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BARRIERS TO DRUG ABUSE TREATMENT FOR LATINO MIGRANTS: TREATMENT PROVIDERS' PERSPECTIVES[1]

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Abstract

This paper disseminates findings from a pilot study undertaken to learn more about treatment providers' perceptions of treatment access barriers faced by Latino migrants with substance use disorders (SUDs) in Northern California. Semi-structured interviews were conducted with treatment providers (n=11) at 7 residential treatment programs with Spanish-language services. Interviewees identified and described three primary types of treatment barriers: language, legal, and gender-based. In response to these barriers, Latino migrants with SUDs have opened their own residential recovery houses called *anexos* (annexes). Collaborative efforts by community clinics and public health agencies are needed to facilitate Latino migrants' access to SUD treatment.

Keywords

migrant; Latino; drug abuse; treatment; access; barriers

INTRODUCTION

Each year, an estimated 150,000 to 200,000 migrants from Mexico, El Salvador, Guatemala, and Honduras enter the United States in search of work opportunities. Since many are unable to obtain immigration visas, they often enter the country illegally. Of the 8 million unauthorized immigrants from Mexico and Central America currently residing in the U.S., nearly half are men between the ages of 18 and 34 (Hoefer, Rytina, & Baker, 2012). Roughly 40% of the Mexican and Central American immigrant population currently resides in the state of California (Brick, Challinor, & Rosenblum, 2011).

Faced with long-term separation from their families and difficult working conditions, many migrants develop depression and anxiety disorders and turn to alcohol and other drugs to cope (Negi, 2011; Pérez & Fortuna, 2005). Regional studies of Latino migrant laborers have identified prevalence rates as high as 80% for regular binge drinking (García, 2008), 39% for alcohol dependence (Grzywacz, Quandt, Isom, & Arcury, 2007), and 25% for methamphetamine and/or cocaine use (Hernández et al., 2009).

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When Latino migrants seek treatment for substance use disorders (SUDs), they encounter many barriers. Individual-level barriers include limited English proficiency, work demands, internalized stigma around drug abuse, and lack of health insurance (Sentell, Shumway, & Snowden, 2007; Zemore, Mulia, Yu, Borges, & Greenfield, 2009). System-level barriers include few Spanish-language programs, long waiting lists, and some programs' reluctance or inability to admit unauthorized immigrants (Guerrero, Cepeda, Duan, & Kim, 2012; Moya & Shedlin, 2008). Further, undocumented Latino migrants often avoid treatment programs and other forms of health care because they fear their legal status will be revealed to immigration authorities (Maldonado, Rodriguez, Torres, Flores, & Lovato, 2013; Moya & Shedlin, 2008; Vargas Bustamante et al., 2012).

Due to these barriers, Latino migrants often go without treatment until they are court-mandated to a program (e.g., following a DUI conviction) or suffer injuries and other substance use-related health crises that require emergency medical services (Vega & Sribney, 2005). One study found that 66% of Latino migrant laborers' emergency department (ED) visits were related to alcohol misuse (Steinhorst, Dolezal, Jenkins, Snyder, & Rotondo, 2006). This situation poses a serious public health problem because Latino immigrants—especially Mexican-origin men—suffer disproportionately severe health and legal consequences from substance misuse, such as cirrhosis mortality and DUI (driving under the influence) convictions (Amaro, Arévalo, Gonzalez, Szapocznik, & Iguchi, 2006; Caetano, 2003; Centers for Disease Control, 2002).

Latinos, defined by the U.S. Census Bureau as people of "Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin," are the largest minority group in the United States, currently estimated at 52 million (U.S. Census Bureau, 2011). In this paper, the term "Latino migrants" denotes Mexican and Central day laborers and agricultural workers who come to California with the intention of obtaining temporary employment and eventually returning home (Organista, 2007). Migrants often move back and forth between their home and host countries over the course of several years.

This paper disseminates findings from a qualitative pilot study undertaken to answer the following research questions: 1) What treatment options, if any, are available to Latino migrants with SUDs in Northern California? 2) What barriers, if any, does this population encounter when attempting to access treatment? I first describe residential treatment programs accessible to Latino migrants in the selected area, then I discuss three major types of barriers identified through interviews with treatment providers: language, legal, and gender-based barriers.

