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Authors

Carson, Mariam
Haro-Ramos, Alein
López-Solano, Naomi
et al.

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RESEARCH ARTICLE

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Facilitators and barriers of alcohol goals for Latinx men hospitalized with alcohol use disorder seen by an Addiction Consult Team

Mariam S. Carson[a], Alein Y. Haro-Ramos[b], Naomi López-Solano[c], Carla Fernandez[c], Marcus Cummins[d], Alicia Fernandez[c], Triveni DeFries[c] and Marlene Martin[c]

[a]School of Medicine, University of California, San Francisco, CA, USA; [b]UC Irvine Joe C. Wen School of Population & Public Health, Department of Health, Society, and Behavior, University of California, Irvine, CA, USA; [c]Department of Medicine, University of California, San Francisco and San Francisco General Hospital, San Francisco, CA, USA; [d]Department of Medicine, University of California, San Francisco Fresno, Fresno, CA, USA

ABSTRACT

Introduction: Latinx individuals are disproportionately affected by alcohol use disorder (AUD). Understanding Latinx individuals' barriers and facilitators to reach AUD-related goals can help implement culturally and linguistically concordant interventions to improve alcohol-related outcomes.
Methods: We conducted semi-structured qualitative interviews with Latinx, Spanish-speaking men with AUD within 20 weeks of hospital discharge who were seen by an addiction consult team during hospitalization in an urban, safety-net hospital in San Francisco. Interviews focused on the facilitators and barriers to participants' AUD-related goals pre-, during, and post-hospitalization. We recorded and transcribed interviews and used a mixed deductive and inductive analytic approach until we reached thematic saturation ($n=10$).
Results: We identified three major themes: 1. Hospitalization was an actionable moment for change; 2. Social factors were closely intertwined with AUD goals; and 3. Accessible addiction, physical health, and mental health services can help achieve AUD goals.
Conclusions: Hospitalization may serve as a facilitator for Latinx individuals with AUD to achieve AUD goals. Addressing social determinants of health including housing, immigration status, and social support networks before, during, and after hospitalization, may help facilitate AUD goals. Providing language-concordant and accessible services may decrease barriers to achieving AUD goals.

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Latino; Latinx; alcohol use disorder; unhealthy alcohol use; social determinants of health; language concordance; addiction; hospital

1. Introduction

Alcohol is one of the leading causes of preventable deaths in the United States (US) [1]. Mortality has increased in recent years, with the age-adjusted rate of alcohol-induced deaths in the US increasing from 10.4 per 100,000 in 2019 to 13.1 per 100,000 in 2020 [2]. Unhealthy alcohol use (UAU) is prevalent among Latinx individuals in the US, with approximately 10% and 23% of Latinx individuals aged ≥12 years reporting past-year alcohol use disorder (AUD) and past-month binge drinking, respectively [3–5]. The alcohol-attributable death rate is 21.9 per 100,000 for Latinx men, compared to 18.2 per 100,000 for white men and 13.8 per 100,000 for Black men [6]. Increased mortality may result from decreased access to healthcare, stigma, and lack of culturally- and linguistically-concordant services [7,8].

Hospitalizations involving AUD have also increased [6,9]. Hospitalization is a critical period to diagnose AUD, engage patients in goal-setting, offer and initiate evidence-based medication treatment, and link patients to community services [10]. However, routine hospital services rarely engage individuals in discussions about their alcohol use. Addiction consult teams (ACT) are one intervention that addresses the needs of hospitalized patients with substance use disorders [11,12]. In our safety-net hospital, the ACT comprises addiction medicine physicians, nurse practitioners, patient navigators, and licensed vocational nurses. The team assesses patients for substance use disorders, offers

CONTACT Mariam S. Carson mariam.carson@ucsf.edu Department of Medicine, Zuckerberg San Francisco General Hospital, Box 1364, 1001 Potrero Ave, Building 10, Ward 13, San Francisco, CA 94110, USA.
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and initiates evidence-based medications, and connects patients to follow-up addiction care.

