SAMHSA's Center for the Application of Prevention Technologies

Increasing Cultural Competence to Reduce Behavioral Health Disparities

Training and Technical Assistance Toolkit








September 2016

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Developed under the Substance Abuse and Mental Health Services Administration's Center for the Application of Prevention Technologies task order. Reference #HHSS283201200024I/HHSS28342002T. For training use only.

INTRODUCTION

According to *Healthy People 2020*, a health disparity is a "particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage." Health disparities pose a significant threat to the most vulnerable populations in our society. Whether manifesting themselves as elevated rates of substance use among American Indian/Alaska Natives; high rates of suicide among youth identifying as lesbian, gay, bisexual, or transgender; or reduced access to quality health care among people living in rural areas, these disparities threaten the health and wellness of our society as a whole.

Health disparities can severely affect the quality of individuals' lives, often leading to increased rates of disease and premature death. Between 2003 and 2006, the combined cost of health inequalities and premature death in the United States was approximately $1.24 trillion.[1]

In the context of substance misuse prevention, prevention practitioners recognize the importance of addressing *behavioral health disparities*—that is, differences in substance use or related mental health outcomes. Yet doing so can be challenging. First, identifying groups that experience such disparities can be difficult, for while finding and examining data for at-risk sub-populations is an essential first step toward uncovering disparities, these data are not always readily available. In the absence of these data, the pressing needs of these groups often remain hidden.

Moreover, reducing behavioral health disparities in these populations, once they *are* identified, can also be difficult. Multiple underlying factors contribute to disparities, including but not limited to reduced access to culturally and linguistically appropriate services. To overcome systemic barriers that may contribute to disparities, practitioners must develop and deliver prevention interventions in ways that ensure that members of diverse cultural groups actively participate in, feel comfortable with, and benefit from these efforts.

This toolkit offers prevention practitioners an introduction to behavioral health disparities, highlighting the important relationship between cultural competence and reducing disparities. The fact sheets, case examples, and worksheets included in the kit are designed to help practitioners accomplish two main objectives: (1) more readily identify those sub-population groups in their communities that are experiencing disparities, and (2) develop culturally competent approaches to use in their prevention efforts.

Many of the tools included in the toolkit were originally developed to support the prevention efforts of local-level practitioners funded under SAMHSA's Strategic Prevention Framework Partnerships For Success grant program. However, all are relevant to and appropriate for use by practitioners working across behavioral health sectors. Our hope is that these tools will serve as a starting point for forging new partnerships, raising awareness, and developing and delivering the interventions needed to eliminate behavioral health disparities in our communities.

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[1] LaVeist, T.A., Gaskin, D.J., & Richard, P. (2009). The economic burden of health inequalities in the United States. Retrieved from: http://www.unnaturalcauses.org/assets/uploads/file/BurdenOfHealth.pdf

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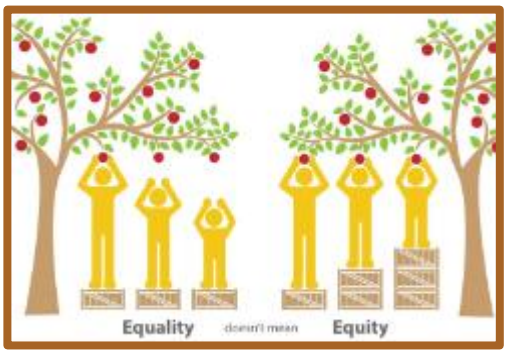
ADDRESSING BEHAVIORAL HEALTH DISPARITIES: KEY DEFINITIONS

Health: A state of of physical and mental well-being.

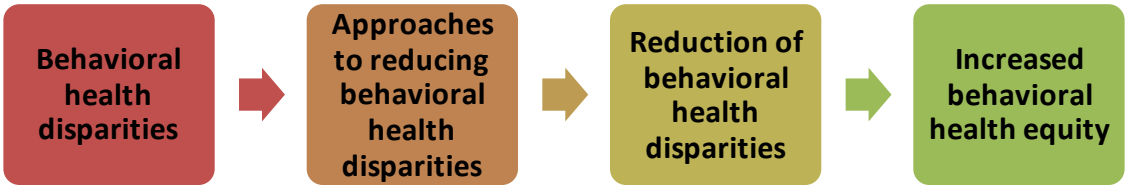
Health Disparity: A particular type of health difference that is closely linked to social, economic, and/or environmental disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion.[2]

Behavioral Health Disparity: A difference in substance use or mental health outcomes, linked to social, economic, and/or environmental disadvantage, which adversely affects a sub-population or group.

Health Equity: The attainment of the highest level of health possible for all groups.[2] Sometimes our differences and/or history can create barriers to achieving good health. Health equality is *not* the same as health equity. While *health equality* emphasizes sameness, fairness, and justice by giving everyone the same resources, *health equity* highlights the importance of providing people with access to the same opportunities. To achieve health equity, communities must work to address avoidable inequalities, historical and contemporary injustices, and existing health and health care disparities.



The goal of practitioners working to prevent substance use and misuse is to increase behavioral health equity. One way to foster health equity is by implementing **culturally competent** prevention approaches that may contribute to the reduction of behavioral health disparities. (See figure below.)



[2] U.S. Department of Health and Human Services. (2008). The Secretary's Advisory Committee on National Health Promotion and Disease Prevention Objectives for 2020. *Phase I report: Recommendations for the framework and format of Healthy People 2020.* Retrieved from: http://www.healthypeople.gov/sites/default/files/PhaseI_0.pdf

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Cultural Competence: The ability of an individual or organization to understand and interact effectively with people who have different values, lifestyles, and traditions based on their distinctive heritage and social relationships.

Based on practice, SAMHSA's Center for Substance Abuse Prevention has identified the following principles of cultural competence for prevention practitioners:

- Ensure community involvement in all areas
- Use a population-based definition of community (i.e., let the community define itself)
- Stress the importance of relevant, culturally appropriate prevention approaches
- Employ culturally competent evaluators
- Promote cultural competence among program staff that reflects the communities they serve
- Include the target population in all aspects of prevention planning

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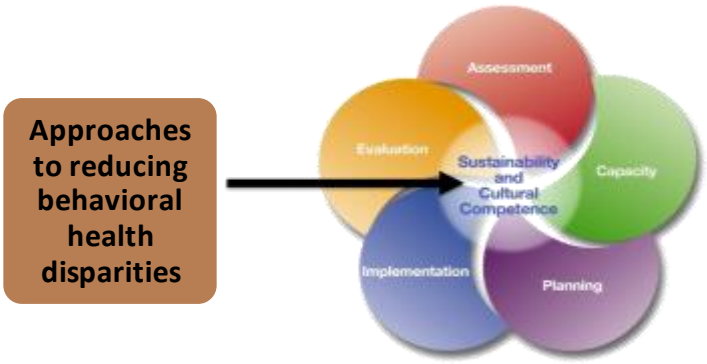
CULTURAL COMPETENCE, HEALTH DISPARITIES, AND THE SPF

Cultural competence is a guiding principle of SAMHSA's Strategic Prevention Framework (SPF)—a five-step planning model designed to help practitioners more effectively address substance misuse and related behavioral health problems in their communities. By considering culture throughout the SPF process, practitioners can help to ensure that members of diverse population groups can actively participate in, feel comfortable with, and benefit from prevention practices.



There are opportunities to reduce health disparities at each step of the SPF. Here are just some examples:

- **ASSESSMENT:** Take steps to identify those sub-populations vulnerable to behavioral health disparities and the disparities they experience. Identify data gaps and take efforts to fill them. Develop plans to share and solicit input about assessment findings with members of these sub-populations, and describe these findings using terms and phrases that are devoid of jargon.

- **CAPACITY:** Build the knowledge, resources, and readiness of prevention practitioners and community members to address disparities, and to provide culturally and linguistically appropriate services. Make sure that practitioners understand the role of cultural competence in their work, overall, and the unique needs of those sub-populations experiencing disparities. Develop new partnerships that will help you engage members of these groups in prevention planning efforts.

