

SAMHSA's Center for the Application of Prevention Technologies (CAPT)

**Increasing Cultural Competency to Reduce Behavioral Health Disparities:
Approaches for Communities**

September 10, 2015

Facilitator: Molly Ferguson, M.P.H., C.P.S., CAPT National and Cohort Services Manager

Presenters: Debra Morris, M.P.H., Associate Director of Coaching for Success; Maria Valenti, Ph.D., Epidemiologist, CAPT Northeast Resource Team; Ivan Juzang, M.B.A., Founder of MEE Productions

Grantee Presenter: Heather Schjenken, Planning and Implementation Coordinator, School District 317, Deer River, Minnesota

Molly: Just, you know, before we get started, if you haven't registered, or if you have others in the room with you, or sitting watching or listening to the webinar in your office with you, if you could please share their names and emails in the chat box, that would be great. So, if you didn't register or if you have others sitting with you, please share. And continue to share everyone here, as well, what you're planning to do at the end of summer.

So, we're going to go ahead and get started. Welcome to our webinar, *Increasing Cultural Competency to Reduce Health Disparities Approaches for Communities*. This training was developed under SAMHSA's Center for the Application of Prevention Technologies, and we are recording this webinar just in case people weren't able to attend and do get a chance to listen to it after the fact.

As I said, my name is Molly Ferguson; I'm the national and cohort-based services manager for the CAPT, and so I oversee the services delivered for different cohorts of Partnership for Success grantees, as well as services delivered to all grantees—CSAP grantee's across the country—and I'm pleased to be here today to facilitate and to get to introduce you to our wonderful presenters.

So, we have Debra Morris, who is the associate director of CAPT's Coaching for Success program, which is a SAMHSA pilot initiative providing intensive training and TA to high-need communities. She's also a technical assistance liaison for the CAPT Central Resource Team here in Chicago, and she has extensive experience in

designing and delivering training and TA services on health disparities, cultural competency, and engaging communities. So we're thrilled to have her here, as always. Maria Valenti is an epidemiology technical assistance provider for the CAPT, and she provides training and TA on substance abuse prevention, surveillance activities, data-driven decision-making, and assisting the presentation and dissemination of epi findings. She also has a background in community psychology and program evaluation, with a special expertise in sexual minority issues. So her expertise will really shine through today in that area. We're really pleased to have her.

And then last, but most certainly not least, we have Ivan Juzang, who is the founder of MEE Productions, which is a market research and behavioral health communications and social marketing firm that is dedicated to reaching and positively influencing underserved urban and ethnic audiences. And Ivan specializes in conducting qualitative audience research that provides that insider's view of challenging daily realities of urban living. So he has conducted numerous community-based participatory research studies and he has both developed and implemented evidence-based, culturally-relevant behavioral health intervention campaigns, and so he'll be talking a lot about how to build that community readiness at the local level to address disparities.

So our objective for today—by the time that you leave this call—you should be able to describe some of the connections between behavioral health disparities, cultural competency, and other key terms that can often be confusing. And so, how do those relate to one another? You should also be able to talk about different approaches for identifying and addressing behavioral health disparities among identified subpopulations throughout the SPF process. So, we'll be using that as a framework that we all know to kind of ground that discussion and then identifying approaches for building community-level readiness and capacity to address behavioral health disparities among identified subpopulations, which Ivan Juzang will be talking about, as I said, as well as a grantee presenter that we have on the call, Heather Schjenken.

So let's just take a minute before we get started and I turn it over to our experts. I want to ask you a short-answer poll question. And this poll will be completely anonymous, so feel free to share openly; your name will not be attached to your answer. What is the most confusing thing to you about addressing behavioral health disparities?

Prioritizing them, that's—yup—that's always difficult, especially if we see a lot; How do we know which ones we should be addressing? Missing data. So, those data gaps on different sub-populations can be hard. Sounds like language barriers, more around data, how different groups define this task. And so, we definitely are going to spend some time on today's webinar talking about that, just to get our heads around the language so that we know how we should be talking about this in prevention and how we can think about it together as a group.

So, a lot around data and identifying disparities, and just how do we even get that data identifying who the populations experiencing disparities are—prioritizing them? How do disparities fit into substance abuse prevention? And some of those silos—you know, and behavioral health and substance abuse versus mental health—and how do we unpack that when some of those disparities are so intertwined? So that's great. Some issues specifically in rural America. So, not having enough people who are qualified to address those problems. Workforce development issues. So you know are they ready, is there readiness for that? And so we'll definitely be talking about that today. Great.

So, it sounds like there is a lot around data, having, you know, small numbers, data gaps; How do we identify and prioritize what disparities to address? How do we talk about and define what they are? There is some stigma around that and readiness issues at the local level, and so how do we overcome those? And this is great because these are all things that we're going to be talking about today and touching on.

I encourage you to sort of have those conversations in the states, tribes, and jurisdictions where you work, because it's definitely an ongoing conversation.

Great, thank you for sharing. Let's go back to the slides, and with that I'm going to go ahead and turn it over to Debra, our first presenter.

Debra: Hi. Thank you, Molly. As you introduced us and you talked about me being an expert, but it's clear that everyone on the call—just by some of the questions and the responses to the poll question—we have great experts on the call, so not only will we provide during this webinar things that we know about this topic, but also welcome your input.

One of the responses to Molly's question was: So how do we define behavioral health disparities? One of the toughest things is understanding the language. And so, with understanding the language, we hope to be able to connect the dots from thinking about health disparities. Equality, equity, cultural competency ... I know all those terms ... sometimes we use them and sometimes it doesn't quite fit, but we think it works, so we'll spend time today talking about the whatever addresses behavioral health disparities. Many of these terms are often thought of as being—are used interchangeably. But we'll spend time today unpacking these terms and getting a better idea of what they mean—what do they really mean, and how can we address behavioral health disparities?

So SAMHSA and CSAP use Healthy People 2020's definition of health disparities, and there are particular words that I'll point out as I read this definition. So a health disparity is a particular type of health difference that is closely linked with social, economic and/or environmental disadvantages.

Words that stick out to me are the *differences*. So what is the health difference, and why is there a difference? But also thinking about the words “social, economic, and/or environmental disadvantage.”

When I think about social disadvantage—and I'm sure I could ask this question and you'd have many answers for this one—the one way of thinking about it is—it's a social disadvantage is an unequal share of resources. For instance, low education attainment. And then we think about an economic disadvantage, and I immediately think about a low-wage job, a low pay for the jobs that a person has. Then think about environmental disadvantage as crowded living spaces, no place to exercise. So throughout this presentation we'll use icons: We'll use icons ... here we go icons. There you go! We'll use icons and a case study to help us travel between behavioral health disparities and then how do we—what do we use or what needs to happen to increase behavioral health equity?

The U.S. Department of Health and Human Services prioritizes the goal—one of its priorities is to eliminate disparities between populations and moving us from ... moving us into a nation toward health equity. And that's ... but the question is ... so yes, we want to do that; we want to eliminate disparities. We also want to move to a health equity. But how do we do that?

So let's talk about how do we do that? So thinking about reduction of behavior health disparities moving toward increased behavioral health equity. I bet many of you have seen this slide—it is one of my favorites. Here again, terms of equality and equity are often used interchangeably. But what does it really mean ... and this picture really illustrates the differences in the terms.