METHODS

Programs and Recruitment

This study took place in two urban Northern California counties with large concentrations of Latino migrants. Residential SUD treatment programs were identified through each county's Department of Public Health and through a community health clinic that serves primarily Latino migrants from both counties. Our inclusion criteria were program type (residential); location (in the two selected counties); and primary language of services (Spanish). We

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chose to focus on residential programs after exploratory inquiries revealed that these are less accessible to Latino migrants than, for example, 12-step meetings conducted in Spanish (Vega & Sribney, 2005).

Ten programs met our criteria, but three programs declined to participate. The final sample comprised 7 programs and 11 individual interviewees. Brief descriptions of programs and directors have been included in the “Findings” section. Details (e.g., directors’ age, sex, qualifications; programs’ treatment type, capacity) are summarized in Tables 1 and 2.

Data Collection

Between February 2012 and April 2013, semistructured interviews were conducted with 8 directors, 2 assistant directors, and 1 program founder from 7 Latino-serving residential treatment programs in the selected area. At Programs 4 and 7, directors and assistant directors were interviewed in pairs as per their request. The remaining 7 participants were interviewed individually. At Program 4, two successive directors were interviewed at different time points.

Interviews were digitally recorded and conducted in English (n=4) or Spanish (n=5). Each lasted between 90 and 120 minutes. Interview questions were grouped into the following domains: demographic information; immigration experiences; addiction and treatment concepts; program details; Latino migrants’ access to treatment; and Latino migrants’ barriers to treatment. IRB approval was obtained from the Committee for the Protection of Human Subjects at the University of California, Berkeley.

Data Analysis

We used a grounded theory approach (Glaser & Strauss, 1967) to conduct thematic analysis of qualitative data from interview transcripts. Rather than applying predetermined thematic codes based on the literature, we reviewed the data and identified emergent themes that were relevant to our research questions. Then, we used QDA Miner software (Provalis Research, 2013) to create an electronic codebook, or a comprehensive hierarchical list of these themes and subthemes. After uploading field notes and interview transcripts to QDA Miner, we applied the thematic codes electronically to sections of text in which they appeared.

After coding was complete, we used the program to sort text passages by theme, generate frequencies of each theme’s occurrence in the text, and explore correlations among themes (e.g., “barriers” and “gender”). “Correlations” refers here to instances in which themes appeared in close proximity to one another across cases. This three-step process helped us to assess theme salience and to ascertain patterned relationships between interviewee characteristics, program characteristics, and responses to interview questions. Finally, we prepared detailed descriptions of our findings and selected direct quotes to substantiate them.

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FINDINGS

I. Description of Programs

Programs 1–4: Mutual help recovery homes—Programs 1–4 are mutual help recovery homes called "24 Hours" (*24 Horas*) or *anexos* (annexes) and are modeled on residential AA programs that originated in Mexico City in 1975 (Rosovsky, 1998). These anexos use Alcoholics Anonymous (AA) literature although most residents are recovering from polydrug use. Anexos in our sample each accommodated 15 to 25 residents, and intended length of stay was 12 to 18 months.

Anexos in the selected area accept only men and are staffed by volunteer recovering addicts who originally came to the U.S. as migrant laborers. Directors (one per anexo) and assistant directors (one to three per anexo) enforce program rules such as abstinence from drugs and obtaining permission before leaving the anexo for any reason. The daily schedule is tightly structured with household chores and meetings. Each anexo holds required nightly AA meetings for residents that are also open to members of "traditional" (non-residential) Spanish-language AA groups.

Unlike their counterparts in Mexico, U.S. anexos allow residents who have been in the program for approximately one month to leave the premises daily for work. The directors in our sample held stable jobs in construction, automobile repair and food service, whereas program residents tended to work odd jobs as day laborers. Because the anexos receive no external funding, each resident must contribute $60–75 per week for room, board, and AA meetings and services (e.g., informal counseling, access to AA literature).

Interviewees from the anexos included director Juan from Mexico (Program 1); director Francisco from Mexico (Program 2); former director Miguel from El Salvador (Programs 1 and 2); director Eduardo from Mexico (Program 3); and director Jorge from El Salvador. After Jorge left his post, we interviewed his replacements: director Patricio and assistant director Victor, both from Mexico (Program 4).

Programs 5 and 6: Christian recovery homes—Programs 5 and 6 are connected to a prominent neo-Pentecostal church that has created similar recovery homes all over the United States. Programs 5 and 6 are located in residential neighborhoods and each houses up to 12 men. Treatment activities include daily Bible study and prayer, attendance at church services, and one-on-one spiritual counseling from program directors. After residents have been in the program for a few months, they are permitted to work off-grounds during the day. Intended length of stay is 12 to 18 months.