To date, qualitative studies of hospitalized patients with AUD exclude Spanish-speaking patients' experiences. Existing qualitative studies focus on individuals hospitalized with primarily non-alcohol substance use disorders, individuals with AUD in non-hospital settings, and English-speaking individuals [13–16]. To inform interventions aimed at improving alcohol-related outcomes, we sought to understand the barriers and facilitators that Spanish-speaking, hospitalized Latinx patients seen by the ACT experience in addressing their AUD goals.

2. Material and methods

2.1. Study design and sample

This is a qualitative study of Latinx, Spanish-speaking adults (age ≥18 years) with AUD discharged from an urban, safety-net hospital in San Francisco, California, between November 2020 and October 2021. We conducted telephone interviews between March 2021 and March 2022. All patients were hospitalized for alcohol-related complications and seen by the ACT at least twice during their hospitalization [12].

We identified potential participants by querying the electronic health record for those who met the inclusion criteria. Inclusion criteria were age ≥18 years, AUD diagnosis, Latinx ethnicity, primary Spanish language, seen by ACT ≥2 times, and an active phone number. We confirmed AUD diagnosis *via* ACT documentation using the Diagnostic Statistical Manual of Mental Disorders, Fifth Edition criteria (DSM-5). Focusing on individuals who had at least two encounters with ACT allowed for more insight from participants who had substantially interacted with ACT. This approach allowed us to capture more nuanced perspectives on the effectiveness of the interventions and the challenges faced by participants. Patients received a gift card for participating. We interviewed patients until we reached thematic saturation. The UCSF Institutional Review Board approved this study (IRB # 20-31104). This study adhered to the declaration of Helsinki.

The investigator group consisted of 4 Latinx women (MM, AF, AH, NL), 1 White/Persian (MSC), and 1 White/Indian (TD) cisgendered women. Three are physicians, two of whom are double-boarded in internal medicine and addiction medicine (TD, MM), and one is a medical student (MSC). AH is public health researcher focusing on immigrant health, and NL is a non-physician members of the Addiction Consult Team.

We developed the interview questions in English and AH and CF, both fluent in Spanish, translated these into Spanish. To ensure that the meaning of each question was preserved during translation, the Spanish questions were back-translated into English and reviewed by MM. All interviews were conducted and transcribed in Spanish. Participants provided verbal consent at the beginning of the interview, as interviews were conducted after discharge from the hospital. Verbal consent was approved by the UCSF IRB and was documented in the pre-interview checklist. Interviews were recorded to an MP3 file and stored in a secure Box folder. All coding was completed with the Spanish transcriptions. The quotes in the results section were translated into English for the manuscript by MSC and MM, who are both fluent in Spanish.

Reflexivity within the research group was managed by discussing objectivity during data collection and analysis and by practicing trauma-informed strategies such as confidentiality, safety, and empathy throughout data collection and analysis.

2.2. Data collection

Two bilingual researchers (CF and AH) trained in qualitative interviewing called patients who met the study criteria [17]. The researchers explained the study goals and obtained informed consent. Researchers used a semi-structured interview guide with follow-up prompts to interview patients, focusing on the facilitators and barriers of patients' AUD goals pre-, during, and post-hospitalization (Appendix 1). Interviews lasted between 20 and 58 min, were audiotaped, and were professionally transcribed in Spanish. Participants received a $50 gift card for their participation. We uploaded transcripts into Dedoose (SocioCultural Research Consultants LLC, 2016) for analysis (version 9.0.78) [18]. We obtained patient demographics and hospitalization characteristics through structured chart review and securely stored these in Research Electronic Data Capture (REDCap) [19].

2.3. Data analysis

Four bilingual researchers (AH, MM, NLS, TD) used a single codebook and individually coded Spanish transcripts in sets of 2–3. We generated codes deductively and met after reviewing each set of transcripts to add emergent themes inductively. We refined the codebook using a Grounded Theory approach [20]. We met weekly to review transcripts, codes, and themes and identified exemplary quotations for key themes [21,22]. We followed the Standards for Reporting Qualitative Research (SRQR) checklist for reporting guidelines [23].

3. Results

We identified 13 individuals with severe AUD who met the inclusion criteria. Ten consented to participate, two declined, and one died prior to contact. Patient and hospitalization characteristics are available in Table 1. Interviews revealed three key themes: 1. Hospitalization was an actionable moment for change; 2. Social factors were closely intertwined with AUD goals; 3. Accessible addiction, physical health, and mental health services can help achieve AUD goals.