So let's take a deeper dive. So, when I think about equality using this slide, height could be a metaphor for terms we just talked about, for instance, social?? economic and environmental disadvantages. The children all want to participate—enjoy a baseball game. But so the first idea we might have is a great idea to treat them equally by providing the same size box for them to stand on and look over the fence. Well that works for some, but doesn't quite work for others. What we didn't take into account is a different starting point. And just using height here as a metaphor for the differences, we have a child to the very left under the "equality" that's taller, so having that box would work perfectly. Then we have a child that's not so tall—not as tall as the one to the left—and that's better, but may not be able to see when the ball is hit out in left field. And then we have the child who, "Thank you for the box, but it doesn't allow me to enjoy the game."

So in our work, we often think that people begin at the same starting point. But what we know when we think about equity, is that people may need to begin at a different starting point, and often need that additional support. So while the child to the left under "equity" doesn't need a box, the child is able to view the game easily. And then the middle child ... boy, that box really does make a difference ... that one box makes a difference. But then the child to the right needs two boxes so she can in fact view the game and enjoy the game. So thinking about our work, how do we move to that from equality thinking that everyone starts at the same spot—same point—and moving to equity? So equity is about understanding what type of support people need and then providing the additional tools and resources that will contribute in their success.

And this is where we talk about that connection. We can identify, for instance, behavioral health experience about a vulnerable population. And so we can talk about, for instance, African American youth between the ages of 12 and 17 may have a higher rate of substance abuse. So we need to think about: What is the approach? What is the approach we need to work with a particular population to reduce

behavioral disparities in this population, which will then lead to an increased behavioral health equity? So the question is here is: What is the strategy or approach that will provide the best opportunity ... not only for the children to see the baseball game—or in our work, to increase behavioral health equity.

Another tool that we use to discuss a reduction of behavioral health disparities is cultural competency. And just to give a quick definition: a cultural competency basically says that you have the ability as an individual or in an organization to work effectively with people of a different culture. Cultural competency is also a tool used to improve the reach and access an outcome that can lead, in fact, to reduction of health disparities. And I know most of you or all of you are very familiar with the Strategic Prevention Framework, and cultural competency is an important component of each step of the Strategic Prevention Framework, or the SPF.

So today we'll introduce you to additional terms—we'll work through addressing or reducing behavioral health disparities with using a case study. We'll be in Anytown, U.S.A., and we'll provide examples of cultural competency that will be woven through each step of the SPF. And with that, I'll turn to Maria. Maria?

Maria: Thanks, Debra. Let's see ... I'm going to talk a little bit today about how you can begin to address health disparities in your community by integrating cultural competency in the Strategic Prevention Framework—or as you probably all call it, the SPF. Let's see. So, I'm just going to give some examples here. The first, as you all know—or many of you may know—the first step of the SPF is “assessment,” and this is an example, if you look on the slide, of data by an institution. And by institution, I mean a school, a military base, campus, and institutional setting. And this is military data from a 2011 health-related behavior survey of active-duty military personnel. It was a report, and it presented findings on the health of the armed forces, including Army, Navy, Marine Corps, Air Force, Coast Guard—really the active duty personnel.

And what we see here is that approximately one-third, or 33.1 percent, of active-duty service members reported binge drinking in the past 30 days, which is higher than the civilian estimate of 27.1 percent. And just for your information, according to the report, the Marine Corps reports the highest rate of binge drinking at 48.6 percent, and the Air Force reports the lowest rate at 22.9 percent.

So, it just goes to show that there is often diversity within diversity. And so there are service members—diversity may need to consider and unpack a little bit more through data.

Let's keep going. Here is another example ... and it's looking at race and ethnicity. This is a community-level example from high school data, and data that a community or coalition would look at. So, let's see what this one says: 24.9 percent of students who are Hispanic reported taking a prescription drug without a doctor's prescription, compared to 10.9 percent of students who are white. I'd just like to mention that the term Hispanic is broad, and it encompasses various nationalities and ethnicities ... again, diversity within the diversity. So you might want to collect a little more data about what Hispanic means in that community. So, doing research—perhaps some qualitative interviews or focus groups.

All right—so this is the third example, which is the geographic example looking at rural versus urban settings. And it's data from the treatment episode data set, or commonly called "TED," that was part of a report published in 2012. And, it was used to explore characteristics of rural and urban admissions at substance abuse treatment entry. You can see here a comparison of admissions located in the most rural areas and admissions receiving treatment at facilities located in the most urban areas. So what does the data tell us? Rural admissions were more likely than urban admissions to report primary abuse of alcohol. So, 49.5 versus 36.1 percent. Or non-heroin opiate: 10.6 versus 4 percent. Urban admissions were more likely than rural admissions to report primary abuse of heroin. So 21.8 percent versus 3.1 percent. Or cocaine: 11.9 versus 5.6 percent.

OK, so now that you've seen some examples of what data showing disparity looks like, I'd like to introduce the case example. And for our case example, we're going to go to Anystate and Anytown, and let's learn a little bit about Anytown.

So, the community of Anytown, U.S.A., is located within a state that has identified lesbian, gay, bisexual, queer, and questioning as a population of focus. The state has nine high-need communities, and includes a mix of rural and urban settings and one tribal community, and they're focused on prevention of prescription drug misuse among 12- to 25-year-olds.

And this is some data ... let's take a look here. This actual data is from a national study, and although it's not community-depth data, it could be used as a proxy for what's going on in Anytown. What this graph shows is that the percentage of 12- to 17-year-olds and 18- to 23- year-olds who report a misuse of prescription drugs in the past year. Let's see, the orange-ish color represents the participants who identified as completely heterosexual, and the reddish color are the percentages of the participants who identified as lesbian or gay. And you can see, the participants who identified as lesbian and gay were more likely to report use for both age groups than participants who identified as completely heterosexual. There is a difference there. So people who—or students who identified as lesbian and gay—seem to misuse more than their peers who identify as heterosexual. And the difference seems to be a little bit greater for ages 12-17.

Just one more thing just before I move on ... just a little footnote, I guess you could say. You may notice that there isn't a "T"—it's often you hear of LGBTQ. It's purposeful that there is no "T," because in the study that I just mentioned, transgender community, the "T," weren't included in the sample. And I just also want to mention that gender identity and sexual orientation aren't necessarily synonymous. So people who are transgender may have different experiences due to their gender expression, and not necessarily their sexual orientation expression. That's just a little caveat. Let's keep going.

All right—so let's go back—let's talk a little more about Anytown. So Anytown has been chosen to be funded by the state PFS grant. And what we know is that schools within the state do collect student survey data about youth prescription drug misuse, which looks at youth rates by subgroups—race, ethnic, populations, gender, grade level—but there has been a little pushback about including questions regarding sexual orientation identity. Fortunately, there are questions related to bullying and safety in the survey. Anytown has formed a youth health task force to address the rising rates of NMUPD by students—non-medical use of prescription drugs—particularly those identified as—identifying as lesbian or gay. And the task force includes parents, youth, healthcare professionals from the local hospital and outpatient clinic, as well health educators and the vice principal of Anytown High School.

OK, so that is what's going on with Anytown. And I'd like to pass it over to Molly.

Molly: Great, thanks, Maria. So, based on what we know here, we're going to go ahead and go to a poll. So we want to hear from you.

