018; Yedinak et al., 2016). Structural barriers to behavioral health and social services highlighted the dearth of youth-centered services at every stage of care (i.e., prevention, treatment, and recovery (Linton et al.,2021).

Stakeholders also described practices, as unique to institutional barriers to service delivery, to include lack of youth-centered approaches, one-size-fits-all programming, zero-tolerance policies in multiple service settings (e.g., mental health treatment, juvenile system), and lack of integrated mental health and drug treatment (Linton et al., 2021). Such practices particularly focused on youth and family-level barriers that may or may not include cognitive development, perceived invincibility, and lack of knowledge about opioids that hinder drug

treatment and harm reduction efforts. In fact, researchers found that Black teens were 85% less likely to be prescribed Naloxone treatment after an overdose than white teens (Alinsky et al., 2020). Such racial disparity exists among Black adults as well, who are also significantly less likely to be prescribed this medication (Noakrawczyk et al., 2020).

Other practices, as unique to behavioral health professionals, described one wave of research as tailoring services to the needs and interests of youth and their families, delivering services in an informal way, and integrating substance-use education into curricula or programs as not being focused on health (Linton et al., 2021). Stakeholders also noted efforts to reduce organizational and structural barriers by establishing flexible hours of operation, providing transportation, delivering medications to youth (e.g., extended-release injectable naltrexone), and integrating mental health and substance use services, helping youth and their families acknowledge and address stigma, empowering youth through self-guided action planning, educating youth on the impacts of trauma on cognitive development and behavior, and explicitly preparing youth for the challenges associated with recovery (Linton et al., 2021). A second wave of research focused on culturally tailored strategies. Culturally competent interventions are needed to target populations at risk. These interventions include increasing awareness about synthetic opioids in the drug supply and expanding evidence-based interventions, such as naloxone distribution and medication-assisted treatment (Linton et al, 2021).

Community-Focused, Culturally-Responsive Plan for the National Black Church Initiative to Address the Opioid Crisis for African Americans and Latinos

The depth and breadth of the insights gained from perspectives, perceptions, and practices involving African Americans and Latinos unique to the opioid crisis has generated a unique opportunity for the National Black Church Initiative to offer a community-focused,

culturally responsive plan. The National Black Church Initiative is thereby poised to propose a community-focused, culturally-responsive program inclusive of a goal and objectives with relevant, rigorous, and results oriented (R^3) endeavors to address the opioid crisis for African Americans and Latinos.

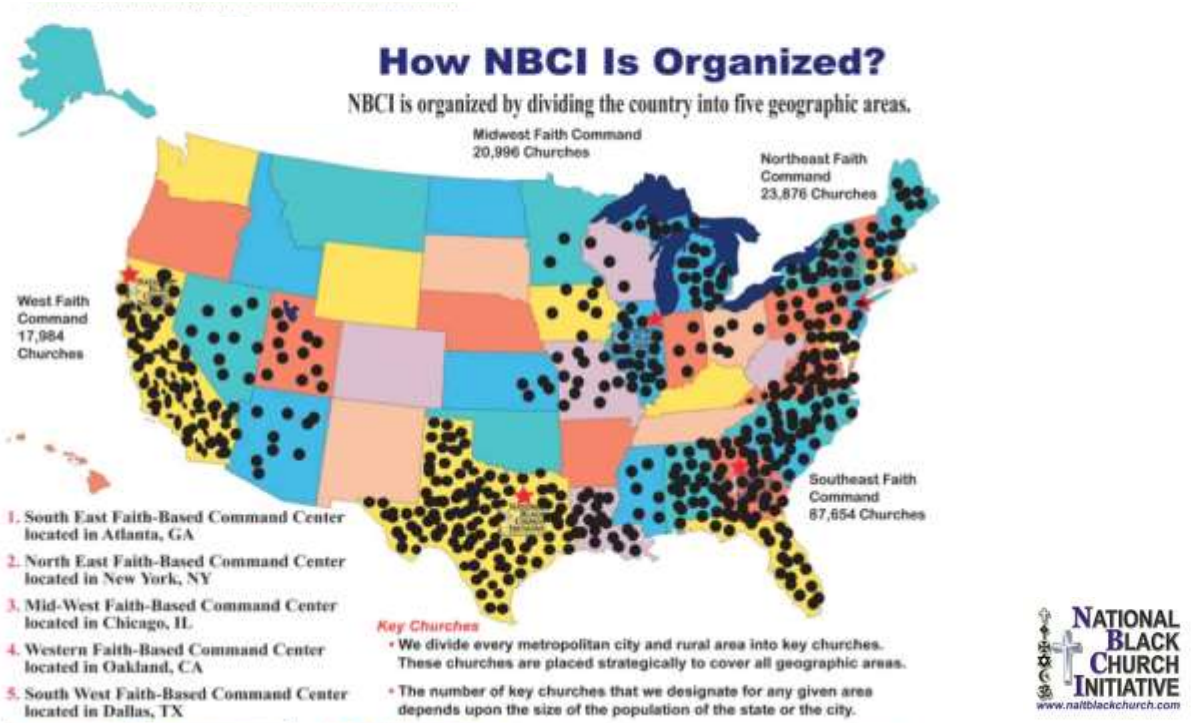
Proposed Goal: To provide comprehensive support of church-going African Americans and Latinos who have been directly or indirectly affected by the opioid crisis within the most highly affected areas within the United States.