- **PLANNING:** Involve members of your focus population as active participants and decision-makers in the planning process. Identify and prioritize factors associated with disparities. Develop logic models that include the reduction of health disparities as a long-term outcome, and incorporate effective prevention interventions that have been developed for and evaluated with an audience similar to your focus population.

- **IMPLEMENTATION:** Implement prevention programs that target populations experiencing behavioral health disparities. Involve members of these groups in the design and delivery of these programs. Adapt and/or tailor evidence-based practices to be more culturally relevant—for example, create an

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in-person version of a training that was originally meant to be delivered virtually, so that it is accessible to audiences with limited access to the Internet.

- **EVALUATION:** Conduct process and outcome evaluations to demonstrate whether selected interventions and strategies are having the intended impact on identified disparities. Track all adaptations. Allocate the evaluation resources needed to understand if the interventions you selected are having the intended impact on the behavioral health disparities you are hoping to reduce. Conduct follow-up interviews with program participants to better understand program evaluation findings.

- **SUSTAINABILITY:** Engage in sustainability planning efforts partners who represent and work with sub-populations experiencing behavioral health disparities. Sustain processes that have successfully engaged members of these populations and programs that produce positive outcomes for these groups.

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IDENTIFYING DISPARITIES: PRIMARY DATA COLLECTION METHODS

Data is essential to understanding the behavioral health disparities that may exist in our communities. It helps us determine which, if any, groups are experiencing poorer behavioral health outcomes, and to quantify the extent of these disparities. Reaching members of these groups can be difficult, as membership isn't always immediately apparent. But the more we learn about these populations, the more we can help identify those characteristics and situations that place members at higher risk for substances misuse, as well as those factors that might mitigate those risks.

Practitioners frequently engage in primary data collection efforts to assess the needs of specific focus populations. Primary data collection offers a unique opportunity to raise awareness of health promotion and prevention efforts, and to involve members of these groups, from the start, in the data collection process—in making decisions about methodology, developing tools and questions, and interpreting findings. The greater the involvement of community members, the greater the likelihood that data collection strategies and survey questions will reflect the culture and attitudes of the populations experiencing disparities.

Primary data collection methods include, but are not limited to, interviews, focus groups, and surveys. Many communities choose to use a mix of methods. This fact sheet provides a quick overview of these three methods: interviews, focus groups, and surveys. When selecting an approach, or combination of approaches, it is important to think carefully about the methods employed, and to understand that a 'one-size-fits-all' approach to data collection is unlikely to reveal the critical needs of those populations most often underserved.

INTERVIEWS

Interviews are structured conversations with specific individuals who have the experience, knowledge, or understanding of a topic or issue about which you want to learn more. Relatively easy to prepare for and conduct, interviews offer practitioners the chance to find out how community members are thinking about an issue or situation. Interviews can be conducted in-person or by phone, depending on people's schedules and availability. The structure of the conversation is also somewhat flexible; additional questions and topics can be added or omitted as needed. Key informant interviews are conducted with select people who are in key positions and have specific areas of knowledge and experience. They can be useful for exploring specific problems and/or assessing a community's readiness to address these problems. One-on-one community interviews, typically conducted by coalition members, tend to be less formal and offer excellent opportunities to build relationships, raise awareness, and inform community members about pressing problems and prevention efforts.

FOCUS GROUPS

A focus group is a systematic way to collect qualitative, or descriptive, data through small group discussion. Focus group participants are chosen to represent a larger group of people from whom you want information. Through focus groups, practitioners can explore prevention-related topics in depth, and participants can share their unique perspectives. Specifically, focus groups allow prevention practitioners to ask questions that may

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be hard for people to answer in writing, clarify participants' responses through follow-up questions, create a rich dialogue as participants build on one another's responses, and generate narrative information that is compelling and easy to understand.

SURVEYS

Surveys provide standardized data that is relatively easy to manage and can be compared to other surveys that use the same questions. They are beneficial in situations where you want to collect information across a large geographic area, hear from as many people as possible, and explore sensitive topics. Survey modes of administration can include phone, paper/mailed, and online surveys. Phone and mailed surveys can be expensive and time-consuming to implement. On the other hand, respondents may be more likely to respond honestly to questions presented in an anonymous, written survey than to those posed during a one-on-one interview. Online surveys are less expensive to administer, but tend to yield lower response rates.

For more on collecting data on vulnerable populations, see the CAPT article *Shining a Light on "Hidden" and "Hard-to-Reach" Populations*.

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PROS AND CONS OF INTERVIEWS, FOCUS GROUPS, AND SURVEYS

	 **PROs**	 **CONs**
INTERVIEWS	• Low cost, assuming relatively few conducted • Respondents define what is important • Relatively short turn-around time • Possible to explore issues in-depth • Opportunity to clarify responses through probes • Can be source of leads to other data sources and other key informants • Generally lower refusal rates • Opportunity to build partnerships	• Can be time consuming to schedule • Requires skilled and/or trained interviewers • Limited generalizability • Produces limited quantitative data • Potential for interviewer bias • May not be good for sensitive information unless rapport is established • May be more difficult to summarize and analyze findings
FOCUS GROUPS	• Relatively low cost • Relatively short turn-around time • Participants define what is important • Some opportunity to explore issues in depth • Opportunity to clarify responses through probes	• Can be time consuming to assemble groups • Produces limited quantitative data • Requires trained facilitators • Less control over the process as compared to key informant interviews • Difficult to collect sensitive information • Limited generalizability • May be more difficult to summarize and analyze findings
SURVEYS	• Can be highly accurate • Can be highly reliable and valid • Allows for comparison with other/larger populations when items come from existing instruments • Generates quantitative data • Easy to summarize and analyze findings • Possible to add more sensitive questions	• Relatively high cost • Relatively slow to design, implement, clean, and analyze • Accuracy depends on who and how many people sampled • Accuracy limited to willing and reachable respondents • May have low response rates • Little opportunity to explore issues in depth • Cannot clarify questions • No rapport built with respondents

"Thumbs Up" and "Thumbs Down" icons by Josh T. Garcia from thenounproject.com

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IDENTIFYING AT-RISK POPULATIONS (WORKSHEET)

As part of your data collection efforts, you need to identify vulnerable populations in the community that may be experiencing behavioral health disparities. This worksheet is designed to help prevention practitioners recognize and better understand the needs of local high-risk populations. Understanding these needs can help you make informed decisions about which populations to engage in your prevention efforts.

INSTRUCTIONS

Identify three high-risk groups/populations in your community about which you would like to learn more. For each group/population, answer the following questions:

- **How many are affected?** Do you have an estimate for how many people within this group or population exist in your community? If yes, how many? If not, why not? Also, are there different prevalence rates among sub-populations within these groups or populations (e.g., LGBT Hispanic/Latino youth as a sub-population of Hispanic/Latino youth)? If so, please specify.
- **What do you already know?** What do you already know about the behavioral health problems this population is experiencing?
- **What do the data tell you?** What behavioral health data are available for this population (excluding anecdotal information)? What does it tell you?
- **What is your capacity?** On a scale of 1-5 (with 1 being "no capacity" and 5 being "a lot"), to what extent does your community have the capacity (e.g., cultural liaisons, trust, interpreters, existing organizations or community groups) to serve this population?
- **What should you consider?** What ethical considerations may arise in working with this population (i.e., differences in cultural beliefs and practices in accessing health care services)?

After completing the chart on the following page, review your answers, paying particular attention to your current capacity to serve the identified population. Based on the responses, select at least one priority group/population with which to work.

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IDENTIFYING AT-RISK POPULATIONS - WORKSHEET

Population:	How many are affected?	What do you already know?	What does the data tell you?	What is your capacity (1-5)?	What should you consider?
Population #1					
Population #2					
Population #3					

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BUILDING COMMUNITY READINESS TO ADDRESS DISPARITIES: STAGES & GOALS

Readiness describes the extent to which community members are prepared and motivated to take action to address a problem. Until community members recognize that behavioral health disparities exist, and the impact that these disparities have on individuals as well as the community as a whole, it will be difficult to change the status quo. Community members who are "ready" to address behavioral health disparities are more likely to support and/or get involved in efforts to do so.