Based on what you see on the left—the information we just found out about the data that Anytown U.S.A. has on prescription drug misuse, specifically among LGBTQ use ... based on your experience in substance abuse prevention, what advice would you give Anytown task force about approaches they could use to fill some of those data gaps?

So, take a minute to answer that question. What advice would you give, based on your experience, on how they could fill some of those data gaps? And their specific data gaps are things like, you know, they have this issue around resistance from the school board to include specific questions on sexual orientation and gender identity and their surveys, et cetera. So what are some suggestions that you have for Anytown about how they could fill those gaps?

Focus groups. Great. So, Sue is suggesting, how about some qualitative data to go ahead and fill some of those gaps if you can't get that on your student survey?

Key informant interviews is another example of some of that qualitative data. So getting some interviews, maybe, with some of those key informants, including LGBTQ youth, those who work at the schools, et cetera.

Reaching out to a local LGBTQ local organizations for help. Exactly. We'd always have to work in silos, and there are people who might be accessing this population already who can get to some of that data might have it. So, it's a great point, Susanne.

Survey about recreation options. Use of social media to potentially do a survey—so not just relying on the school survey, but using some other opportunities. Leveraging relationships with universities or, you know, continuing to educate school officials and other key stakeholders in the community. So maybe working towards filling those data gaps in the long run that relate to those quantitative data from the survey by doing some of that education, shares Brooke.

And, you know, even collaborating with those LGBTQ centers to do some of those surveys or key informant interviews or focus groups.

Engaging the youths themselves to create and conduct a survey. That's great—it's really that “nothing without me,” or “nothing about me without me.”

There, so that's a great point.

Information sharing with other key stakeholders—so maybe entering into some data-sharing agreements. That qualitative information can help until that relationship is strong to collect the quantitative data. So, building that relationship with the school is key. And we'll get into that a little bit in the next step of the SPF, but that can take years; so what are you going to do in the meantime? And that's maybe some of that qualitative data.

Great. So, these are all great suggestions. And so, I'm wondering then, as we're going to put the next question up here for you, which is just sort of a follow-up and really builds on what Katie said. And that is, you know, how can you work to—you know we talked a little bit about infusing cultural competency throughout the SPF is one of the approaches to help disparities—and so how can—what are some approaches that Anytown could use to include representatives from LGBTQ populations in data collection and dissemination efforts? So, some of you have already started to touch on this when you talked about having them create or conduct those surveys, and asking for their input. But what about directly in the data collection and dissemination itself as an approach for a cultural competency?

We have a few people typing, and it looks like a few people who have already shared that. But—yup—involving that center again, that LGBTQ center, could be really helpful in terms of reaching out, too, to identify some of that population or to help you with that work. In addition to having them help you conduct—and create and conduct the survey—as was suggested by Maribeth.

Gay-Straight Alliances in schools. So, maybe engaging those groups in schools to help you with the data collection/dissemination. So, really involving that population itself in that process since they will probably have a sense of where to reach others.

Getting them involved in your coalition or epi assessment team to develop and administer the tools—exactly. That's a great suggestion, Carly. Involving them from

the beginning. And, involving them in that task force, so that you make sure that from throughout the process that they're included.

And it's culturally competent for a reason—it's not just for, you know, involving them for the sake of it, but they're probably, you know, going to be gatekeepers for that population in the community, and also, we'll have a good understanding of some of the important issues, as well. And even if you can't maybe access that population directly, Charlotte is saying, gaining inside information from others who come into contact with them that can help kind of make those connections for you. So that's great—those are some of those gatekeepers, as well.

So, thank you all for sharing; this is a great brainstorm that helps with kind of moving things forward in Anytown, and I think we'll go back to the slides and kind of take it into our next portion of the case example around capacity. And I'll turn it over to Debra for that.

Debra: Thank you, Molly. As Molly said—and you've actually talked about ways to address health disparities in your community—what are some of the tools? And as I listened, I heard, as Molly was reading the responses, they divided back in two particular categories. One was resources. So, you know, thinking about resources, we have human, fiscal, and organizational resources in our community.

And when you think about human resources, does the staff reflect the community that's being served? This may mean doing a different type of outreach. Also, think about providing staff with information about the goal of your program and what is expected about how to work—what are some of the tools or information about a particular community—so the staff will understand how to work with a specific population. What are the norms, beliefs, and cultures—has the staff bought these to the program?

Also, in thinking about resources, we talked about fiscal. Not only does the community, but does the staff know the goal of the funding? What do we want to do with our money, and how do we use resources? And I said, fiscal, but as I mentioned, there are other types of resources.

Is our organization ready to engage with a community? What have we done as an organization to build our capacity? Have we talked to people in the community? Have we reached out to other groups that are doing this work or working with community?

And so, also thinking about your partners. Are some of the partners in the community? Are there other groups in the community linked to a specific issue that may be important to the population you're trying to serve? I think about—and Ivan will talk more about it—but the strength in numbers is important. Who are your gatekeepers and your champions? Who can help make introductions into their communities for you? What protocols are in place to recruit, train, and even retain? I think it's really important to retain community members. Is there a safe and supportive environment where people can come and be thoughtful and respectful, but also be able to share information about a particular community?

And I talked a bit about the gatekeepers and the champions, and we want them to help us have entrees into the community. But engaging community in every aspect of your work is important. So, engagement is continuous. Have we—and then think about readiness. Have we asked the right questions to determine readiness—determine if the community is ready to engage in your issue? What documentations have you put in place with your community partners? Do you have memorandums of understanding? Do you have any type of agreement? Are they in place, so their voices will be heard? And, last thing I'll say ... about a term Molly used earlier and reminds me, also, to always remember “nothing about me without me.”

So with that, Ivan, I'll turn it to you.

Ivan: This is Ivan Juzang— let me let this fax run—I'm in a part of the airport that's supposed to be the quietest.

So, I'm Ivan Juzang, and glad to be on the call here. I run a company that focuses on health communications and social marketing. Our goal really is to, you know, reach and engage underserved, hard-to-reach audiences, particularly around a variety of health disparities. So I'm going to talk about how we reach and engage these audiences, and particularly, you know, why we're trying to reach and engage them, how we build community readiness and capacity at the same time. So that's what I'll focus on here with the few slides that I have.

So, just real quickly on this next slide here ... just to kind of give you a little bit of overview of our approach, how we approach health disparities.

Basically, what we do is when we realize there is a lot going on in communities—particularly that have the kind of social determinants that put them high at risk for health disparities—we realize that there is what we call a lot of “noise.” And one of the things we’ve found—and find with hard to reach communities—they tell us through our qualitative research that “you’re not talking to me.”

The campaigns and interventions aren’t talking to them; they’re not talking to their worldviews, they’re not talking to their environmental realities. And so, what we try to do is figure out ways that the community can’t opt out of our messages. So what we do is focus on how we develop social marketing campaigns that do that, and what we’ve realized is that community engagement and capacity building is a key part of that.

So our framework, again, really focuses on moving the audience from what we call point A—which is basically “survival mode,” we call it—to point B, which is thriving. And we also like to say—because the media sometimes paint negative images of communities that have high health disparities—we always say that these communities and these audiences aren’t making “bad choices”—what we want to frame it as is that they’re making “uninformed choices.” And our goal is to try to figure out how to increase the range of options and choices that they have so that they can make better decisions. It’s not like people are going to change their behavior immediately, but you can’t even start changing their behavior until you know other options—the consequences of those other choices and options—so that you can start moving down what we call the “behavior chain spectrum.”