3.1. Hospitalization was an actionable moment for change

Hospitalization was an opportunity for participants to learn more about AUD and explore AUD-related goals. Sub-themes included: recognizing the morbidity and mortality of AUD, non-stigmatizing interactions with addiction experts facilitated recognition of AUD as a disease with evidence-based treatment, and hospitalization offered options to start AUD-specific treatments.

Table 1. Patient and hospitalization characteristics.

Characteristic	Number of Participants ($N = 10$) (%)
Sex	
Male	10 (100)
Age	
18-30	2 (20)
31-50	0 (0)
51-65	8 (80)
Country of origin	
Mexico	6 (60)
Guatemala	2 (20)
Peru	1 (10)
Nicaragua	1 (10)
Time in US (years)	
<5	1 (10)
5-10	2 (20)
11-15	2 (20)
16-20	1 (10)
>20	4 (40)
Housing status	
Housed	7 (70)
Unhoused	3 (30)
Length of hospitalization (days)	
Mean	7 (70)
Required ICU	
No	9 (90)
Medications for AUD Initiated during Hospitalization*	
Oral naltrexone	1 (10)
Extended-release naltrexone	6 (60)
Gabapentin	1 (10)
Acamprosate	1 (10)
None	2 (20)
Alcohol goals during hospitalization	
Reduce alcohol use	4 (40)
Quit alcohol use	6 (60)
Self-reported alcohol use after hospitalization	
No use	6 (60)
Reduced use	1 (10)
Not reported	3 (30)
Primary Care Doctor before Hospitalization	
Yes	7 (70%)

*All medications mutually exclusive except for one patient who was started on extended-release naltrexone and gabapentin.

3.1.1. Recognizing the morbidity and mortality of AUD

Hospitalization provided patients time to reflect on their alcohol use, including recognition of their morbidity and mortality and its impact on their life, health, and relationships. One participant explained that he decided to stop drinking during hospitalization because of the impact of alcohol on his health: *Not drinking is definite. I can't drink. My liver is bad, my kidneys are bad, and my stomach is bad. It's time to stop.* Another participant described how hospitalization made him reflect on his mortality and family, saying, *I don't want to die. I want to be with my kids.*

3.1.2. Non-stigmatizing interactions with addiction experts facilitated the recognition of AUD as a disease with evidence-based treatment

Conversations with ACT led participants to recognize AUD as a medical condition. One participant explained that *several doctors told me that this is an illness, that I shouldn't feel bad…More than anything, they gave me psychological support.* Another participant described appreciation for ACT members, especially their empathy and non-judgmental, patient-centered care:

> I am very grateful because they helped me a lot, and everyone who came, all the doctors never judged me for my situation. Because in reality they are not responsible for the decisions that one makes in drinking, but they do give you moral support and they tell you that it is a disease, that you can keep going. (J)

Participants also explained how ACT connected them to resources after discharge, helping them feel that they were not alone and they had support.

> The hospital had resources to refer me to places where I can get help. And well, I was desperate in that moment, so I said yes, please help me, and a professional from the team would come, sometimes a doctor, a therapist or social worker to ask me how I was feeling, to motivate me, to tell me that they were working on my case, that I wasn't alone, and that also has been fundamental. (H)

3.1.3. Hospitalization offered options to start AUD-specific treatments

Facilitators to AUD goals during hospitalization included access to AUD-specific medications, as well as connections to residential and outpatient treatment. One

participant described how important it was to be offered treatment during hospitalization:

> …many people visited me and asked if I wanted resources for my alcohol use or to start treatment with injections, medications, and all of that. I felt the necessity to say yes because I was tired of the life I was living, not doing anything, and that's when I said yes, I'm done, I am going to try to stop drinking, that's when I started taking treatment. (C)

Another participant shared how getting the medication during hospitalization affected him after discharge:

> It was already set in my mind that I couldn't drink, because I hadn't for a month, and the [naltrexone] injection helped me a lot. It calmed my anxiety. (M)

3.2. Social factors were closely intertwined with AUD goals

Social factors both negatively and positively influenced AUD-related goals. Sub-themes included lack of access to resources to address the social determinants of health and social networks.