Roberto and León, the directors of Programs 5 and 6, are former addicts and graduates of the church's recovery program. Although directors received no formal training in addiction counseling, they had completed a required course on Christian recovery that was compiled from existing Christian Twelve Step materials and administered by the church.

Program 7: Social model recovery—Program 7 is a social model recovery program (Borkman, Kaskutas, Room, Bryan, & Barrows, 1998) that uses Twelve Step materials

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translated into Spanish and holds Spanish-language AA and NA meetings several nights per week. The program is licensed and accredited by the state and receives county funding. It provides short-term (2–6 days) nonmedical detox services on one side of the facility, and longer-term (90 days) residential treatment on the other. The program accepts only men who speak Spanish as their primary language and can accommodate up to 12 men.

At Program 7 we interviewed director Julio, a Mexican American in his twenties, and assistant director Marcos, a Mexican American in his sixties, both recovering addicts. At the time of our interview, Julio was a certified addictions counselor and Marcos was pursuing certification as a Registered Addiction Specialist (RAS).

II. Thematic Analysis of Interviews

Theme 1: Language Barriers

Subtheme 1: Too few Spanish-language programs: When asked about possible barriers to treatment for Latino migrants, all 11 interviewees mentioned too few linguistically appropriate programs for monolingual Spanish speakers. According to Marcos, “The language barrier–that's a lot [of the problem]. Most places don't have Spanish-speaking counselors or people who work for them.” Marcos attributed the lack of Spanish-language treatment services to county funding priorities. While county funds were available for other special populations such as adolescents and incarcerated persons or parolees, the language in which services were delivered was not a criterion for fund allocation.

Anexo directors were particularly outspoken about the lack of Spanish-language programs for Latino migrants. Juan, Victor, and Eduardo, who had each graduated from U.S. anexos, discussed the difficulties they had encountered when trying to find a recovery program with services delivered in Spanish. At the time of the interviews, none of the anexo directors spoke more than basic English. Juan emphasized the importance of attending AA meetings in one’s own language, and described AA as “pure conversation therapy” (*la terapia de la pura conversa*).

Subtheme 2: Cultural Appropriateness: The other subtheme that emerged from interviewees’ discussions of language barriers was cultural appropriateness. “Culturally appropriate” healthcare refers to services that have been adapted to patients’ cultural backgrounds and identities in order to maximize accessibility. Although language is just one element of culture, it is often at the center of efforts to create culturally appropriate services, especially in the area of behavioral health (Williamson & Harrison, 2010). Julio viewed the use of Spanish language as an important part of his program’s “culturally appropriate recovery environment,” but also stressed the need to incorporate common Mexican and Central American cultural references: “We try to make [the clients] feel as comfortable as possible…we'll talk about things that have a lot to do with our culture–from food to sports to anything.”

Other Mexican American directors noted the importance of high Spanish proficiency and knowledge of regional language differences for working with Latino migrant clients. León and Marcos commented that they had to “relearn” Spanish in order to communicate

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effectively with their clients, since both had grown up in the United States and rarely spoke Spanish at home. “I found out I spoke *pocho* Spanish,” said León, using a somewhat derogatory slang term for “Americanized” Latinos. Both directors also mentioned that they made a conscious effort to incorporate words and expressions from El Salvador, Guatemala, and Honduras into their communication with clients from those countries. They described these communicative practices as important tools for overcoming language barriers and increasing clients’ engagement in treatment.

Theme 2: Legal Barriers

Subtheme 1: Fear of deportation: All interviewees mentioned fear of deportation as a treatment access barrier for Latino migrants. This fear was frequently expressed by the directors of the anexos, who described the fear of deportation both as a barrier to accessing public programs and as a motive for choosing anexos instead. Juan claimed that undocumented immigrants who are also drug addicts are at greater risk for deportation: “The U.S. doesn't want drug addicts; that's why they deport us.”

Fear of deportation, however, was not limited to anexos. According to Roberto and León, undocumented Latino immigrants often choose faith-based programs because these programs are not supported by public funds and therefore do not require residents to provide a social security number. Roberto noted that undocumented immigrants were sometimes even reluctant to enter his faith-based program, despite the fact that the program has no connection to the government:

> We've gotten people without papers, and it's a little difficult with them. Only reason why is because you know, they're full of fear…There's walls already built that they think they cannot tear down. So it's definitely a challenge, but they still be here (*sic*).