So what we do is we look at the sender-message-channel-receiver model: this is the basic model that folks use even in all social marketing. But whoever your audience is, what we advise you to do is start with the right. Don’t go left to right, go right to left. Start with the receiver, then move to the channel message, and then sender. And that way, we find that, overwhelmingly, you will respect the audience that you’re trying to reach. This process means that you’ll involve the audience that you’ll try to reach, and then, ultimately, it will reflect the audience that you’re trying to reach. So, that’s our

framework that I wanted to give you before I move into the importance of community engagement so you can have a context for what we're talking about.

So, why community engagement? The No. 1 reason why you want to have community engagement, and surpass the readiness, is you're ultimately trying to build a trusting relationship. It's hard to do behavior health intervention campaigns if you don't have a real relationship—trusting relationship—with the audience that you're trying to reach. And what we find is that community-based organizations and community partners—or “campaign partners,” as we sometimes call them—are the gatekeepers that can help you access these audiences, because this is who they trust. And so, it's ultimately about trying to develop relationships and because behavioral health and behavior change usually happens within that kind of context. So, that's the overall reason.

Then what we do is, we talk about—and let me just expand on that a little bit. Trust, as you guys may know, working in these communities, trust really is an issue. And many communities that have high health disparities, the audience has what we call “legitimate reasons” not to trust institutions, why not to trust government, why not to trust [non-governmental organizations] because in many ways they've been let down. So, what we find is a lot of times it's about building trust again with communities that we're trying to have interventions on. And so, that's the overall strategy.

On a tactical level, though, it's good to do community engagement. One is because you're actually building what we call a “communication channel” to the community. And what we have found over the 20 years of doing this is—what I mean by a communication channel, I'm talking about a channel that can compete with radio, and transit, and TD PSAs, and social media, and websites. It's actually a communication channel to both put your message in and to take information out. So, you want to understand from a tactical perspective that provides that benefit.

The second reason, as I kind of mentioned—but even on the tactical level, it's really about, again, building the trust.

And then, third, is once you really start building the trust with community-based organizations and gatekeepers, then you can start down the process of not only making sure that they're ready to help you out on your campaign, but you're actually creating social fabric so that they can be engaged in future campaigns, as well.

So, those are the main reasons why you want to do community engagement. I'll talk a little bit more about that now in this slide, and what I mean by the first pillar—what we call the channels—is that you get what we call “access in reach.” You have to be able to actually access the audience and reach them. And we find is that when you engage community-based organizations and community partners, you get what we call a “culturally-relevant channel,” but, also, it's cost-effective. And, it's cost-effective because these organizations are going to be there whether they get grant funding or not—they're committed to these communities—and so, ultimately, we find that it's a great way to work with the community in a way that's culturally-relevant and cost-effective. You get reach—I mean we actually have developed metrics on how you can actually measure how many folks that you're reaching. I'll have a graphic in a minute that talks about that a little bit more. You're also creating conversation. You're creating what we call “word of mouth.” Because, if you're ultimately educating community-based organizations and campaign partners, they can what we call “take ownership of the message” and continue the conversation once the campaign resources have been expended. And then, really, if you're doing even high-level community engagement and capacity building, you know, you're actually putting those skills into the community.

So, that's just the first pillar of why you want to do community engagement.

But again, the second one, as I mentioned before, is you have trust—you're getting credible access, and you're having a real meaningful relationship with the gatekeepers, the opinion leaders, the go-to folks in the community. And what I mean by the go-to folks is the folks that the audience goes to because they trust them and they have credibility with them.

And then, once you have, again, a true channel in place and then trust in place, and then you can really move into readiness. And readiness is really based on a relationship that includes reciprocity. I think it's important for us as grantees and providers to realize that, yes, we want to work with a community, and we want to execute our agenda, and our aims, and our objectives, but we have to do it in a spirit of reciprocity where, yes, we're going to take, but we're also going to give back, as well. And that's how you can—and when the community sees that you deliver on your

promise—then you're really in a true position to start doing what we call capacity building and community readiness.

So, let me go to this next slide before the announcement comes back on.

Really what we're talking about here is the goal. As I mentioned with community engagement, it's about gaining credible access and reach. And we really, truly have learned over the years that this competes effectively with media messages. It's cost-effective, it's culturally-relevant—I'll show you what we mean by "the multiplier effect." But what you're trying to do is really, what I say, "peel back layers of the onion."

If you look at the community as an onion, you know there is the top layer, which is what we call "grasstop" leaders, but what you want to do is keep on pulling back layers of the onion to get to the true grassroots leaders, and that's how you're going to get the real big multiplier effect.

The benefits are what we call "the three C's," again, cost-effective versus traditional media. You'll find that even with traditional media, you'll do a radio bio, you'll do trans—you'll even maybe be doing a lot of stuff with social media—but once that stops, then the campaign stops. What we're saying is that through community ownership, once you may end the campaign, if you've done good community engagement, the community takes ownership of the message, and it keeps on living on.

And then, culturally-relevant, as I mentioned, it's credibility and trust. Our end game is what we call "the three D's." We want our campaign partners to display our information, we want them to disseminate it—a lot of them have their own outreach activities—and then more importantly, to dialogue about it.

Dialoging gets you the word-of-mouth, and it also means you're starting to change the community attitudes and norms, because you're getting the community to talk about it. Now, they may not talk about it the exact way you want them to, because they're going to put it in their own language, and vernacular, and idiom, depending on what ethnic group you're working with, but that's what you wanted them to do—because that's really letting them have some ownership of the campaign, and then you create word-of-mouth.

This last one, I just want to spend a minute on, is because we find that by doing good community engagement, you actually bring partners, and service providers, and agencies, and nonprofits, and churches together, and what you're able to do is get them to refer to each other. You'll find that if you do good community engagement, they will be appreciative of the fact that you're creating a networking opportunity even for folks that sometimes don't see each other on a day-to-day or quarterly basis. So, the referral aspects can't be underestimated.

And, I'll just give you what we call "the keys to community." I'll always say to folks, even as an African American, I don't think just because I'm black, I could go into any African American community; I go through the gatekeepers. But I still have to develop what I call the "keys" to the community.

And, the first thing, as I mentioned, is building credibility, and you build credibility by understanding the environment and the worldview—and this is what Debra was talking about in terms of taking the time to understand some of the social determinants. What you'll see is that most of the issues come out of how the audience views their world. Then by listening and starting to be there long term—and long term is in some cases can be six months, can be 12 months—we want it to be longer than two to three, four, five years. But they're really looking for consistency, and they're looking for you to listen first, so we focus a lot on credibility and trust. Those two things give you access. And by access, then you can start by putting in your messaging, and your information to the community, but to go to the next level really around capacity building and readiness, then you have to do what we call "involvement." And that's being inclusive, and creating a shared vision. Yes, you should go in with your epidemiology, your data, but ultimately by listening and involving the community, you may ultimately craft a better social marketing campaign because they've been included in the process.

And then, finally, you get the true strong relationship when you create what we call "reciprocity." And I know in many communities you realize, particularly in low-income communities, there is a spirit of reciprocity that they're looking for. They're not looking for you to give them the same resources you may have received; they're just looking for any way that you can show them that you appreciate them being at the table and share what you can share. I always tell people they think they have to have a lot of resources. I said, "no," it's just a fact that you're giving back whatever you can share

and doing that in a transparent way—that helps you close the loop and let the community know that you're really, truly building a strong relationship
I think most of this is laid out in a newsletter—kind of white paper that we have provided for the webinar as well—so if you want more information, you can check that. I wanted to get back to the multiplier effect.