This resource introduces nine stages of community readiness[3] identified by the Tri-Ethnic Center for Prevention Research at Colorado State University. Understanding where community members are in relation to behavioral health disparities will help you develop goals for moving forward that are well-matched to community needs.

STAGES OF READINESS

Stage 1: Community Tolerance/No Knowledge

Community norms actively tolerate or encourage the behavior, although expectations of participation in the behavior may vary by social group (for example, by gender, race, social class, or age). The behavior is viewed as acceptable when it occurs in the appropriate social context. Those who do not engage in the behavior may be tolerated, but might be viewed as somewhat deviant. Stage 1 strategies include small-group and one-on-one discussions with community leaders to:

- Identify perceived benefits of substance misuse and how norms reinforce use
- Discuss the health, psychological, and social costs of substance use and misuse to change the perceptions of those most likely to participate in prevention activities

STAGE 1 PREVENTION GOAL
Increase awareness of priority problem(s)

Stage 2: Denial

There may be recognition that the behavior is or can be a problem. Community norms usually would not approve of the behavior, but there is little or no recognition that this might be a local problem. If there is some idea that it is a problem, there is a feeling that nothing needs to be done about this locally, or that nothing can be done about it. Stage 2 strategies include:

[3] Plested, B.A., Edwards, R.W., & Jumper-Thurman, P. (2006). *Community readiness: A handbook for successful change.* Fort Collins, CO: Tri-Ethnic Center for Prevention Research

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- Educational outreach programs on the health, psychological, and social costs of substance use and misuse to community leaders and community groups interested in sponsoring local programs
- Use of local incidents that illustrate harmful consequences of substance misuse in one-on-one discussions and educational outreach programs

STAGE 2 PREVENTION GOAL

Increase awareness that problem has local implications

Stage 3: Vague Awareness

There is a general belief that there is a local problem and that something ought to be done about it. Knowledge about local problems tends to be stereotypical and vague, or linked only to a specific incident or two. There is no immediate motivation to do anything. No identifiable leadership exists, or leadership lacks energy or motivation. Stage 3 strategies include:

- Educational outreach programs on national and state prevalence rates of substance use and prevalence rates in other communities with similar characteristics to community leaders and possible sponsorship groups. Programs should include use of local incidents that illustrate harmful consequences of substance misuse.
- Local media campaigns that emphasize consequences of substance misuse

STAGE 3 PREVENTION GOAL

Strengthen belief that community CAN do something

Stage 4: Pre-Planning

There is clear recognition that there is a local problem and that something should be done about it. There is general information about local problems, but ideas about etiology or risk factors tend to be limited. There are identifiable leaders, and there may be a committee, but no real planning. Stage 4 strategies include:

- Educational outreach programs that include prevalence rates and correlates or causes of substance use to community leaders and sponsorship groups
- Educational outreach programs that introduce the concept of prevention and illustrate specific prevention programs adopted by other communities with similar profiles

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- Local media campaigns emphasizing the consequences of substance misuse and ways of reducing demand for illicit substances through prevention programming

STAGE 4 PREVENTION GOAL

Increase understanding that prevention can increase community wellness

Stage 5: Preparation

Planning is going on and focuses on practical details. There is general information about local problems and about the pros and cons of prevention programs, but it may not be based on formally collected data. Leadership is active and energetic. The program may have started on a trial basis. Funding is being actively sought or has been committed. Stage 5 strategies include:

- Educational outreach programs open to the general public on specific types of prevention programs, their goals, and how they can be implemented
- Educational outreach programs for community leaders and local sponsorship groups on prevention programs, goals, staff requirements, and other startup aspects of programming
- A local media campaign describing the benefits of prevention programs for reducing consequences of substance misuse

STAGE 5 PREVENTION GOAL

Increase awareness of effective prevention programs

Stage 6: Initiation

Enough information is available to justify a prevention program, but knowledge of risk factors is likely to be limited. A program has been started and is running, but it is still on trial. Staff is in training or has just finished training. There may be great enthusiasm because challenges have not yet been experienced. Stage 6 strategies include:

- In-service educational training for program staff (paid and/or volunteer) on substance misuse consequences, correlates, and causes and the nature of the problem in the local community
- Publicity efforts associated with the kickoff of the program
- A special meeting to provide an update and review of initial program activities with community leaders and local sponsorship groups

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STAGE 6 PREVENTION GOAL

Increase requisite capacity to address problems

Stage 7: Institutionalization/Stabilization

One or two programs are running, supported by administration, and accepted as a routine and valuable activity. Staff are trained and experienced. There is little perceived need for change or expansion. Limitations may be known, but there is not much sense that the limitations suggest a need for change. There may be some form of routine tracking of prevalence. There is not necessarily permanent funding, but there is established funding for the program to implement its action plan. Stage 7 strategies include:

- In-service educational programs on the evaluation process, new trends in substance misuse, and new initiatives in prevention programming. Either trainers are brought in from the outside or staff members are sent to programs sponsored by professional societies.
- Periodic review meetings and/or special recognition events for local supporters of prevention program
- Local publicity efforts associated with review meetings and recognition events

STAGE 7 PREVENTION GOAL

Stabilize efforts/ideas

Stage 8: Confirmation/Expansion

Standard programs are viewed as valuable and authorities support expanding or improving programs. New programs are being planned or piloted in order to reach more people. Outreach may be targeted to higher risk populations or different demographic groups. Funds for new programs are being sought or committed. Data are obtained regularly on extent of local problems and efforts are made to assess risk factors and cause s of the problem. Stage 8 strategies include:

- In-service educational programs on conducting local needs assessments to target specific populations for prevention programming. External experts may provide training or staff members may attend professional development training.
- Periodic review meetings and/or special recognition events for local supporters of prevention programs
- Results of research and evaluation activities of the prevention program are presented to the public through local media and/or public meetings

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STAGE 8 PREVENTION GOAL

Expanded and/or improved services

Stage 9: Professionalization

Detailed and sophisticated knowledge of prevalence, risk factors, and etiology exists. Some programs may be aimed at general populations, while others are targeted at specific risk factors and/or at-risk groups. Highly trained staff members are running programs, authorities are supportive, and community involvement is high. Effective evaluation is used to test and modify programs. Stage 9 strategies include:

- Continued in-service training of staff
- Continued assessment of new drug-related problems and reassessment of targeted groups within community
- Continued evaluation of program effort
- Continued updates on program activities and results for the benefit of community leaders and local sponsorship groups and periodic stories through local media and/or public meetings

STAGE 9 PREVENTION GOAL

Maintained momentum and capacity to address other issues

"Goal" icons by Lemon Liu from thenounproject.com

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APPLYING THE ENHANCED NATIONAL CLAS STANDARDS TO REDUCE BEHAVIORAL HEALTH DISPARITIES

Many health care stakeholders are developing initiatives to support cultural competence in the areas of health care policy, practice, and education.[4] Cultural competence has emerged as an important issue for three practical reasons. First, as the United States becomes more diverse, practitioners will increasingly see people with a broad range of perspectives on health, often influenced by their social or cultural backgrounds. Second, research has shown that provider-patient communication is linked to health outcomes. For example, a recent Medicaid study suggests that language and cultural competence practices are positively related to childhood asthma outcomes.[5] And third, two landmark Institute of Medicine (IOM) reports—*Crossing the Quality Chasm* and *Unequal Treatment*—highlight the importance of patient-centered care and cultural competence in improving quality and eliminating health disparities.[6]

One of the most modifiable factors contributing to health inequities is the lack of culturally and linguistically appropriate services, broadly defined as care and services that are respectful of and responsive to the cultural and linguistic needs of all individuals. Culturally and linguistically appropriate services (CLAS) are increasingly recognized as effective in improving the quality and effectiveness of care and services.[7]

The **Enhanced National CLAS Standards** are the gold standard for providing these services in the most responsive and responsible way. They help users respond to the changing demographics in the United States and expand access to health care for diverse populations, thereby advancing the health and wellness of our nation.

This section provides an overview of how and why the National CLAS Standards were created, a description of each standard, and a few examples of how states are currently adopting these standards in the field.