Subtheme 2: Ineligibility: Given the anexo directors’ emphasis on fear of deportation, we were surprised to learn that not all of the anexo clients were undocumented; a few chose the anexos even though they were eligible for public treatment programs. Eduardo stated that he did not accept legal residents or U.S. citizens because “they [are able to] receive a different kind of care.” He added that Latinos born in the U.S. were more difficult to deal with than foreign-born Latinos because “[U.S.-born Latinos] expect the government to give them everything.” Other anexo directors, by contrast, had a few legal residents and citizens in their programs. At the time of his interview, for instance, Jorge’s program housed two Mexican men with green cards and one man from Puerto Rico.

When asked whether undocumented migrants could access the few local, publicly-funded treatment programs, the anexo directors replied unequivocally that they could not. However, Marcos and Julio reported that they often have clients who are undocumented immigrants. To fund these clients, they use county block funding—which is discretionary—as opposed to billing Medi-cal through individual social security numbers, as they do for documented clients. Roberto and León had not only treated undocumented clients, but had also helped them obtain social services and apply for green cards.

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Marcos and Julio claimed that immigration status is "not a question" during their program's intake process. Program eligibility requirements are minimal, according to Marcos: "All they need to know is to be able to read, speak, and that's it…and [speak] Spanish." Julio added, "I get why [other programs] want to have documented clients, because they can get money. They have more money that is going through their Social Security numbers and all that. I get it, but we're looking for who's going to be willing to help what we're working with. They got nowhere else to go."

Subtheme 3: Program "illegality": Although they were not the only directors of unlicensed/unaccredited programs in the study sample, anexo directors were the only interviewees to identify program "illegality" as a treatment access barrier. As Juan stated, "These groups are illegal (*fuera de la ley*). We don't have permission to be doing this. We do it because otherwise we'll die. Who will want to help us, a bunch of drug addicts? Nobody." He and other anexo directors expressed fear that "the authorities" might close down their programs. This fear limits the number of anexos, they explained, because few potential directors have the courage to open new programs.

Anexo directors were also concerned that their programs could be shut down for violating building codes. Juan observed that the commercial space occupied by his anexo did not permit residents. Jorge's program was in violation of a fire code which imposed a limit of 15 people on the premises at any given time (25 people were living there at the time of the interview). As he observed, "We [anexos] are illegal.…and I try to stay within the law, not on the margins. I don't like to cross the line of illegality." Jorge recalled that police had closed down some anexos about ten years prior to our interview: "When the anexos began, they were clandestine. We were persecuted…there were anexos where the police arrived and shut them down, here and in [Southern California]."

Later in the interview, however, Jorge noted that "today, the authorities are more accepting of us." He was not sure why, but thought they might have seen that the programs were helping people and "fulfilling a need no one else wants to address." For this reason, Jorge did not really believe they would shut down his program, although he was concerned about its unlicensed status.

Like Jorge, Juan also gave somewhat contradictory responses about the issue of program illegality. Although he had expressed fear of being shut down earlier in his interview, he later reported that the local authorities seemed to be looking the other way: "They say nothing because if they close down the groups [anexos], what will they do with all the addicts?"

Each anexo in our sample displayed the international *24 Horas* symbol in their windows and on their front doors. Further, all four anexos were located on or near a busy avenue in the heart of the county's largest Latino neighborhood. It did not appear that the anexo directors were attempting to hide the purpose of their programs.

Even if they were given the chance to obtain licensing and accreditation for their programs, both anexo and faith-based program directors stated that they would not take it. Jorge and

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Juan explained that if their programs were made "legal," they would have to complete copious paperwork and maintain client records in addition to hiring clinical staff. Roberto stated that his church's administrators did not want the government to monitor or fund its activities because they wanted to maintain autonomy over their treatment curriculum.

Theme 3: Gender-Based Barriers

Subtheme 1: Fewer female addicts: None of the directors interviewed were aware of any residential treatment options for Latina migrants—only for men. Three directors attributed this lack to women's supposedly lower rates of addiction. Marco, for instance, said: "I think if there was [such need], they'd come out. It's more of the family keeping the woman and throwing the man out of the door." He observed that Latino immigrant families often preferred to deal privately with women's addictions.

Miguel viewed the family as a protective factor that prevented many women from developing addictions in the first place: "Women have less freedom to drink than men because they have children."

The other seven interviewees believed there were equal numbers of men and women addicts. Eduardo, for instance, pointed out that in Mexico there are anexos for both men and women (both sex-segregated and co-ed). "Women have the same problems we do, and they have an equal right to treatment," he added.