If you look at yourself as a grantee or a provider in the middle, that's you where it says Y-O-U. If you start engaging other community-based organizations, small nonprofits, after-school programs, early childhood development programs, health clinics—even in some cases hair and nail salons and barber shops—what you're identifying is folks that have access to the audience that you're trying to reach. If you start working with them, you start building your first layer of your network. And then they refer you to other [community-based organizations] and agencies that are working in this issue, and then you start seeing that you have their constituencies to be able to access. This is how you develop a true community channel. And don't look at the channel just from the perspective of you putting information into it. I heard in the questions, you know: we want to do surveys, we want to do qualitative research, community participatory research.

It also becomes a channel to take information out of the community. So, that's how we've really approached it. And then, ultimately, if you go back to the key, then you're in a position to then do community readiness. So you can use the community engagement as a way to help you with your social marketing as the first step towards then positioning the community to start helping them in terms of capacity building and readiness.

One thing I always mention, when you're doing good community engagement, is that it can't all be about the literature and the science. It is about the science in terms of what we're trying to do; it's not about the literature and science in terms of our communications with the audience.

One of the things in public health is we tend to work from a literate-based perspective, but we have to remember that, yeah, we write their proposals, we do good evaluation, we do good reporting—but we're going into audiences and communities that are reflective of what we call an oral-based culture. They come from a history of storytelling. And what you want to do is understand that when you really go do

community engagement, the communications culture and the way you interact with the community has to shift from a literate-based approach to an oral-based approach.

And what I mean by that—which is what a lot of people misinterpret—is that the community is going to challenge you. They're going to challenge you about what you're up to, why you're here, who is funding you, so-and-so did some research last time and, you know, we never heard back from them—you're going to get all of those things. It's the community's way of venting, and it's the community's way of making sure that you're going to try to at least be there for the long-term and what your intentions are.

The good news about being challenged is—is that in true communities of color, and oral based communities, and low income communities, and urban communities, many Native American communities and Hispanic communities—what they're doing when they're challenging you is they're saying, "Are you open to a relationship?" because they want to know that it's going to be two ways. And that's a part of the oral tradition, is that communication happens in a social context. So, I just want you guys to know that it's not just about dropping off brochures, and literature, and research; it's about engaging the community in a social context, and that's how you ultimately start getting not only ready—getting the community ready for capacity building—but really ready to be involved in the behavior change process.

So, this is it, my summary slide, and I just want to say that, you know, when you really do good community engagement, then you can get really more towards the activation and readiness. It's about building and maintaining trusting and authentic relationships, not just at the *grasstop* level, but at the *grassroots* level. It's about enabling the community that network with each other so that they feel that you're providing some added value to them. I can't tell you how many times we've brought community-based organizations together, and the referral and usage just amongst them increased because they're now updated on what each other is doing.

The other benefit that people don't realize is that through this process of engaging the community, you'll identify community members who really can be advocates; they'll kind of rise to the top—we always call them the peer-group leaders. But by going through this process, you're going to identify who those leaders are that want to be

involved, and maybe some additional training—some additional advocacy training or TA—that can really help you take your message to the next level.

And then finally from my perspective, the last two things I want to point out, is that you're creating social fabric. You're helping—by doing this process you're helping—create village. And I truly think that if we do this well, then we can get into position of identifying smaller [community-based organizations], nonprofits, and organizations that maybe we can do some capacity building around fiduciary responsibilities and maybe helping them apply for micro-grants and small grants that continue to help build them out. And I think it's important to understand that we're trying to create community ownership by doing community engagement.

And that's all I have; thank you very much.

Molly: Great. Thank you so much, Ivan.

This is Molly, and we really appreciate all of that rich information. It looks like we did have some questions—people are already saying how valuable these slides were, and they wanted to be able to access them. So, at the end of the webinar, we'll have a file-share pod up where people can download those, and we'll also send them out after the fact. They were also sent out ahead of time with the access information in that same flyer.

I'm wondering if other people have questions for Ivan. I know this is a lot of rich content to take in, but we do have a couple of minutes to ask questions of Ivan. So, I see some people typing, and we want to make sure that we take advantage of this opportunity when we have an expert like this on the line. So, any questions from you?

Yup, so Brooke is just sort of saying "thank you so much," because she's a social worker and highly-trained in community engagement, and preaching this to coalitions for years. So, sometimes it's just easier said than done. And so we hear this information, and it makes a lot of sense to us, but it can be hard when you get to doing the work at the local level. And so, I'm wondering, Ivan, one question for you. How would you recommend that people navigate an experience—so if they go into a community because they've identified a particular health disparity in substance abuse prevention that they want to address, but the community doesn't see that issue as a

problem, what are some of the ways that they can kind of improve those relationships and engagement, but also sort of building people's understanding that this is an issue that they should be caring about?

Ivan: Oh, that's a good question. And the way we do it is, one, we acknowledge that we may be going into communities where what we're talking about may not be on their agenda. And so, what we always say when we're going in and doing community engagement, is that community-based organizations and these partners may not be experts on the health disparity that we're dealing with, but they're experts on knowing the dynamics of the communities. So, this is where the whole notion of give-and-take involvement comes into play.

Oh, man, I'm sorry ... this announcement is about to ... but I'll talk through it, I hope it wasn't too bad before.

But what I would say is to do two things. One, I would start trying to—with the existing relationship that you have at the community level—start asking them to give you other lists of community-based organizations—so you're, again, trying to get their list, and that's the way you kind of start peeling back the layer of the onion. Sometimes when we go into communities and people don't have a list, you may have to do just a little canvassing, and we actually have a process of where we go out and canvas particular communities in a very safe way. But we start talking to retail, we start talking to hair and nail salons, barber shops, and try to have them help us identify who the gatekeepers are and the community leaders, and sometimes they get you to a grandma up the street or someone working at a church. But you really want to start, again, having those low-level conversations trying to get lists, and then you want to try to get referrals, and then you want to start maybe doing a little bit of canvassing. So, that gets you more on the tactical side.

But I think what you're really asking about is: How do you reframe the conversation with the audience so that you can get what you're talking about on their agenda, and a lot of that is really just putting things—not necessarily in scientific terms—but what I find is that putting it in the terminology of social justice is helpful. When people realize—and that's what part of what health disparities are ... is that it kind of ...we look at it from a perspective of social determinants, the community looks at it as a set-up for failure. And when you kind of really start helping them understand it, things

should be different in that we have to start this process of trying to do environmental change, we have to start the process of getting folks to make better decisions and choices within their environmental constraints. And what we always say is, “Start with small successes.”

Many communities that have high health disparities have had so much failure, repeatedly, that you have to create a level of self-efficacy with these communities and create what we call “small wins” to get them confident to go further and further. Don’t give them something where you’re trying to ask them to go to legislators when right now they’re just trying to figure out, you know, maybe who a local person is.

So, I mean, there are ways, but it’s all about framing. And what I always say is, “If you don’t know how to frame it, identify those what I call ‘peer group’ leaders, and they’ll help you put it in the language and vernacular that you need it to be so that you can start reframing things from what I call ‘their worldview.’”