3.2.1. Lack of access to resources to address the social determinants of health hindered AUD goals before, during, and after hospitalization

Participants frequently cited housing issues, immigration status, and employment as factors that permeated their experiences with alcohol use pre-, during, and post-hospitalization. Two participants experiencing homelessness described being unable to prioritize AUD goals when faced with unstable housing.

> The first thing I need here where I am, which I'll repeat, is only a temporary place, a housing assessment, and to apply. Because I need a stable place and to stay in one location, not be in the streets. (L)

Even when ACT members facilitated connections to outpatient medical care, unstable housing and unreliable communication hampered patients' ability to access care. One noted,

> There were two nurses when I was in the hospital that told me that they were going to help me with [Medicaid] to continue my medicine and everything. But since I don't have an address or a phone… (I)

Participants also described how experiencing homelessness exposed them to violence and substance use—including sleeping in locations where drug transactions and drinking were common—which triggered their AUD.

Due to immigration status, several participants relied on day labor and other informal job markets that did not require social security numbers. Participants felt the stress of shrinking employment opportunities. One participant stated, *There isn't a lot of work right now. If I go where the offices are, they always ask me for social security, papers, and stuff like that.* This led to episodic employment, which participants reported as stressful due to their desire to provide for their families.

> I have to think about my family abroad and here, and it's stressful. Suddenly, I say, 'What do I do?', and then I start to drink a beer and forget. But the problem is that I have one, or two, and I continue and don't eat anything. (U)

In contrast, consistent employment provided participants with stability and focus. A participant described, *Before I landed in the hospital, I worked one day yes, one day no, and that's how it went, but since then I'm working almost daily, and it is going well for me.*

3.2.2. Social networks both hindered and facilitated AUD goals after hospitalization

Participants described how their communities both triggered and helped them after discharge. Parties and social gatherings with alcohol were no longer enjoyable, causing some participants to forego special events altogether:

> The difficult thing for me is that when I go to a party and I see people drinking, I withdraw a bit, or sometimes I prefer to not attend the party, because people encourage drinking and it makes me nervous. (J)

Connections to family, friends, and community members who drank alcohol made reaching AUD goals more difficult. This led participants to avoid critical social spaces.

> Seeing alcohol every day, but not having it, well, not having it in my hand, but seeing everyone walking with theirs…where I live many people drink in the streets, and sometimes I go to the corner to buy stuff for the house or take a walk and I see everyone in the world is drinking. (M)

Social networks that facilitated AUD goals included church, family, and friends. Several participants referenced their spirituality as a source of strength. One participant shared, *I went a year without drinking. I went to a Christian church, and I didn't understand much, but I attended.* Other participants described their church as providing food, showers, and other resources beyond spiritual services, including using the church's physical address for healthcare-related mail.

Others relied on family members and friends. One participant described his relationship with his wife and

how their communication with one another improved after his alcohol use changed:

> Now we're a couple and can talk. Before we couldn't, since I lived intoxicated and didn't talk to her. I didn't know what I felt, but now I do, and now we communicate. (M)

3.3. Accessible addiction, physical health, and mental health services can help achieve AUD goals

Participants frequently cited access to addiction, physical health, and mental health services as facilitators to achieving AUD goals. Sub-themes include language-concordant services and accessibility of services.

3.3.1. Language-concordant services facilitated AUD treatment

Participants stressed that language concordance is essential for all aspects of care, including services after hospitalization. One participant described how his team facilitated access to therapy by connecting him with a bilingual therapist and why the language concordance was effective.

> I speak a little English, now, because I have been in this country for several years, but speaking in Spanish is always more comfortable. I express my feelings better, my emotions, and this is also super important. (H)

3.3.2. Accessibility mattered outside the hospital

Participants described how accessible care facilitated post-discharge AUD goals, improved mental health, and helped them reduce alcohol consumption. They also described how inaccessible services hindered access to medications and follow-up care following hospitalization, which caused delays in care.