Subtheme 2: Greater stigma: Another common explanation was that Latinas are more reluctant than men to enter treatment because they experience internalized stigma. Within Mexican and Central American cultures, according to interviewees, alcohol use is normative for men, whereas both alcohol and other drug use are considered shameful in women. Jorge claimed that women have more difficulty accepting their addictions because they "worry more about what society will think of them. There are female addicts, but they hide at home; they're not in the streets like men." Similarly, Miguel stated that women are "afraid to accept that they're alcoholics. Women stay at home to drink, while men drink in the street." Two other anexo directors mentioned discouragement from intimate partners as a possible barrier to Latinas' seeking treatment. According to Jorge, "It's more difficult for women to come to (AA) groups because their partners don't want people finding out their wife is an addict."

Subtheme 3: Women are more complicated than men: Three interviewees attributed fewer residential programs for Latinas to their supposedly more volatile emotions, and to their effect on men in the case of co-ed programs. When asked why anexos in the study area were not co-ed, directors replied that romantic or sexual interest would threaten clients' recovery. Miguel recounted some problematic experiences he had had with eight women whom he attempted to house in his anexo. The male clients "competed" for the women's' attention, which often led to both men and women relapsing and leaving the program. Eduardo and Jorge attributed male clients' "lack of control" to their "drug addict mentality, which is accustomed to thinking that women are easy, and that she is just like them because she is here. It's a twisted mentality… Latino men think women are for [sex]."

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Roberto attributed the dearth of Latina women's programs to treatment providers' reluctance to work with women addicts: "I don't want to say men are easier to deal with, but there are more men and women who are either couples, or men who are single who are ready to work with men, rather than women." He also stated that women's emotional issues were more severe than men's and thus needed to be managed more carefully in treatment. Similarly, León said, "Women are harder. I don't know why…maybe their attitude or [difficulty] getting along with other women."

Subtheme 4: Family responsibilities: Five interviewees identified family obligations as a treatment barrier for both men and women. Miguel observed that while many men in the anexos have children, they are not the primary caretakers. Since Latinas are often responsible for childcare, however, and most programs do not accept children, they are often unable to enter residential programs. Roberto also pinpointed parenting responsibilities as the main reason his program does not accept women:

> There's not too many places to house women, because when it comes to women and family, they're most likely gonna be the ones with the kids. So it would take a specific program and a specific housing structure to house them–one room would have to be for one woman and her children…. We can house more men by themselves than we can women with kids.

Three interviewees cited men's need to provide for their families back home as a financial barrier to entering residential treatment. As Julio explained:

> Especially in the Latin community, [men] work, they take care of their family, they take care of their kids, they pay their bills, lights are on, food's on the table–[and they say] 'I don't have a problem.' Culturally, you're a man, you're supposed to be able to handle it.….Like I said, a lot of [clients'] wives call for them. I hear over the phone, 'you better talk to this guy or I'm leaving you. Get in this program or I'm leaving you.' And that's when they come in–because now you've lost what was supposedly–the reason you didn't have a problem….Once they lose that, they come in here because now they're broken: [they say] 'I couldn't even take care of my family.'

Marcos agreed, saying that Latino men "don't want to feel weak, that 'I gave up' or 'I gave in'." Julio attributed their rejection of vulnerability to "the whole *machismo* thing."

Roberto also spoke at length about Latino immigrants' drive to provide for their families, observing that their "provider" role can undermine their recovery. Because they need to continue working, he said, many Latino migrants choose to attend AA meetings rather than entering residential treatment:

> [In outpatient programs] they're able to go and leave. They're able to work….Some just can't get the understanding of the recovery process or a healing process… taking a short period of time now in your life to really hit the nail on the head … rather than trying to make it struggling out on the streets. So a lot of them are trying to patch up their lives with a meeting here and there, trying to find work. Mostly what they're making has to go on their living expenses. Some go to these AA

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> programs and still live on the streets. So what they're making is barely making it for themselves. And they're still not sending nothing back home. But yet [they think], 'I can't go through a program because I've got to provide for my family.' So it's really a mindset that a lot of Hispanics that go to NA and AA in Spanish are struggling with.

DISCUSSION

This qualitative pilot study 1) identified treatment options available to Latino migrants in two Northern California counties; 2) described one community-based response to the shortage of accessible public treatment programs (the creation of anexos); and 3) reported treatment providers' perspectives on the barriers faced by Latino migrant laborers in need of treatment for severe SUDs.