"One of the most modifiable factors contributing to health inequities is the lack of culturally and linguistically appropriate services."

[4] Betancourt, J. R., Green, A. R., Carillo, J. E., & Park, E. R. (2005). Cultural competence and health care disparities: Key perspectives and trends. *Health Affairs*, *24*(2), 499-505.

[5] Lurie, N., Jung, M., & Lavizzo-Mourey, R. (2005). Disparities and quality improvement: Federal policy levers. *Health Affairs, 24*(2), 354-364.

[6] Betancourt, J. R., Green, A. R., Carillo, J. E., & Park, E. R. (2005). Cultural competence and health care disparities: Key perspectives and trends. *Health Affairs, 24*(2), 499-505.

[7] U.S. Department of Health and Human Services, Office of Minority Health. (2013). *Standards for culturally and linguistically appropriate services in health and health care: A blueprint for advancing and sustaining CLAS policy and practice.* Retrieved from https://www.thinkculturalhealth.hhs.gov/pdfs/EnhancedCLASStandardsBlueprint.pdf.

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ABOUT THE CLAS

The original National CLAS Standards, developed in 2000, provided guidance on cultural and linguistic competence, with the ultimate goal of reducing racial and ethnic health care disparities. In 2010, the Office of Minority Health at the U.S. Department of Health and Human Services launched the National CLAS Standards Enhancement Initiative to recognize the nation's increasing diversity, reflect the tremendous growth in the fields of cultural and linguistic competence over the past decade, and ensure relevance with new national policies and legislation, such as the Affordable Care Act.[8]

The enhanced National Standards for Culturally and Linguistically Appropriate Services provide a blueprint for community-based and health care organizations to implement culturally and linguistically appropriate services that will advance health equity and improve quality. The 15 Standards incorporate broad definitions of culture and health to ensure that every individual has the opportunity to receive culturally and linguistically appropriate health care and services.[9]

The enhanced CLAS Standards are accompanied by the *National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care: A Blueprint for Advancing and Sustaining CLAS Policy and Practice (The Blueprint)*. This guidance document is designed to help users establish and expand culturally and linguistically appropriate services. The Blueprint devotes a chapter to each CLAS Standard, describing the purpose, components, implementation strategies, and additional resources for each Standard.

Implementation of the CLAS Standards will vary from organization to organization. Organizations should identify the most appropriate implementation methods, given their size, mission, scope, and type of service. They should also develop measures to examine the effectiveness of the programs being implemented, and to identify areas for improvement and next steps.[9]

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[8] U.S. Department of Health and Human Services, Office of Minority Health. (n.d.). Executive summary. *National standards for culturally and linguistically appropriate services in health and health care: A blueprint for advancing and sustaining CLAS policy and* practice. Retrieved from https://www.thinkculturalhealth.hhs.gov/CLAS/Clas_Overview.asp.

[9] U.S. Department of Health and Human Services, Office of Minority Health. (2013). *National standards for culturally and linguistically appropriate services in health and health care: A blueprint for advancing and sustaining CLAS policy and practice.* Retrieved from https://www.thinkculturalhealth.hhs.gov/pdfs/EnhancedCLASStandardsBlueprint.pdf.

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THE STANDARDS

The enhanced National CLAS Standards comprise one principal standard and 14 related standards which, if adopted, implemented, and maintained, will support attainment of the principal. The 14 standards are organized according to three themes:

- *Theme 1: Governance, Leadership and Workforce* – emphasizes the importance of CLAS implementation as a systemic responsibility that requires the endorsement and investment of leadership, and the support and training or all individuals within an organization.
- *Theme 2: Communication and Language Assistance* – recognizes that appropriate services must address all communication needs and services (e.g., sign language, Braille, oral interpretation and written translation).
- *Theme 3: Engagement, Continuous Improvement, and Accountability* – underscores the importance of establishing individual responsibility for ensuring that CLAS is supported, while maintaining that effective delivery of CLAS demands action across organizations.

Principal Standard:

1. Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.

Governance, Leadership, and Workforce:

2. Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices, and allocated resources.
3. Recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce that are responsive to the population in the service area.
4. Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.

Communication and Language Assistance:

5. Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.
6. Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.
7. Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.
8. Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.

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Engagement, Continuous Improvement, and Accountability:

9. Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organization's planning and operations.
10. Conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities.
11. Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery.
12. Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.
13. Partner with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness.
14. Create conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints.
15. Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents, and the general public.

The enhanced National CLAS Standards apply to all members of the health and health care community, including those who provide behavioral health, mental health, and community health services, and to consumers, workforce, and federal, state, tribal, and local governments.[10] To download the enhanced CLAS Standards, *The Blueprint*, and related documents to support standard implementation and maintenance, go to the Office of Minority Health's Think Cultural Health website.

[10] U.S. Department of Health and Human Services, Office of Minority Health. (2013). *National standards for culturally and linguistically appropriate services in health and health care: A blueprint for advancing and sustaining CLAS policy and practice.* Retrieved from https://www.thinkculturalhealth.hhs.gov/pdfs/EnhancedCLASStandardsBlueprint.pdf.

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USING THE ENHANCED NATIONAL CLAS STANDARDS: EXAMPLES FROM THE FIELD

Maryland's Office of Minority Health and Health Disparities created a pair of toolkits to facilitate implementation and increase awareness of the CLAS Standards in health and health care settings throughout the state:

- *The Toolkit for Health Care Delivery Organizations* is aimed at assisting health care agencies, such as hospitals, clinics, local health departments and physicians' offices, implement the CLAS standards in their organizations.
- *The Toolkit for Community-Based Organizations and Outreach Workers* is aimed at helping community-based organizations and outreach workers increase awareness of CLAS implementation among the clients they serve. This toolkit also provides community-based organizations with the information needed to implement CLAS in their own agencies.

The Mississippi Department of Mental Health expects all its substance abuse prevention and treatment grantees to implement and assess their implementation of the CLAS Standards. This approach includes three components:

- *Training*: Grantees receive from the state extensive training in cultural competence and the CLAS Standards, and are convened regularly to share resources and discuss how they are addressing and implementing the standards.
- *Policy and Protocol Development*: The Mississippi Department of Mental Health developed a Health Disparities Statement; grant applications and proposals are assessed on how well they address behavioral health disparities based on this policy statement.
- *Program Evaluation*: Grantees are required to assess and report cultural competence as part of their process and outcome evaluation procedures, and quality improvement plans need to address any disparities identified so that equity can be restored.

Mississippi further encourages communities to develop their own health disparities statements, and to include these as appendices to their grant proposals.

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MAPPING CLAS STANDARDS TO THE SPF

The charts below offer a starting point for identifying opportunities to apply the Enhanced National CLAS Standards to the five steps of SAMHSA's Strategic Prevention Framework (SPF).

Please note: For ease of reference, the numbers in the right-hand column of each chart (e.g. "(12)") indicate the number by which that CLAS Standard is listed on pages 19-20 above.

STEP 1: ASSESSMENT

Assessment, the first step of the SPF, involves identifying local prevention needs based on data.

CLAS CATEGORY	OPPORTUNITY TO APPLY CLAS STANDARD
Engagement, Continuous Improvement, and Accountability	(12) Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area. *Note: There are also opportunies to apply this standard in SPF Steps 3 & 4*

STEP 2: CAPACITY

Capacity, the second step of the SPF, involves building and engaging local resources and readiness to address identified prevention needs.

CLAS CATEGORY	OPPORTUNITY TO APPLY CLAS STANDARD
Governance, Leadership, and Workforce	(2) Advance and sustain organizational governance and leadership processes that promote CLAS and health equity through policy, practices, and allocated resources
	(3) Recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce that are responsive to the population in the service area
	(4) Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis
Engagement, Continuous Improvement, and Accountability	(9) Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them into your prevention infrastructure

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	(13) Partner with community members to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness. *Note: There is also an opportunity to apply this standard in SPF Step 3*
	(14) Create conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints.
	(15) Communicate progress implementing and sustaining CLAS to all stakeholders, constituents, and the general public.

STEP 3: PLANNING

Planning, the third step of the SPF, involves figuring out how to best address identified prevention needs and associated factors.

