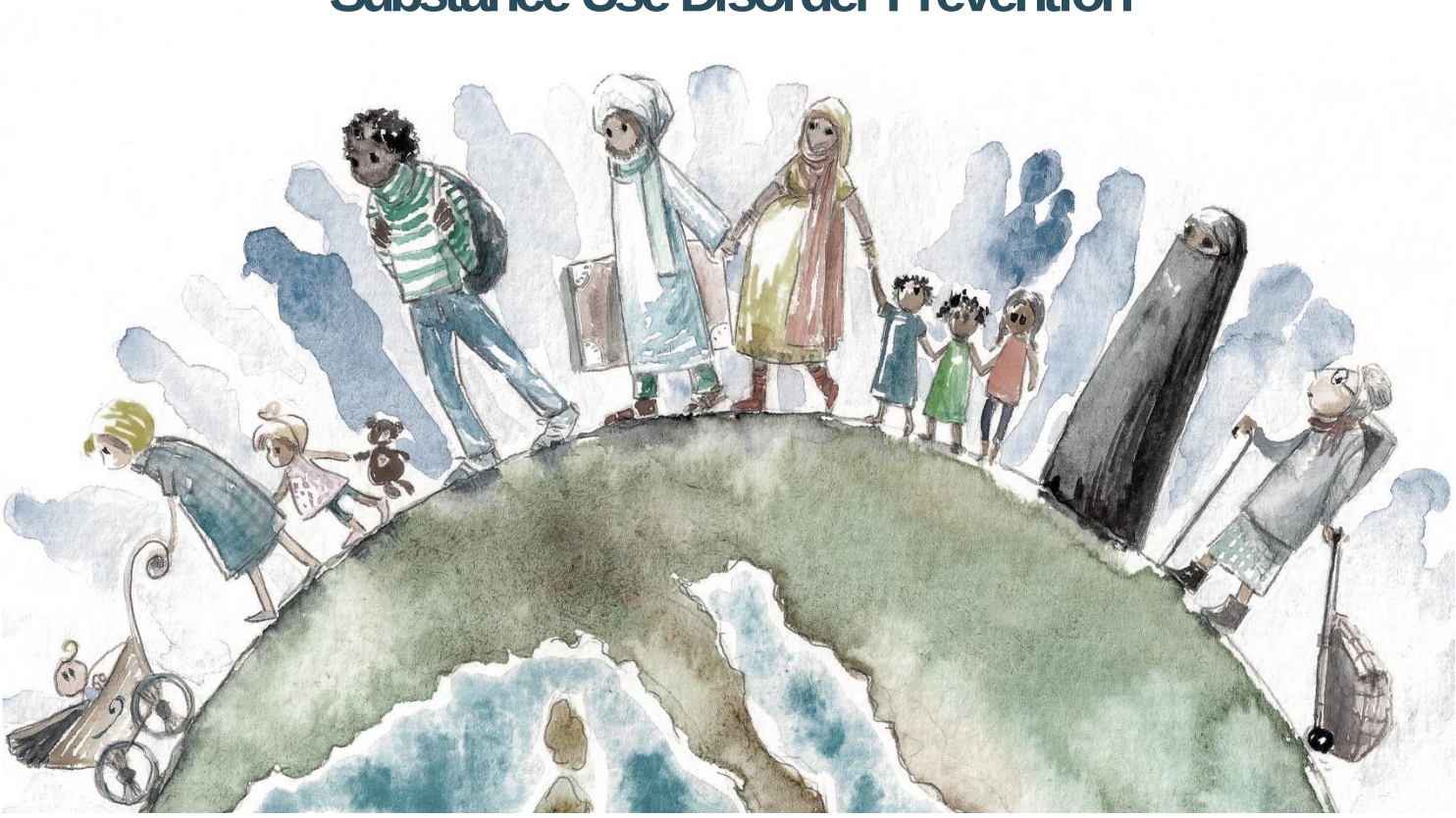
Community
PREVENTION INITIATIVE

CPI Regional Training

Sacramento County
July 13~14, 2017

Examining Cultural Competence in Substance Use Disorder Prevention



www.ca-cpi.org

CARS
CENTER FOR APPLIED RESEARCH SOLUTIONS

The Community Prevention Initiative (CPI) is funded by the California Department of Health Care Services (DHCS) and administered by the Center for Applied Research Solutions (CARS).