Barriers identified by providers fell into three main categories: language barriers (i.e., an insufficient supply of Spanish-language programs); legal barriers (i.e., actual or perceived risk of deportation); and gender-based barriers (i.e., gender norms that restrict Latinas'—access to residential treatment, and which contribute to an insufficient supply of Spanish-language programs for women).

In response to language and legal barriers, undocumented Latino migrants in the study area have created a parallel treatment infrastructure that better serves their needs (anexos). Not only are anexo clients assured that their immigration status will not affect their access to the programs, but all anexo activities are conducted in Spanish by fellow migrants and former addicts with whom they identify. The program format is also familiar to the primarily Mexican and Central American clients since they are modeled upon the "24 Horas" programs in those countries and even utilize the same logo and AA print materials. Anexos may provide valuable information on this population's treatment needs and preferences since they are a community-generated recovery resource.

Although anexos may represent a life-saving alternative for undocumented Latino migrants with SUDs, they also perpetuate a gender-based access barrier since they accept only men. Furthermore, the houses are few in number and are often filled to capacity. Part of the reason for the insufficient supply of anexos, according to interviewees, is the pervasive fear that authorities will close them down.

Many Latino migrants believe that government-funded programs cannot or will not accept undocumented individuals. As indicated by the directors of the county-funded program interviewed for this study, this is not necessarily the case. Informal telephone conversations with program directors who declined to be interviewed for the study also indicated that other programs in the region are willing to accept undocumented immigrants. That anexo directors —all monolingual Spanish-speaking migrants —were unaware of this fact illustrates the extent to which this population is isolated from mainstream channels of information, and thus from knowledge of public services that may be available to them.

It is important to note that the policy of providing government-funded addiction treatment to undocumented immigrants differs substantially by city, state, and region of the country.

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Another issue that may affect the generalizability of pilot study findings is the small number of participants, although the programs sampled represented over half of all Spanish-language treatment programs in the selected area. Finally, the data presented in this paper represent the views of directors, not clients themselves or Latino migrants who have been unable to access treatment.

CONCLUSION

Given the large presence of Latino migrants in the United States, their contribution to the U.S. economy (Hinojosa-Ojeda, 2012; Porter, 2005), and the high cost of SUD-related health problems (National Institute on Drug Abuse, 2011), it is important to identify treatment barriers and accessible SUD recovery resources for this often hidden population. These findings point to a need for treatment providers to disseminate information about service eligibility to Latino migrants. This could be accomplished through outreach efforts at strategic locations such as community clinics, county EDs, and day laborer hiring zones. Increased funding for both men's and women's Spanish-language treatment programs is also needed in areas with many Latino immigrants in order to meet the growing demand for services. Finally, improved articulation between ERs, community clinics and SUD treatment programs would help to address gaps in care that occur between substance use-related doctor visits and SUD treatment referrals. Further research is needed to identify other potential barriers and recovery resources for the Latino migrant population in other parts of the country.

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Table 1

Program Characteristics

Number	Type	Capacity	Language(s)	Funding	Client Gender(s)
1	Residential AA	15–25	Spanish	Self-funded	Men only
2	Residential AA	15–25	Spanish	Self-funded	Men only
3	Residential AA	15–25	Spanish	Self-funded	Men only
4	Residential AA	15–25	Spanish	Self-funded	Men only
5	Christian Recovery	5–10	Spanish/English	Church	Men only
6	Christian Recovery	5–15	Spanish	Church	Men only
7	Social Model	12	Spanish	County	Men only

Table 2

Interviewee Characteristics

Pseudonym	Sex	Age	Ethnicity/Nationality	Immigrant	Program	Qualifications
Juan (D)[1]	M	45	Mexican	Yes	1	In recovery (IR)
Miguel (F)[2]	M	60s	Salvadoran	Yes	1, 2	IR
Francisco (D)	M	56	Mexican	Yes	2	IR
Eduardo (D)	M	45	Mexican	Yes	3	IR
Jorge (D)	M	65	Salvadoran	Yes	4	IR
Victor (AD)[3]	M	50s	Mexican	Yes	4	IR
Patricio (D)	M	40s	Mexican	Yes	4	IR
Roberto (D)	M	29	Mexican American	No	5	IR/Church
León (D)	M	66	Mexican American	No	6	IR/Church
Julio (D)	M	20s	Mexican American	No	7	IR/RAS
Marcos (AD)	M	60	Mexican American	No	7	IR/RAS

[1] Director

[2] Former director

[3] Assistant director

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