CLAS CATEGORY	OPPORTUNITY TO APPLY CLAS STANDARD
Principal Standard	(1) Provide effective, equitable, understandable, and respectful services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs *Note: There is also an opportunity to apply this standard in SPF Step 4*
Engagement, Continuous Improvement, and Accountability	(12) Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area. *Note: There are also opportunies to apply this standard in SPF Steps 1 & 4*
	(13) Partner with community members to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness *Note: There is also an opportunity to apply this standard in SPF Step 2*

STEP 4: IMPLEMENTATION

Implementation, the fourth step of the SPF, involves putting your plan into action by delivering evidence-based interventions as intended.

CLAS CATEGORY	OPPORTUNITY TO APPLY CLAS STANDARD
Principal Standard	(1) Provide effective, equitable, understandable, and respectful services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs. *Note: There is also an opportunity to apply this standard in SPF Step 3*
Communication and Language Assistance	(5) Offer language assistance to individuals who have limited English proficiency and/or other communication needs to facilitate timely access to all health care and services
	(6) Inform all individuals of the availability of language-assistance services clearly, both verbally and in writing, in their preferred language
	(7) Ensure the competence of individuals providing language assistance, avoiding the use of untrained individuals and/or minors as interpreters
	(8) Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the focus population(s)
Engagement, Continuous Improvement, and Accountability	(12) Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area. *Note: There are also opportunies to apply this standard in SPF Steps 1 & 3*

STEP 5: EVALUATION

Evaluation, the fifth step of the SPF, involves examining both the process and outcomes of prevention interventions.

CLAS CATEGORY	OPPORTUNITY TO APPLY CLAS STANDARD
Engagement, Continuous Improvement, and Accountability	(10) Conduct ongoing assessments of CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities.
	(11) Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery.

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CREATING AN ACTION PLAN (WORKSHEET)

Having a written action plan that spells out what you are going to do to address behavioral health disparities in your community, when you will do it, and who is responsible for what, will greatly enhance your potential for success. A clear action plan will help your prevention team identify the specific steps needed to move your efforts forward, monitor your progress, and keep the group accountable.

INSTRUCTIONS

- For each of three time intervals—within one week, within one month, and within six months of completing the tool—write down the action steps you will take to address behavioral health disparities in your community.
- For each action step, determine who will be responsible for completing the step, as well as any resources and/or capacity building needed to complete the step.

The chart on the following page includes an example of one possible action step for each timeframe. Your completed chart is likely to include multiple steps.

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CREATING AN ACTION PLAN - WORKSHEET (EXAMPLE)

Timeline:	Action Step(s)	Individual(s) Responsible	Needed Resources	Needed Capacity Building	Outcome
Within one week	*Find existing survey data that describe substance use patterns for target sub-population compared to the rest of the population.*	*Epidemiologist, Grant coordinator*	*Local epidemiological profile*	*Information on finding existing/archival data. Consider providing key stakeholders with access to the CAPT self-paced online course* Go Get It! Finding Existing Data to Inform Your Prevention Efforts	*Identify available data on substance use patterns for target sub-population*
Within one month	*To increase awareness among target sub-population, develop and disseminate fact sheet that (1) compares health outcomes for sub-population and general population, and (2) identifies risk and protective factors for target population.*	*Grant coordinator, Hispanic Community Liaison*	*Local health survey data*	*Design assistance (maybe from Graphics and Design Department at local university?)*	*Fact sheet*
Within six months	*Identify 1-2 strategies for addressing identified factors*	*Grant coordinator in collaboration with Evidence-based Workgroup*	*National Registry of Evidence-based Programs and Practices (NREPP)*	*T/TA on selecting evidence-based interventions*	*1-2 strategies selected*

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CREATING AN ACTION PLAN - WORKSHEET

Timeline:	Action Step(s)	Individual(s) Responsible	Needed Resources	Needed Capacity Building	Outcome
Within one week					
Within one month					
Within six months					

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PUTTING IT ALL TOGETHER: A CASE EXAMPLE FROM ANYTOWN, USA

While most practitioners working to prevent substance use and misuse appreciate the importance of addressing behavioral health disparities, the process of determining the specific disparities that exist in a community, identifying those populations most affected, and developing a concrete plan for working toward health equity can be challenging.

This case example is designed to help prevention practitioners better understand this process by illustrating the types of decisions and actions a community might take at each step of SAMHSA's Strategic Prevention Framework (SPF) to address the needs of their vulnerable populations. Though this case explores the steps that prevention planners from Anytown took to address behavioral health disparities among Hispanic/Latino youth, with some adaptation and tailoring, similar approaches can be applied to any focus population.

***Please Note**:* In this case example, the state directs Anytown to address underage drinking. The reader can assume that Anytown addresses this problem among *all* youth. However, the following narrative focuses solely on those steps taken to address underage drinking among Hispanic/Latino youth, a sub-population experiencing higher rates of underage drinking and related consequences than their peers.

STEP 1: ASSESSMENT

The Anytown Prevention Coalition recently received funding from the state to address underage drinking among youth ages 12 to 20. To better understand what this problem looks like in their community, the coalition examines Anystate Youth Survey data to find out if there are any sub-populations within the community that are experiencing more problems related to underage drinking than others.

Survey data reveal that Hispanic/Latino 8th, 9th, and 11th graders attending the local middle school and high school are more likely than their non-Hispanic peers to report past 30-day alcohol use (see Figure 1 below).

Addressing Behavioral Health Disparities in SPF Step 1

Consider the following questions:

- ✓ Are certain sub-populations in the community experiencing more substance use problems and/or consequences than others?
- ✓ What does the data say about the health differences they are experiencing?
- ✓ What other information is available about these sub-populations?
- ✓ Which risk or proactive factors are associated with substance use or misuse problems in these sub-populations?
- ✓ What additional data can fill any data gaps related to these vulnerable sub-populations?
- ✓ Are there any other organizations and/or groups currently addressing these problems?

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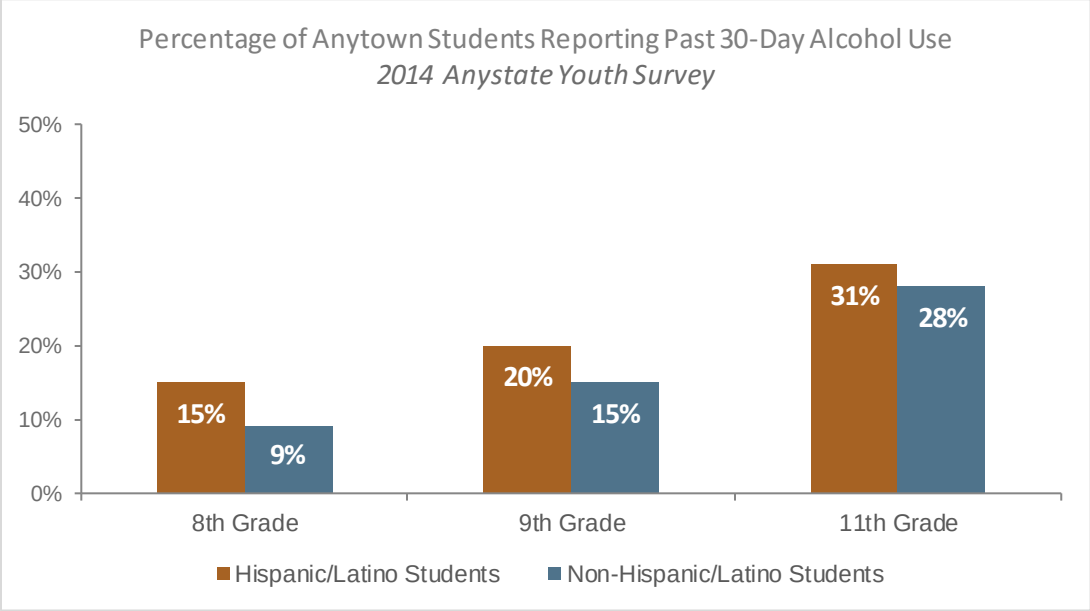
Figure 1. Percentage of Students Reporting Past 30-day Alcohol Use



Recognizing that these data expose a potential behavioral health disparity within the community, the coalition decides to learn more about this population. Census data reveals that Anytown's Hispanic/Latino population has been growing in recent years—population estimates show that it has doubled from 4% in 2000 to 8% in 2014. In addition, 40% of the community's Hispanic/Latino residents are under age 18, compared to 28% of non-Hispanic residents.