Because this is an important point—otherwise they opt out of what you’re talking about—and what you want to do is reframe things from how they view the world, and that way they’re more willing to understand it and then internalize it.

Molly: Great. Thank you so much. That’s really helpful information, and it sounds like a lot of people are saying that, you know—a lot of those at the local level that don’t have some other kinds of systems training—it’s hard to sort of grasp this concept of community engagement. So, we really appreciate you taking the time to share your work with us today.

Turning it over now, I think you know one of the things that we wanted to provide for all of you is an example of how to infuse cultural competency to address disparities at the local level from one of your peers—so someone who has done this in substance abuse prevention at the local level. And so, I’m pleased to turn it over to Heather Schjenken, who is currently and has been a planning and implementation coordinator within School District 317 in Deer River, Minnesota, for the last four years. And so, prior to her focus on substance abuse prevention, she had been serving and partnering with that community for 16 years through several youth programs. She has a degree in social work with a minor in chemical dependency, and her current program

is funded by the Minnesota Department of Human Services' Alcohol and Drug Abuse Division.

So, I'm going to turn it over to Heather now.

Heather: OK, thank you, Molly. So, yeah, my name is Heather, and again, to just touch a little bit about who we are, our coalition. So, we're the Standing Together Embracing Prevention Coalition, and also called "The Movement," which is our youth group name. We do prevention work around underage drinking within school district 317. And Molly already stated ... the planning implementation grant funded by Minnesota Department of Human Services.

So, can we skip to the next slide? Thank you. So, basically, first of all, I just want to say I appreciate what Ivan had to share, because he's just so spot-on about, you know, how to do community engagement and how to work within our community is so important. And basically, my slide speaks for itself: relationships matter. What we've realized, you know, just at a local level in doing the work for the last four years, was that really has become sort of the #1 thing that we've been able to use to make a difference in our community around underage drinking.

Prior to this grant, we had never had a grant that, you know, that dealt specifically with this underage drinking, and so we were really starting kind of like at the beginning. And we realized that we needed to start looking at our relationships. And so, we took a look at who should be at our table. And one thing we realized, obviously, right off-the-bat, was our school population—and our school population is somewhere 40–50 percent Native American students, so we knew that we needed to bring in key leaders—key Native American leaders, to the table. But what we did is when we began that process, we really didn't want it to be a box that we checked. You know, so often when we start community engagement work, or coalition work, or building, you know, we look at sectors and we look at, "OK, well, let's see, we need to have this, this, and this represented."

And we didn't want it to be that. And so, we got together a core group of people, and we started to look at, "OK, where have there already been relationships developed with key Native American leaders, and who has those relationships already?" and then "What are the new relationships that we should be working with?"

And all of this is really about time, and that's what we found to be really critical, is it takes time to build relationships. It's something—it's just so—it's so simple, but it's so key. And you really have to take the time to, like, look at inviting people to sit at your table, and also sitting at *their* table that it really is something, it is giving-and-taking. It isn't as simple as just going to somebody and saying, "Hey, can you represent our sectors and, you know, sit on our coalition?"

It was about having a conversation and building a relationship, and over time that relationship becomes sort of a mutual partnership and working together, which is why on my slide here you'll see, you know, just one of my favorite quotes by, you know, Willie Walker, "If you're here to help me, then you are wasting your time. But if you have come because your liberation is tied up in mine, then let us begin."

And that has been a really key quote for our coalition, is that we want to walk forward together. Not "What can you give us?" or "We want to be—let's partner together."

Another example that we had was we recognized we are right next to—we border a reservation in our community, and we knew we needed to reach out. And so there was a grant, a SPF TIG grant, on the Leech Lake reservation, and they were beginning a coalition. And so, the coordinator of that coalition and I got together, and that is exactly how it started—was just having a cup of coffee, sitting at a table, and building upon a relationship. And that relationship now has turned into a really cool partnership. They sit on our coalition, we sit on their coalition; we partner together to work with our youth. So, that's been a really powerful thing for us.

I think I'll jump to the next slide. I'll try to be quick—I have like five, seven minutes, but very passionate about this work, as you can probably tell.

So, in this slide, pilot testing has been something that's been huge for us. You know, just to talk a little bit about the process—to put it simply, it's really getting people's opinions. Are we hearing from everyone? I mean, whether we realize it or not, with everything that we do, we are throwing out a message somehow—in some way, we are messaging something, and are we hearing from everyone about what we're messaging?

So, in the process of pilot testing, it's asking questions such as, you know, "Is this image attractive? Would this image offend anybody? Would this message offend anyone, or what do you think of when you see this message or this image?"

And we do this in several ways. We do them one-on-one, focus groups, SurveyMonkey™, et cetera. And, you know, to be frank, this has really saved our butts several times. Because you might—we go into things thinking, "Oh, this is a great idea!"

And then, what we find is we're looking at it through our lens, and if we're not pilot testing, then we're not seeing it through other people's lens. And if you're really trying to capture your community, and trying to represent your community, it has to be pilot tested. And so, to give you an example of that, we were starting to test, you know, images about, you know, around underage drinking, and, you know, so we were using images. And so, in the beginning, we realized, OK, we have 40–50 percent Native American students, so most of our images were Native American students because we wanted to be inclusive. We wanted to be like, you know, like, yup, we're in there, and we want to make sure that our students, our Native American students, you know, are identified.

And so, we started pilot testing with our coalition with our community members. And what came back to us was interesting, is: A few key leaders from the Native American community said to us, "You know, we noticed on all the images that most of them were Native American teens." And we were like, "Yeah, you know, that's great; we're trying to be inclusive."

And they said, "OK, we get where you're coming from, but also, did you recognize that Native American students could possibly feel targeted? Like they could begin to feel like, 'Well, it's just a Native American issue, underage drinking?'"

Where, of course, we know, it's not. And so, we never realized that. I mean, we thought we were doing the right thing, and so that really was kind of an "aha" moment for us—and we just—and all of this came out of pilot testing. So, in the pilot testing process, we realized that; so, we didn't do this because of the feedback that we got, which is great, because we would never want our students to feel targeted, ever. And so, that's one example.

Another example is: We were getting ready to do what we call a “cultural transformation sheet” where we talk about how we use our data and how we’ve been able to transform our community around underage drinking. Well, in our eyes—and our coalition was cultural transformation—was we were talking about our community, like the Deer River culture.

Well through pilot testing, it came back to us, again, they said, “Do you think students, though, might see it as cultural transformation as in ... so are you trying to transform our culture? Like is there something ...” (dinging sound in the background) ... here is the bell, I apologize. I work in a school system, and I can’t shut the bell off in my office.

And so, and they said, “Do you think students will feel like you’re trying to transform their culture, and there is something wrong in their culture?” So again, we changed the form; we changed the sheet to our story, our transformations.

And so, these are just a couple of examples; that’s all I have for today. If you have any questions, I think there might be a little bit of time. Again, I’m sorry for the bells.

Molly: Thanks so much, Heather. No problem. Any questions for Heather? Feel free to type them in the chat.

I think it’s so great. So, it really shows the importance of asking for feedback and making some of those kind of midcourse corrections, and that need for that continuous quality improvement that we all know is part of the SPF, but that is so critical and just in terms of making sure that it’s relevant for the community.