AGENDA

DAY 1 – Thursday, July 13, 2017

7:45 – 8:30 a.m. **Registration and Continental Breakfast** ***Gardenia Foyer***

8:30 – 9:00 a.m. **Welcome** ***Gardenia Room***

Maggie Escobedo-Steele, *Founder, 7th Generation Warriors for Peace*

Denise Galvez, *Policy and Prevention Branch (PPB) Chief, Substance Use Disorder Program, Policy, and Fiscal Division (SUD PPFD), Department of Health Care Services (DHCS)*

Erika Green, *MS, CPI Project Director, Center for Applied Research Solutions (CARS)*

9:00 – 9:30 a.m. **Keynote Speaker: Intersection of the Role of Cultural Competence in Service Implementation and Planning: Review and Reflections** ***Gardenia Room***

Rachel Guerrero, *LCSW, Guerrero Consulting*

Rachel Guerrero will discuss how culture influences service delivery and planning. Rachel will provide a brief history of implementation challenges, examine why engaging cultural issues is critical for effective care, and provide some recommendations for organizations to institute cultural competency principles.

9:30 – 10:45 a.m. **What's Culture Got to Do with It? Culture and SUD Prevention Services** ***Gardenia Room***

Rocco Cheng, *PhD, Principal, Rocco Cheng and Associates*

Dr. Rocco Cheng will provide an overview of cultural competence concepts and the importance of cultural competence in SUD prevention services. Rocco will discuss how cultural competence is reflective of SUD prevention frameworks, including risk and protective factors.

10:45 – 11:00 a.m. **Break**

11:00 – 11:30 a.m. **Refresher: The Cultural Competence Continuum** ***Gardenia Room***

Ebony Williams, *PsyD, California State University Sacramento*

Dr. Ebony Williams will review and define each stage of the cultural competence continuum.

11:30 – 12:30 p.m. **Cultural Competence in Action: Examples of Culturally Competent Prevention Services** ***Gardenia Room***

Daniel Toleran, *MS, Project Director, CARS*

Daniel Toleran will facilitate a panel discussion of how organizations and programs implement cultural competence. The panelists will share what cultural competence looks like in action, successes and challenges with implementation, and recommendations for others to consider.

Melissa Struzzo, *Prevention Coordinator, Marin County*

Nicole Bozzo, *Behavioral Health Department Manager, Sacramento Native American Health Center*

12:30 – 1:30 p.m. **Lunch** ***Gardenia Foyer***

1:30 – 3:00 p.m. **Concurrent Breakout Sessions**

Breakout Session 1: Preventing Substance Use Disorders in Rural California ***Bondi – Level 2***

Charlie Seltzer, *CPI Consultant/Independent Consultant, Grandview Consulting*

Charlie Seltzer will discuss the unique aspects of rural culture, identify risk and protective factors of rural communities, and introduce best practices for providing culturally competent SUD prevention services for rural populations.

Breakout Session 2: Creating Culturally Competent Substance Use Disorder Prevention Services for LGBTQ Populations ***Camellia Room***

Willy Wilkinson, *MPH, Writer and Public Health Consultant, LGBTQ ACCESS*

Willy Wilkinson will provide an overview of terms, concepts, and identities associated with LGBTQ communities and address access and legal issues that impact LGBTQ groups. Willy will explore and share culturally competent best practices for addressing and working with LGBTQ individuals and families.

Breakout Session 3: Cultural Competency in Working with Immigrant and Refugee Populations ***Compagno – Level 2***

Mireya Munoz, *Program Director, PALS for Health*

Mireya Munoz will present the cultural and linguistic issues of immigrant and refugee populations, language and communication considerations, how these considerations impact SUD prevention, and recommendations for culturally competent interactions.