The coalition also wants to find out which factors are associated with underage drinking among this group. Here's what the Anystate Youth Survey revealed:

- Hispanic/Latino youth, like all youth in Anytown, are most likely to report getting alcohol from social sources. However, Hispanic/Latino youth are more likely than their peers to report buying alcohol (see Table 1).
- Hispanic/Latino students in Anytown are less likely than non-Hispanic/Latino youth to report feeling that adults, including teachers and other adults at school, care about them (see Figure 2 below). Interestingly, there were no differences between Hispanic/Latino students and their non-Hispanic/Latino peers regarding the extent to which they feel their friends care about them.
- Hispanic/Latino youth in Anytown were less likely to report participation in school activities but more likely to report participation in community and religious activities (see Table 2 below). This finding was important because research shows that youth activities can protect against substance use.

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Table 1. Alcohol Sources for Anytown Students Reporting Past 30-Day Alcohol Use

Alcohol Source	Hispanic/Latino Students	Non-Hispanic/Latino Students
Bought at gas station/convenience store	5%	2%
Bought at bar or restaurant	7%	2%
Bought at liquor store	9%	5%
Got from friends	43%	46%
Got from parents	15%	14%
Got from other family members	13%	12%
Got at parties	38%	37%
Took from home	22%	25%
Took from a friend's home	9%	10%
Took from stores	3%	3%

No data were available by race/ethnicity from local law enforcement related to underage drinking citations. The Anytown Coalition requested data on alcohol-related injuries from area hospitals, but none were provided.

Figure 2. Youth Perception of How Much Adults Care

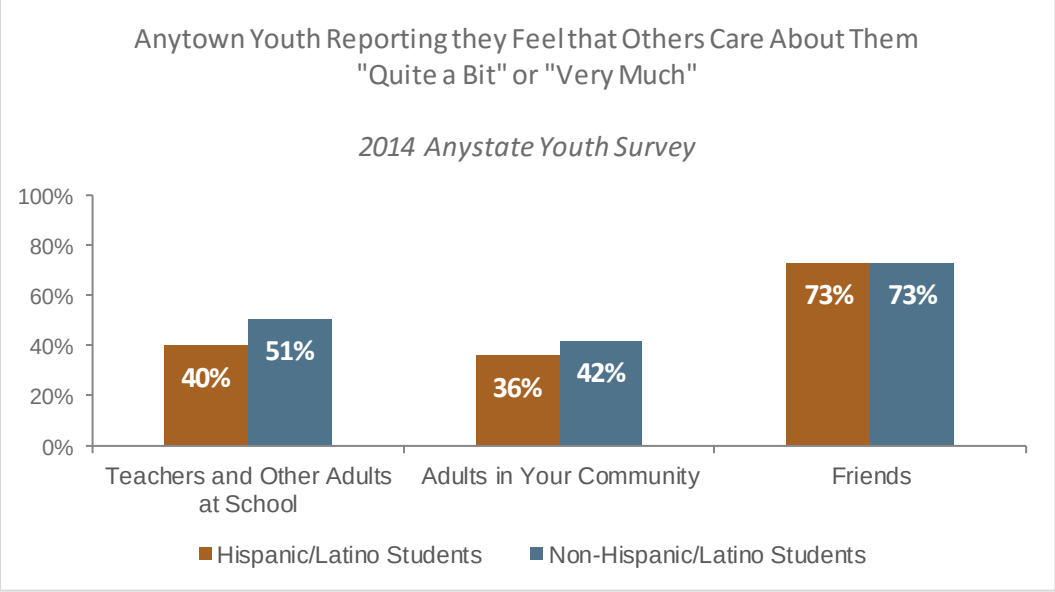

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Table 2. Anytown Student Participation in Activities

Activity	Hispanic/Latino Students	Non-Hispanic/Latino Students
School sports	39%	64%
Other school activities (e.g., drama, academic clubs, student government)	15%	24%
Community activities (e.g., 4-H Club, Boys and Girls Club)	33%	28%
Religious activities (e.g., attendance at religious services, participation in youth groups)	52%	47%

The Anytown Coalition wants to determine if there are any other factors contributing to the problem of underage drinking among Hispanic/Latino youth in the community that were not captured in the Any state Youth Survey. To identify possible data gaps, they hire a Hispanic/Latino Ph.D. candidate from the local university who is fluent in Spanish and has experience and proficienty in conducting research with Hispanic/Latino populations. She conducts key informant interviews with Hispanic/Latino community leaders, as well as focus groups with Hispanic/Latino parents. To identify and recruit interview and focus group subjects, the coalition posts flyers in local area churches, develops and broadcasts public service announcements on the local Spanish-language radio station, and develops Spanish language flyers that school administrators agree to send home with Hispanic/Latino students.

Interviews with community leaders reveal the following:

- Hispanic/Latino families are actively involved in the community, caring for the sick and/or elderly and providing social support to new community members.
- Many older Hispanic/Latino teens and young adults (ages 16 and older) work in local bars and restaurants.
- Many Hispanic/Latino parents work multiple jobs and so have less time to monitor their children's behavior.
- Numerous celebrations are held in the community. Though alcohol is frequently available, youth access is restricted.
- Some Hispanic/Latino families don't speak with authorities for fear of deportation.

Focus groups with Hispanic/Latino parents reveal the following:

- Many parents feel that their children don't talk to them about the problems they're having.

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- Several parents wished they could spend more time with their families but noted that it's difficult to take time off of work. Few parents report having jobs that offer vacation time.
- Concerns about being able to afford rent, utilities, groceries, health insurance, and transportation were mentioned often.
- Many parents said that their kids don't feel like they fit in at school. Several parents also said that there were few opportunities to communicate with school staff about these or other concerns.
- When asked about youth alcohol use in the community and whether they were concerned about it, many parents responded that drinking is just something kids do.

Factors Associated with Underage Drinking among Anytown Hispanic/Latino Youth

Risk Factors

- ✓ Social access to alcohol
- ✓ Retail access to alcohol
- ✓ Low perception of harm
- ✓ Low parental monitoring

Protective Factors

- ✓ Participation in community activities
- ✓ Participation in religious activities

Potential Protective Factors to Strengthen

- ✓ Having non-parent adult role models
- ✓ Participation in school activities
- ✓ Perceived teacher support
- ✓ Perceived community support
- ✓ Adolescent-parent communication

The coalition also takes stock of the resources available in Anytown to address underage drinking among Hispanic/Latino youth. They start by finding out whether there are any other organizations working on the same problem. They know that many Hispanic/Latino youth attend the local Boys & Girls and 4-H Clubs, so they contact these organizations to learn more about their programs. Although neither organization addresses underage drinking, they discover that over half of the youth that attend the Boys and Girls Club are Hispanic/Latino. The coalition asks the Boys & Girls Club if they would be interested in partnering in the future and they agree.

Finally, the coalition examines their own membership to make sure that they have representatives from the Hispanic/Latino community on the team. Discovering that it does not, they prioritize the need to recruit new members to address this resource gap.

STEP 2: BUILD CAPACITY

With a better understanding of the scope of underage drinking among Hispanic/Latino community youth, as well as the factors associated with the problem, the Anytown Prevention Coalition's next task is to build the community's capacity—that is, its resources and readiness—to address the problem.

Addressing Behavioral Health Disparities in SPF Step 2

- ✓ Ensure that your coalition includes members of sub-populations experiencing behavioral health disparities
- ✓ Raise awareness of problem with sub-populations experiencing the problem

To address the lack of Hispanic/Latino stakeholders in their coalition, they reach out to a community liaison

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who works with a local non-profit that serves Hispanic/Latino families and is a member of the Hispanic/Latino community herself, who enthusiastically joins. They also reach out to and recruit the owner of a Hispanic restaurant, having identified restaurants and bars as a source of alcohol for Hispanic/Latino youth, in particular. Finally, they connect with the high school guidance counselor, who recommends a Hispanic/Latino student who she believes will be a great addition to the team. They reach out to the young woman and she agrees to join.