And that’s really what we mean by cultural competency, which is so critical when we’re thinking about addressing disparities among different groups at the local level. So I think that that is such a great example, and we’re so happy that you were willing to sort of share that with us, because I think oftentimes people aren’t willing to share some of those kinds of situations because they feel like, “Oh, does that reflect on me in a certain way?”

But, in reality, we’ve all been there. And so, it’s just so valuable to hear about an example of that specifically at the local level.

And so, yeah, it sounds like, you know, we're having some people saying they agree with you that that issue of a cup of coffee always works, as it is neutral territory, and, you know, getting out there and networking in the community with other existing groups is really important to getting the buy-in which both Ivan and Heather echoed.

So, thank you, again, Heather. We really appreciate it.

Heather: Yup. Thank you!

Molly: So, with that I'm going to go ahead and turn it over to Debra.

Debra: All right, Thanks, Molly.

Boy, I tell you, listening to Ivan and Heather, we have a lot to think about as we go back to our Anytown case example. So, I encourage you, as we are going through Anytown and talking about what Anytown is doing to address disparities in their town, that we think of some of the lessons learned, the lessons shared by Ivan and Heather. So, with that said, let's move on and figure out what Anytown has been doing since we talked about them last.

So, they have a task force—Anytown has a task force. On the task force, they have parents who are involved, and local school staff to address youth prescription misuse with the focus on the LGBTQ youth in the community. They have several community partners that have emerged, including local prescribers and pharmacists. Focus data—focus group data—reveals that Anytown residents largely do not believe the prescription drugs are as harmful as other substances. So let's talk about that just a little bit. So we have parents, we have local prescribers, and school staff, and pharmacists. Who else needs to be at the table? I tell you, Ivan and Heather made a good—provided good examples of getting people to sit around our table and to share common information or common passions about working with particular issues.

So this is an opportunity to engage our existing partnerships and also to create partnerships. I tell you, Ivan gave us great examples of how to have that give/get, how to be able to share but also receive information. So who else is working on substance

abuse prevention in the community, and then what other communities are engaging the LGBTQ community?

Another thing that both Heather and Ivan talked about is that it is OK that you don't know about a community. But we have to engage gatekeepers identified and the resources and readiness conversations to learn about community norms. And so, with that, Molly, I'll turn it over to you.

Molly: Great. So, I think we're going to go ahead and do a quick poll where we can think about what are some examples of, you know, resources? So—human, fiscal, organizational—that are still needed to address prescription drug misuse among LGBTQ youths in Anytown? And how ready is the community to address the problem? So based on what you just heard from Debra? And I don't know if there is any way we can bring up the previous slide where we showed that—that data that Debra showed—but about who is involved, and how ready is the community? So what are some examples of resources that are still needed to address prescription drug misuse in Anytown? And how ready is the community to address that problem of prescription drug misuse? So, just quick responses here; these are anonymous as well. We would love to hear from you.

Yup, so hospital, staff, data, you know, there is a need for some additional connections potentially with law enforcement, hospital staff, more representatives from community sectors, specifically those with the target groups. So they have some school staff on board, and they have parents on board, but, you know, some community partners including prescribers and pharmacists, but it looks like they need the youths themselves. More representatives from key leaders, definitely need more data.

It sounds like a lot of people are saying they're not very ready. So, there is still some work that needs to be done. They don't, you know, initially they don't also believe that prescription drugs are as harmful as other drugs. So that's just an issue in and of itself when addressing the priority problem in the community, but then specifically among LGBTQ use, it seems like there are some issues in terms of some levels of readiness, but there is still the resistance on the data collection side. It doesn't seem to be a real concern for many people.

So, it sounds like they need to do a little bit of work building that readiness and increasing those resources. So, exactly. So, someone says we wanted to address prescription drugs with all youths. Exactly. So, you know, they're trying to address that issue with all youths in the community, but they also know that there is a specific disparity with LGBQ populations. And so, how can they get at that population, as well, and make sure they're targeting them while still addressing the issue in the larger community with youth? Great.

OK, so let's go ahead and go back to the slides to continue on. It seems like we have some consensus that there is still some work to be done in terms of building readiness and resources in this area. So, I'm going to go ahead and turn it back over to here to Debra.

Debra: Thank you, Molly. As I was watching the comments, many of the comments, or questions or responses, were those that I thought about as I was preparing for this presentation—specifically related to the task force collecting additional focus group data. But who was represented in the focus group? That was one of my first questions. And they reviewed the research that—literature to fill identified gaps. And how were the gaps identified? So, they did prioritize the following risk and protective factors for substance abuse use among LGBQ youth.

The first risk factor is harassment. So—felt that victimization and bullying in school was a particular risk factor that we needed to address. And then a protective factor was the positive school climate: anti-bullying policies in the Gay-Straight Alliance clubs. As I said when we started, the real experts were out in the field and on the phones, and you, too, identified the protective factors that would be useful in working with this group.

So, I think there are a couple of things to remember here. One is that we need to make sure that there is community representation in the process and that the community is actively involved, and not only is their voice heard in this particular aspect of understanding about the LGBQ youth, but at the beginning, at the end, and everywhere in the middle.

Also, to think about existing prevention efforts ... what's going on? Sometimes in the community your issue may not line-up perfectly with another organization, but there

may be enough synergy to be able to think about how do we collaborate on different issues. Also what is the past history of working in substance abuse prevention in the community and then with the LGBQ youth? So those are things that are very important to us that we need to remember.

So, let's talk about the interventions that we want to consider in our planning phase of the SPF, and the planning phase of trying to provide guidance and interventions for Anytown, U.S.A.

So, three parts that we can consider: one is effectiveness. Is the intervention effective or in line with the other prevention efforts that may have been successful or effective in the LGBQ community? Do we know other prevention efforts that have been used or implemented? So, is it a conceptual fit? Will the intervention impact the selected risk factor? Were LGBQ youth involved in selecting the intervention? Then we think about practical fit. A lot of you wrote in one of the polls just about the community not being ready, and how do we make sure, you know, what do we need to do in considering if the community is ready? Is the intervention that we have chosen—will the community embrace that intervention? Also, does the intervention consider the norms and beliefs of the community? We talked about that earlier. And is the intervention led by people who are viewed as credible with the target population? And both Heather and Ivan talked about that.

So how do we infuse cultural competency here? How do we use this? So, not only do we need to think about the problem, we also need to think about the LGBT community and their experiences. And so, what has their experience been around this issue and behavioral health disparities are things we need to consider. So, infusing cultural competency, we think about some of the questions we ask when thinking about effectiveness, conceptual fit, and the practical fit. How do we use cultural competence to address some of those issues ... or to answer some of those questions?

Let's go back to Anytown and see what they've been doing in selecting an intervention. If we—the priority problem is prescription drug misuse among youth, with the focus on an LGBQ community. We've talked about the risk factors of harassment, victimization, bullying at the school. And Anytown chose the school-based social marketing campaign that addressed the school climate. And they were trying to promote a supportive learning environment because it is not only linked to the risk

factor and our priority problem that we identified. And there is, so is their school well? Will school administrators and health educators—are they on board? But what we heard is that the—in previous slides that the—school district is not necessarily willing to consider changing the student survey at this point. So, then we have to link back to our community readiness, and build a community awareness and buy-in so that we can work through this issue.

Another possible intervention is a parent education program aimed at increasing perception of harm. So, the question I would have in thinking about this intervention: Were parents in the community involved in providing input on this education program? And then, also, what did we learn from these focus groups about the school board's readiness to focus on LGBQ issues? Those are a lot of things to think about as we decide or think about a possible intervention to use. So with that, Molly, I'll turn it back over to you.