> They called to tell me I needed to get the [naltrexone] injection and told me that I didn't have Medi-Cal. That I couldn't get the injection, and so I searched for it. I came to a trailer with two doctors and talked with them and they started to talk and talk and sent me to the hospital to get the medicine. (I)

For some participants, reducing alcohol consumption unmasked underlying mental health challenges that made it difficult to continue working towards AUD goals. Participants described an inability to access mental health services despite repeated efforts and were discouraged by limited appointment availability.

> The truth is I tried looking for therapists, but they always told me 'we are going to return your call later, we are going to see if there is an appointment so that you can talk to someone,' but they always left at that and never returned my call. (C)

4. Discussion

In this qualitative study of Latinx men with AUD who were seen by an ACT during their hospitalization, we found that hospitalization was an actionable moment for change, addressing social factors may help facilitate AUD goals, and linking to accessible addiction, physical health, and mental health services could facilitate achieving AUD goals.

Hospitalization is a brief but intense touchpoint, and for many participants, hospitalization allowed them to recognize the morbidity and mortality of AUD and treatment options. Though hospitalization is known to be a 'reachable moment' to provide evidenced-based addiction care, previous studies have not included Latinx, Spanish-speaking individuals [24,25]. Our study fills this gap by focusing on, Spanish-speaking patients in a safety-net hospital. Consistent with previous studies, for many participants, hospitalization allowed them to reflect on their AUD, and interacting with addiction experts facilitated their understanding of AUD, treatment options, and their own goals. Our study also highlights the importance of patient-centered and language-concordant clinical interactions in helping Spanish-speaking patients recognize AUD as a medical illness with treatment options. This is important, as <2% of hospitalized patients with AUD are prescribed AUD medications at discharge [26]. In addition, Latinx individuals are less likely to be offered AUD treatment than White individuals, and leveraging hospitalization can connect patients to evidence-based AUD treatment and reduce inequities in care [27–29].

Participants identified how housing, immigration status, and employment affected their AUD care. One study of Latinx individuals showed that those experiencing homelessness and mental health diagnoses had higher rates of unhealthy alcohol use, demonstrating the need to address social, mental health, and addiction needs concurrently [30]. For participants who were undocumented, being excluded from stable job markets meant they relied on informal labor agreements and lacked financial stability [31]. The COVID-19 pandemic decimated this market, further exacerbating job scarcity, and the stress of supporting family members locally and abroad made it more challenging to achieve AUD goals. Stressors related to immigration status increase the risk of AUD, and it is important to recognize and ideally address this intersectionality in offering AUD services [29].

Table 2. Recommendations to address barriers and facilitators of AUD goals among Latinx individuals.

Thematic Improvement Areas	Internal to Healthcare System	External to Healthcare System
Hospitalization as an actionable moment	• Implement and incentivize AUD education among health workers • Support hospital AUD champions • Adapt universal screening for unhealthy alcohol use, addiction consult team models, and electronic health record ordersets to incorporate AUD care into the hospital [1–3]	• Partner with Latinx individuals and community experts to develop a community-wide campaign to educate people about AUD as a medical disease with treatment
Address social factors to facilitate AUD goals	• Screen for unmet social needs • Develop plans to address alcohol use triggers that mitigate social network exposure to alcohol after discharge • Partner with and fund cultural and linguistically informed Latinx community-based organizations (CBO) to link individuals to services that address unmet social needs	• Offer anti-stigma trainings to local spiritual organizations and CBOs that serve Latinx patients with AUD • Review county alcohol licenses, including where they are located to ensure they are not disproportionately available in low-income neighborhoods • Enact policies, such as sanctuary city status, that support employment opportunities for people who are undocumented[4] • Support programs, like California's Housing is Key, to help address housing shortages and homelessness[5,6]
Provide accessible and language-concordant services to decrease barriers to achieving AUD goals	• Enroll eligible patients in insurance and explore other coverage options for those who do not qualify for insurance • Recruit, hire, and train diverse and language-informed healthcare workers [7,8] • Partner with CBOs that include historically excluded populations, including community health workers, to provide access to health and mental health servicesClick or tap here to enter text.[9–11] • Identify local community addiction services and the individuals they serve to link patients to appropriate programs	• Expand access full-scope Medicaid to people who are undocumented [12,13] • Incentive diversifying the workforce to increase access to language-informed services • Ensure that available healthcare services are language-informed

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Particiapnts who resided in areas with many liquor stores and social gatherings with alcohol experienced barriers to reaching AUD goals. This finding is consistent with a qualitative study of ICU survivors of alcohol withdrawal, which found that social networks were both barriers and facilitators of AUD goals [32]. Studies show that weak alcohol control policies in zip codes with high poverty levels can disrupt access to continuous healthcare and exacerbate alcohol-related health outcomes [33–35]. Exposure to alcohol use, especially through family, can also increase the risk of AUD [36]. Some social networks involved spirituality and religion, which can also serve as sources of support [37,38].