To raise awareness among parents and other members of the risk associated with underage drinking, the coalition reaches out to three local churches with large numbers of Hispanic/Latino parishioners. One of the churches agrees to host an informational breakfast on the topic of underage drinking, and the other two churches agree to promote the event. The breakfast is facilitated by the coalition's new community liaison, who brings along an infographic translated into Spanish that describes the relevant assessment findings. During her talk, she presents data about rates and sources of underage drinking in the community and highlights what the coalition has learned about the factors protecting Anytown's Hispanic youth from this behavior—such as participation in community, religious, and school activities. She also leaves plenty of time for questions. The breakfast attracts a large turnout of Hispanic/Latino parents.

Coalition members also meet with the middle and high school principals to present their findings, particularly those related to school involvement. The high school principal is very receptive and eager to partner with them, but the middle school principal seems reluctant to acknowledge that the problem is serious enough to warrant action. They schedule a second meeting with the middle school principal that includes the coalition's youth representative and several other high school students. The students share their experiences with alcohol in middle school, which helps to get the principal's buy-in.

STEP 3: PLANNING

Addressing Behavioral Health Disparities in SPF Step 3

- ✓ Involve members of your focus population as active participants and decision-makers in the planning process.
- ✓ Incorporate effective prevention interventions that have been developed for and evaluated with an audience similar to your focus population.

The coalition spends many months researching programs and strategies that address their prioritized factors and have been shown to be effective at preventing underage drinking among Hispanic/Latino youth. They consult practice-support tools such as *Ensuring the Well-Being of Boys and Young Men of Color: Factors that Promote Success and Protect Against Substance Use and Misuse*, which presents factors that protect against substance use among minority youth. They search the National Registry of Evidence-based Programs and Practices, but are unable to find any programs that meet their criteria. They also consult the tool *Positive Approaches to Preventing Substance Use and Misuse Among Boys and Young Men of Color: Programs and Strategies At-a-Glance*.

In developing their prevention approach, the coalition makes sure that their decisions and planned activities are consistent with the National Standards for Culturally and Linguistically Appropriate Services (CLAS). To

ensure that the strategies they select are culturally and linguistically relevant, they consult with the two Hispanic/Latino coalition members and with adult and youth representatives from the Hispanic/Latino community, to make certain their selected approaches are respectful of and resonate with parents and youth. Table 3 shows the strategies that the coalition will implement to prevent underage drinking among Anytown's Hispanic/Latino youth, and the steps it will take to increase the relevance of each strategy to this group.

Table 3. Selected Strategies and Key Partners

Strategies	Key Partners	Activities Targeting the Needs of Hispanic/Latino Youth
• Conduct compliance checks and provide Responsible Beverage Server Training (RBST) for bar and restaurant staff	• Law enforcement (already on the coalition)	• Hire a bilingual trainer to reach out to and provide training to staff from Hispanic/Latino-owned bars and restaurants
• Implement a mentoring program, pairing at-risk middle school youth with high school youth leaders who have successfully completed Project ALERT—a middle school substance use and misuse prevention program. • Partner with the local Boys & Girls Club to identify Hispanic/Latino middle school youth to participate in mentoring program; club could also provide a fun and venue for program participants to meet • Recruit and train high school youth to deliver the curriculum at the middle school.	• Middle school health teacher (teaches Project ALERT) • High school principal • High school health teacher • The Boys & Girls Club	• Recruit Hispanic/Latino peers to participate in the mentoring program, pairing them with Hispanic/Latino mentors
• Improve communication between middle and high school staff and Latino/ Hispanic parents	• Administrative assistants from each school • Hispanic/Latino parent liaison • Middle and high school principals	• Hire a Hispanic/Latino community member to (1) serve as a liaison between Hispanic/Latino parents and the middle and high school administration and staff, and (2) create or translate materials for Hispanic/Latino parents

Strategies	Key Partners	Activities Targeting the Needs of Hispanic/Latino Youth
• Expand late bus service to ensure transportation for youth who want to participate in school-based after-school programs (e.g., sports, clubs)	• District Superintendent's Office • School bus service coordinator • New Hispanic/Latino parent liaison	• Translate into Spanish and disseminate flyer that describes the expanded late-bus service
• Implement a public awareness campaign aimed at increasing youth perception that adults in the community care about young people and are concerned about their well-being	• Public health and arts departments from local university • Hispanic/Latino youth	• Develop materials in both Spanish and English • Include in campaign materials images of Hispanic/Latino youth • Involve Hispanic/Latino youth in the development of campaign materials (e.g., convene focus groups to elicit feedback)

STEP 4: IMPLEMENTATION

The coalition begins implementing its prevention strategies in 2014, monitoring their progress along the way to ensure that they were delivered as planned. Here's what they learn:

- It took more time than expected to find and hire a bilingual trainer to provide required beverage server trainings for local restaurant and bar staff. These trainings were further delayed because the trainer first needed to attend a training-of-trainers that was only offered a few times a year. But once up and running, the weekly trainings were well-attended.
- The mentoring program is gaining traction. However, because only 9 of the 22 youth

Addressing Behavioral Health Disparities in SPF Step 4

- ✓ Partner with representatives of your sub-populations that are experiencing behavioral health disparities to deliver your prevention strategies
- ✓ Ensure intervention approaches and materials are culturally and linguistically competent and meet the prevention needs of sub-populations
- ✓ Monitor implementation progress along the way. If sub-populations are not engaged, think strategically about steps you can take to enhance program delivery.

leaders identify as Hispanic/Latino, some Hispanic/Latino middle school students were paired with non-Hispanic/Latino mentors.

- The school system successfully hired a parent to serve as a liaison to other Hispanic/Latino parents at the middle and high schools. The Coalition helps fund this position through their grant.
- Despite the availability of expanded late bus service (and of Spanish language flyers describing the service), Hispanic/Latino participation in after-school activities remained low. After three months of no change, the coalition asks the school to host an hour-long activities fair during the school day. Hispanic/Latino students from each club or sport were asked to staff the tables. This recruitment campaign resulted in 38 new students signing up for afterschool activities, 60% of whom were Hispanic/Latino.
- The coalition worked with students from the local university's graphic design department to develop materials for a campaign to communicate the message that adults care about the young people in their community. To inform the design and delivery of the campaign, they convened focus groups with Hispanic/Latino youth. Campaign messages were delivered via social media (Facebook, Instagram, and Twitter) and posters at the middle and high schools, and at youth-serving organizations.

STEP 5: EVALUATION

The coalition meets with their evaluation team to map out a comprehensive evaluation plan that is designed to detect changes in behaviors and perceptions with Hispanic/Latino youth. Their plan includes a review of 2019 Anystate Youth Survey data to detect changes in alcohol-related behavior and perceptions of use, and focus groups with youth, parents, and other community members to identify other changes in factors influencing alcohol use among Hispanic/Latino youth, such as retail access to alcohol, participation in school activities, and perceived community support. They implement their plan during the final year of program implementation and learn the following:

- Between 2014 and 2019, past 30-day alcohol use rates decreased slightly for non-Hispanic/ Latino students but remained higher for Hispanic/Latino youth than for their peers.
- Staff from all but one Hispanic/Latino-owned bar or restaurant received RBST. The one establishment that refused to train their staff failed three compliance checks and their liquor license was eventually revoked.