Proposed Objectives: 1) To offer educational opportunities to enhance the knowledge and skills of dealing directly with the opioid crisis as a victim or indirectly dealing with the opioid crisis as a supporter of victim(s); 2) To utilize financial resources to enhance mental health and/or social conditions for those victims or supporters of victims of the opioid crisis; and 3) To establish *intra-* and *inter*-support networks and resources for those victims or supports of opioid victim(s).

Action Items:

- The Relevancy of a Community-Focused, Culturally-Responsive Comprehensive Plan
    - Our Structural Capacity: The organizational structure of the National Black Church Initiative (NBCI) involves the Washington, DC headquarters along with five faith-based command centers comprised of both denominational and non-denominational churches. The five command centers are located in major urban areas throughout the country (i.e. Atlanta, Georgia; New York, New York; Chicago, Illinois, Oakland, California; Dallas Texas). Figure 3 highlights the organization of NBCI:

      Figure 3: National Black Church Initiative



The membership of the National Black Church Initiative is comprised of 150,000 churches constituting some 27.7 million members.

- Our Structural Commitment: With the broad reach of the structure of the National Black Church Initiative, based upon what became evident this paper, the proposed Community-Focused, Culturally-Relevant Program will do the following:
  - ✓ Utilize our faith-based command centers to identify a collective 30,000 members from the Southeast, Northeast, and Midwest regions who have been affected directly or indirectly by the opioid crisis (i.e. 10,000 per region). These command centers comprise the states where the highest rates of opioid deaths, death rates, and-/or overdoses have been occurring (i.e. Ohio, Delaware, West Virginia, Maryland, Florida, Illinois, New Jersey, Michigan, Missouri, Pennsylvania). The remaining two regions of Western and Sout

Western faith-based command centers would target a combined 10,000 participants from those regions who, too, fit the aforementioned criteria.

- Participants for this program will be selected from the churches within each of these faith-based commands. On overall candidate profile will developed and disseminated to the church memberships.

- The Rigor of a Community-Focused, Culturally-Responsive Comprehensive Plan
  - Our Strategic Components: The mission of the National Black Church Initiative is to provide critical wellness information to all of its members, congregants, churches and the public. The programs of the National Black Church Initiative are governed by credible statistical analysis, science-based strategies and techniques, and methods that work and offers faith-based, out-of-the-box and cutting-edge solutions to stubborn economic and social issues.
  - Our Strategic Commitment: With the strategic commitment of the National Black Church Initiative, based upon what became evident this paper, the proposed Community-Focused, Culturally-Relevant Program will do the following:
    - ✓ Build upon the notable successes of our current Sickle Cell, COVID-19 Initiative, and NBCI Immunization Program particularly as it relates to understanding the vulnerabilities of underserved populations.
      - Expanding the implementation of our current Health Emergency Declaration Model to not only be inclusive of targeted outreach, education, community-based clinics, schools, African American professional clinicians, National Medical Association, National Hispanic Medical Association, and use of government data, but also to

include addiction, drug abuse, and opioid experts and current best practices related to opioid crisis for African American and Latinos.

- The Results of a Community-Focused, Culturally-Responsive Comprehensive Plan
  - Our Sustainable Components: The National Black Church Initiative utilizes faith and sound health science and partners with major organizations and officials reduce racial disparities in the variety of areas cited above.
  - Our Sustainable Commitment: With the sustainable commitment of the National Black Church Initiative, based upon what became evident this paper, the proposed Community-Focused, Culturally-Relevant Program will do the following:
    - ✓ As informed by the overarching Community-Focused, Culturally-Relevant Program, best and/or promising practices of the opioid crisis will be disseminated across broadly the entirety of the membership as well as targeted groups within the National Black Church Initiative.

Concluding Statements

To that end, using structural, strategic, sustainable components, the National Black Church Initiative seeks to partner with you in this comprehensive effort to address the opioid crisis within the African American Latino populations. Our community-focused, culturally relevant program is poised to affect 40,000 persons (i.e. 30,000 from the three highest affected faith-based command center affected regions and10,000 from the two lowest faith-based command center affected regions) who are considered as victims or supporters of the victims of the opioid crisis. This type of initiative is projected to cost $1 to $3 million dollars for the next two years. Depending on their size and resources, a total of 1500 churches among the three faith-command centers will be designated as primary program locations that will be inclusive of the

40,000 participants who will be better informed and/or prepared to respond to the opioid crisis. More specifically, to achieve such outcomes in what needs to be done, by enhancing the level of buy-in from African American and Latino Mental Health Professionals and Addiction Experts, the National Black Church Initiative will provide research-based, data driven, opioid preventive or interventions to its congregants with the utmost confidentiality. Thus, the Community-Focused, Culturally-Relevant Program will provide a top to bottom collection of organizational and individual professional resources, including training to develop community-focused, culturally prepared clinicians to be able to offer comprehensive support to those who are considered as victims or supporters of the victims of the opioid crisis.

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