Lack of access to language-concordant services, including health, addiction, and mental healthcare, was a barrier for participants. Even when participants wanted supportive services, they did not receive follow-up calls, experienced insurance barriers, or faced limited appointment availability. Participants stressed how receiving language-concordant care during hospitalization helped crystalize their AUD goals. This is consistent with studies showing improved outcomes when clinicians match the racial/ethnic and language identity of patients [39,40].

Based on these findings, we present recommendations internal and external to the healthcare system by theme in Table 2. We derived these recommendations

directly from the barriers and facilitators identified by our participants. We used the socioecological model to develop these recommendations, which allowed us to identify upstream policy and practice interventions that could help Latinx patients with AUD achieve better alcohol-related outcomes [21,22]. To address AUD systematically, health systems, even without ACTs, can implement universal screening for unhealthy alcohol use and train clinicians to further assess patients for AUD and offer evidence-based treatment. Various healthcare systems have incorporated addiction care services that can be adapted to deliver language-concordant services [10,41]. Similarly, health systems can screen for unmet social needs that are intertwined with AUD and partner with community-based organizations to link patients to language-concordant services. Health systems can ensure hospitalization offers an opportunity to enroll eligible patients in insurance and explore additional options for the uninsured. One model for increasing access to healthcare services is evident with California's current goal of expanding Medicaid access, including to people who are undocumented, by 2024 [42]. By focusing on public policy and organizational changes, these recommendations aim to contextualize individual experiences within broader systemic factors.

This study has several limitations. First, the Latinx community is a heterogeneous population with varied experiences, and the participants in this study were all Spanish-speaking men, the majority over the age of 50, and hospitalized in a safety-net setting. Additionally, only 13 patients met our inclusion/exclusion criteria, and we recruited 10 patients to participate during the study period. Many Latinx patients with AUD were only seen by the ACT once and were excluded due to this. In addition, we conducted interviews by phone after discharge, and many participants were excluded due to not having a valid phone number. However, we reached thematic saturation with only ten participants, suggesting that our sample size was adequate and that the results from this work can help inform recommendations for designing interventions that support hospitalized Spanish-speaking men over the age of 50 with AUD before, during, and after their hospitalization. In addition, this is a marginalized group with decreased access to services and whose experiences have not been represented in the existing literature. Despite attempting to enroll all sexes, only men were enrolled, consistent with the higher ratio of Latinx men hospitalized with AUD in our setting. Given increasing alcohol-related mortality among Latinx women, future work should include Latinx patients across gender identities [6]

5. Conclusion

Our study had three key findings: Hospitalization may serve as a facilitator for Latinx men with AUD to achieve AUD goals; addressing social determinants of health may help facilitate AUD goals; and providing language-concordant and accessible addiction, physical health, and mental health services may decrease barriers to AUD care. By incorporating interventions across all levels and stages of care, including with community partners *via* health system and policy level interventions, AUD care may become more accessible to Latinx communities, an often overlooked group.

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Authors contributions

MM, AF, and TD led project conception, MC performed chart reviews, and AH and CF interviewed patients. AH, NLS, TD, and MM coded interviews. MSC, AF, and MM led thematic analysis and interpretation of results. MSC led writing with mentorship from MM. All authors edited the manuscript.

Disclosure statement

No potential conflict of interest was reported by the author(s).

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ORCID

Mariam S. Carson http://orcid.org/0000-0002-0630-2881

Data availability statement

The data supporting this study's findings are available on request from the corresponding author, MSC. However, the data are not publicly available due to the sensitive topics covered in the transcripts and participant confidentiality.

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