Addressing Behavioral Health Disparities in SPF Step 5

- ✓ Ensure evaluation plan is designed to capture outcomes for sub-populations experiencing behavioral health disparities
- ✓ Translate evaluation if you are targeting a sub-population with limited English proficiency
- ✓ Conduct focus groups and key informant interviews with representatives from sub-populations to glean additional insights about your data and how your interventions are being received
- ✓ Track adaptation made to evidence-based programs and practices to enhance cultural relevance
- ✓ Share positive findings with the community to help ensure sustainability

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- In 2019, Hispanic/Latino youth were less likely to report buying alcohol, but were more likely to report getting alcohol from friends and at parties.
- An increased percentage of Hispanic/Latino students reported participation in school sports, but not participation in other school activities
- Parents, including Hispanic/Latino parents, reported increased levels of communication with school staff.
- A focus group comprising mentees from the school mentoring program revealed that middle school Hispanic/Latino mentees paired with a Hispanic/Latino mentor experienced greater levels of enjoyment and satisfaction with the program than those paired with a non-Hispanic/Latino mentor.
- Hispanic/Latino youth perception of adults in the community caring improved over the four years, but not their perception of teachers at school caring.

Overall, the coalition is pleased with the progress it's made. Members are now working to ensure that they can sustain those strategies that are most successful. They've shared their findings with the community —both in the newspaper and in a "town hall" style event. They will continue to implement compliance checks and the RSBT trainings, as these produced positive outcomes and are well-supported by the community. They will also continue to run the public awareness campaign each spring. To strengthen the mentoring program, they are exploring ways to engage more Hispanic/Latino student mentors.

The coalition is also interested in learning more about how students are gaining access to alcohol through friends, as they hope to address this emerging risk factor in the future. They will include this in their upcoming assessment and review of Anytown youth behaviors.

ADDITIONAL RESOURCES

CAPT RESOURCES

Online Courses (Available through *Prevention Training Now!*)

- Making the Most of Key Informant Interviews: https://captonline.edc.org/
- Focusing on Focus Groups: https://captonline.edc.org/

Tip Sheets, Tools, and Stories

- Tips for Conducting Key Informant Interviews: http://www.samhsa.gov/capt/tools-learning-resources/conducting-key-informant-interviews
- Strategies for Conducting Effective Focus Groups: http://www.samhsa.gov/capt/tools-learning-resources/effective-focus-groups
- Needs Assessment and Cultural Competence: Questions to Ask: http://www.samhsa.gov/capt/tools-learning-resources/needs-assessment-cultural-competance-questions
- Shining a Light on "Hidden" and "Hard-to-Reach" Populations: http://www.samhsa.gov/capt/tools-learning-resources/reaching-hidden-populations
- Getting Young Adult Survey Data: A Tale of Two States: http://www.samhsa.gov/capt/tools-learning-resources/getting-young-adult-survey-data
- Indiana Surveys Open Doors to Conversations about LGBTQ Prevention Needs: http://www.samhsa.gov/capt/tools-learning-resources/indiana-surveys-lgbtq-prevention-needs

Archived Webinars

- Increasing Cultural Competency to Reduce Behavioral Health Disparities: Approaches for States, Tribes, and Jurisdictions: http://www.samhsa.gov/capt/tools-learning-resources/increasing-cultural-competency-reduce-health-disparities-approaches-for-states-tribes-jurisdictions
- Increasing Cultural Competency to Reduce Behavioral Health Disparities: Approaches for Communities: http://www.samhsa.gov/capt/tools-learning-resources/increasing-cultural-competency-reduce-health-disparities-approaches-communities

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GENERAL RESOURCES

Behavioral Health Barometer, United States, 2014

Substance Abuse and Mental Health Services Administration
http://www.samhsa.gov/data/sites/default/files/National_BHBarometer_2014/National_BHBarometer_2014.pdf

This report provides a snapshot of behavioral health in the United States. It presents a set of substance use and mental health indicators as measured through data collection efforts sponsored by SAMHSA, including the National Survey on Drug Use and Health and the National Survey of Substance Abuse Treatment Services.

Closing the Gap in a Generation: Health Equity through Action on the Social Determinants of Heath

World Health Organization (WHO) Commission on Social Determinants of Health
http://www.who.int/social_determinants/thecommission/finalreport/en/index.html

This 2008 report presents the rationale for the global movement toward health equity, and the Commission's recommendations for promoting it.

Cultural Competence Continuum

The National Center for Cultural Competence (NCCC) at Georgetown University
http://nccccurricula.info/documents/TheContinuumRevised.doc

This resource provides information about the Cultural Competence Continuum—a framework proposed by T. Cross and colleagues that allows organizations to gauge where they are, and to plan for positive movement and growth to achieve cultural competence and proficiency.

Cultural Competence and Self-Awareness Assessments

The National Center for Cultural Competence (NCCC) at Georgetown University
http://nccc.georgetown.edu/resources/assessments.html

This website presents a selection of personnel tools that organizations can use to assess individual and collective progress toward becoming culturally competent.

Curricula Enhancement Module Series: Definitions of Cultural Competence

National Center for Cultural Competence (NCCC) at Georgetown University
http://nccccurricula.info/culturalcompetence.html

This website provides definitions and descriptions of cultural competence and other related terms that have emerged from the health and human services field.

Data 2010–Healthy People 2010 Database

Centers for Disease Control and Prevention
http://wonder.cdc.gov/data2010/

This interactive database contains the most recent monitoring data for tracking Healthy People 2010 data.

Healthy People 2010 Snapshots
Centers for Disease Control and Prevention
http://www.cdc.gov/nchs/healthy_people/hp2010/hp2010_snapshots.htm

This resource comprises five data analysis reports, one for each of the following racial and ethnic populations: American Indian or Alaska Native, Asian, Hispanic or Latino, non-Hispanic black, and non-Hispanic white.

Improving Cultural Competency to Reduce Health Disparities: Comparative Effectiveness Review
Agency for Healthcare Quality and Research
https://www.effectivehealthcare.ahrq.gov/ehc/products/573/2206/cultural-competence-report-160327.pdf

This report reviews the studies of interventions to improve culturally appropriate health care for people with disabilities; lesbian, bisexual, gay and transgender populations; and racial/ethnic minority populations.

Minority Health and Health Disparities
National Institute on Alcohol Abuse and Alcoholism (NIAAA)
http://www.niaaa.nih.gov/alcohol-health/special-populations-co-occurring-disorders/diversity-health-disparities

This website presents NIAAA research related to health disparities.

National Information Center on Health Services Research and Health Care Technology (NICHSR) – Health Disparities
U.S. National Library of Medicine
https://www.nlm.nih.gov/hsrinfo/disparities.html

This website offers news, data, tools, statistics, and funding opportunities related to health disparities, as well as links to relevant guidelines, journals, and key organizations and programs.

Racial and Ethnic Health Care Disparities
The Center for Medicare Advocacy
http://www.medicareadvocacy.org/medicare-info/health-care-disparities

This website answers the question "What are heath disparities?" highlighting the harmful effects of health disparities on individuals and communities.

Racial and Ethnic Health Disparities among Communities of Color Compared to Non-Hispanic Whites
Family USA
http://familiesusa.org/health-disparities

This website contains a series of infographics detailing racial and ethnic health disparities experienced by African Americans, Latinos, American Indian and Alaska Natives, and Asian Americans and Pacific Islanders compared with Non-Hispanic Whites.

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Social Determinants of Health: Frequently Asked Questions

Centers for Disease Control and Prevention
http://www.cdc.gov/nchhstp/socialdeterminants/faq.html

This website describes how the World Health Organization is addressing social determinants of health and offers practical suggestions for incorporating those strategies.

Specific Populations and Prescription Drug Misuse and Abuse

Substance Abuse and Mental Health Services Administration
http://www.samhsa.gov/prescription-drug-misuse-abuse/specific-populations

This resource highlights the ways in which certain population groups are more vulnerable to prescription drug misuse and abuse than others.

Webtreats: Health Disparities

The American Congress of Obstetricians and Gynecologists (ACOG)
http://www.acog.org/About-ACOG/ACOG-Departments/Resource-Center/WEBTREATS-Health-Disparities

This website provides a quick guide to Internet resources about health disparities prepared by ACOG Resource Center Librarians.

CULTURALLY AND LINGUISTICALLY APPROPRIATE SERVICES

Maryland Department of Health and Mental Hygiene. (2015). *Toolkit for health care delivery organizations* and *toolkit for community-based organizations and outreach workers.* Retrieved from http://dhmh.maryland.gov/mhhd/Pages/CLAS-Standards-Toolkits.aspx.

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