Molly: Thanks. And in the interest of time, we're not going to go to a poll here, but I think that the point that Dean made about, you know—it seems like we need to take a step back and look at the reason that people are making these negative choices. And so, if we have this risk factor—or harassment, victimization, and bullying at school—really thinking about which of these interventions targets that and why it would be important. Oftentimes we want to use a comprehensive mix, and so, you know, even if Anytown chose to develop and deliver a school-based social marketing campaign, they might also want to think about the increasing perception of harm as well as thinking about how they can push the school board to update that student survey questionnaire. And those two don't necessarily get at that specific risk factor, but they are larger issues in the community that might be part of a comprehensive mix to address that intervention in particular.

So just moving forward now, I'll give it back to Debra.

Debra: OK, thank you Molly. So how do we infuse cultural competency in the implementation phase? A couple of things we can do: We can train the community to serve as spokesperson if they are ready, or if we need to provide additional guidance and training, engage other organizations that engage this community. Are there other groups working on this issue? Also, we need to consider our norms and beliefs to build so we will understand how to make this intervention culturally relevant. Are materials

written for the community? And who are our non-traditional partners? Who do we need to engage? I think Heather also talked about the images, and images reflective of the target population but also to test that information to make sure that it will be accepted in the community. Also, think about terminology: Is the terminology we're using—is it inclusive of LGBTQ youth, and were representatives of the community involved in the implementation?

We also need to monitor, evaluate, and adjust our plans based on impact on identified disparities. Oftentimes we'll get information, and we'll have an evaluation report, but it's never shared with the community. And that's important that we do that.

Next slide. So, let's go back to Anytown and talk about the implementation. So, they involve the school personnel and LGBTQ youth in development and delivery of the social marketing campaign. So, they build support and capacity of the priority population. And they also tailor the campaign to fit Anytown's community characteristics and feedback. What a great thing for Anytown.

Also, they pilot tested the campaign and refined it based on preliminary results and feedback. And that's something that Heather talked about—about “do that pilot testing to make sure that we have the right message,” that we're sending the right message. So with that, Molly, I know I'm running, going through this really quickly—a lot of it has been covered by Ivan and Heather. So, I will turn it back over to Maria.

Maria: Thanks, Debra. So, I want to talk a little bit about evaluation. And so, there are lots of types of evaluation, but two main ones that you probably already are familiar with: process evaluation and outcome evaluation.

So, process is pretty much looking at implementation and involves documenting implementation from the beginning. Did you do what you said you were going to do? If so, how did you do it? And it's important to document what was done and how in order to provide assurance that you're following the plan that you meant. And by doing this continuous evaluation, you can begin using the data to make adjustments to the implementation program and refine the activities to better focus to meet your outcome.

For outcome evaluation, we're looking at any changes from the initial assessment. So we're checking back to the data from the beginning. Did you move the needle? Are you seeing an impact from the activities that you're implementing on the problem?

While evaluation is important, it's also important to infuse cultural competency in the evaluation process. And you can do that in certain ways—there are many ways. Some ideas may be to be sure that the community is represented in the evaluation process. And like all the speakers before, just reiterating that it's important to include the population that you're working with throughout the whole process evaluation. But in evaluation in particular, you're using data, that—data collection tools, and those tools often may be standardized on a populations such as like a white male student. And so, begin to see, is it really relevant for this population that you're working with? So, the tools that you're using to collect your data reflect the community culture.

Some communities consider using a culturally-competent evaluator for evaluation. Is there someone from the community that has the evaluation skills to collect the data? And like Ivan mentioned before about reciprocity: returning the evaluation findings to the community, and so, gaining permission to disseminate the findings. So you don't want to kind of take the data and then show a whole bunch of other people what's going on with me without also reflecting back and being like, "Is it OK if I share this data, like with this policymaker, or with the newspaper, or whatnot?"

Just being respectful, I'm going to move on. Let's see what Anytown did for their evaluation?

And so, for Anytown, they conducted pre/post surveys and conducted a focus group, discussed impact of the social marketing campaign. They also did some process evaluation and tracked the adaptation they made to the program. They conducted key informant interviews on the impact of the efforts to customize the task force images and terminology in order to be inclusive of lesbian, gay, bisexual, queer, and questioning youths. From the outcome evaluation, they did determine that they—there was an increase in the number of students reporting that they felt safe in school, as reflected from the school survey. And they also saw a small reduction in prescription drug misuse in the LGBQ students. So, they did see an impact from their activities.

And so, Anytown was successful and certainly with reducing misuse. And I also want to pass it onto Molly.

Molly: Great, thanks. For our last couple of minutes before we bring up the last piece to download, we want to have a poll today that will help you move forward with your work.

So thinking about what you've learned today from our presenters, what can you do in the next three to six months to increase cultural competency in your prevention efforts, with an eye towards reducing disparities in your communities?

So, just something you can do in the next three to six months. Something attainable, something that will kind of help you going on the path towards making sure that you're continuously thinking about this as you go about your work—just something that will get you started.

So, expanding some of those community outreach efforts, are some of the suggestions people have given today. That's a great idea. Setting your sights on just building some of those additional partnerships—and that outreach effort is a great choice. Just increasing community contacts. Definitely. So, you know, just making some of those connections as people said: going out for coffee, or attending different community meetings with groups, engaging with people, and they can help assist in building our messages. So really including some of those key stakeholders in your efforts to help you with that and building more relationships.

Doing some training of your coalition just on this similar topic. That's a great suggestion, Brenda. Using data just to identify who those disadvantaged populations are. Great. So, connecting back with the state, tribe, or jurisdiction that funds you in your work to talk about what they've identified and how they can support you in your work. Making those relationships and connections over coffee and in other ways. Doing some community presentations or media releases to increase readiness. A lot of focus groups, says Jane. That's a great point—helpful to fill some of those data gaps.

So, it sounds like people are thinking of focus groups as one of the ways, and that could hopefully even help you build some of those relationships, like you said. And being intentional in asking for those partnerships. I think that's really important, Donna. Really being clear about why you're there, and what the partnership entails, and what you're giving, and what you're asking for, and just keeping up on that data, as Amber

says, and collecting that so you have a good understanding of the work that you're doing. Doing some community mapping to identify those partners, and building capacity by branching out and networking with other agencies. Just going to meetings and getting on their agenda and telling them about what you do is a first step to build those relationships—and you don't know who else is doing the work that you already are doing, and maybe have those relationships in place that you're able to build on.

So, thank you so much. We're going to go now to our final layout where you can download the slides, as well as the agenda, for today. And we're also going to ask you to please give us your feedback. So, it's a really quick evaluation survey. We really appreciate your feedback on these events because it helps us make them better for you in the future. So, in the file share on the left, you'll see if you click on the individual titles, you can download a handout from Ivan, one from us on just definitions and resources on health disparities, and the slides from today. There is also a link to a part of the CAPT area of the SAMHSA website on infusing cultural competence into the SPF. And then our evaluation, which you can click directly on that link—there on that SurveyMonkey™ link—to complete that.

So, thank you again, everyone. We're one minute over, but we really appreciate you taking the time today, and we look forward to your feedback and to talking with you again soon. So take care.

++++++ END OF AUDIO ++++++