Session 4: Cultural Competency SUD Prevention Services for Native Populations ***Beavis – Level 2***

Daniel Domaguin, *Behavioral Health Clinical Manager, California Rural Indian Health Board*
Kathleen Jack, *MPH, Project Coordinator, California Rural Indian Health Board*

Daniel Domaguin and Kathleen Jack will present an overview of the diversity within California Indian communities. Daniel and Kathleen will introduce historical trauma and discuss how it contributes to substance use and health disparities among native populations.

3:10 – 4:15 p.m. **Brainstorming Session: Defining Cultural Competence for the SUD Prevention Field** ***Gardenia Room***

Participants will have an opportunity to share their thoughts and ideas about the role of cultural competence in SUD prevention for California in a group brainstorming format.

4:15 – 4:30 p.m. **Day 1 Wrap-up and Closing** ***Gardenia Room***

Day 2 – Friday, July 14, 2017

7:45 – 8:30 a.m. **Registration and Continental Breakfast** ***Gardenia Room***

8:30 – 9:00 a.m. **Welcome and Day 2 Overview** ***Gardenia Room***

Erika Green, *MS, CPI Project Director, CARS*

9:00 – 9:30 a.m. **Keynote Speaker: Creating and Sustaining Peace in Urban Warzones with Culturally Competent Interventions** ***Gardenia Room***

DeVone Boggan, *Founder and Chief Executive Officer, Advance Peace*

DeVone Boggan will describe how social opportunity creates an extraordinary pathway to peace in an urban American community. DeVone will share how developing mutually beneficial programming and advocacy partnerships with a "hard-to-reach" population transforms mindsets, reduces trauma, stabilizes communities, and improves public safety outcomes.

9:30 – 11:00 a.m. **Concurrent Breakout Sessions**

(See full session descriptions and locations in Day 1)

11:00 – 11:15 a.m. **Break**

11:15 – 12:30 p.m. **World Café - Integrating Cultural Competence into the Strategic Prevention Framework** ***Gardenia Room***

Participants will have an opportunity to share their thoughts and ideas about how to incorporate cultural competence into their strategic prevention plans. Participants will break into small groups and provide feedback at each of the five stations in a world café format.

12:30 – 1:30 p.m. **Lunch** ***Gardenia Foyer***

1:30 – 2:15 p.m. **Youth Culture and Substance Use Disorder Prevention** ***Gardenia Room***

Amanda Lipp, *Technical Assistance Specialist, CARS*
Alex Reale, *Peer Advocate, Butte County Behavioral Health*
Jenny Castaldo, *Peer Advocate, Butte County Behavioral Health*
Kelsey Liou, *Peer Advocate, Butte County Behavioral Health*

Alex Reale, Jenny Castaldo, and Kelsey Liou are three youth who work in the Prevention Unit of Butte County Behavioral Health. They will discuss how and why they became involved in SUD prevention programs, the relevance of their generation's youth and campus culture, and strategies to engage youth as leaders that support their peers.

2:15 – 3:15 p.m. **Gathering Culturally Competent Data** ***Gardenia Room***

Daniel Toleran, *MS, Project Director, CARS*

Daniel Toleran will facilitate a panel discussion about the importance of utilizing culturally competent evaluation techniques to collect local and community-level data. Panelists will share data collection strategies, case studies of culturally competent data collection efforts, and recommendations to gather culturally competent data.

Sandra Villanueva, *PhD, Clinical Psychologist, Loyola Marymount University*

Maureen Wimsatt, *PhD, Program Director, California Rural Indian Health Board (CRIHB)*

3:15 – 3:30 p.m. **Break**

3:30 – 4:15 p.m. **Strategies to Build Organizational Cultural Competence** ***Gardenia Room***

Ebony Williams, *PsyD, Professor, California State University, Sacramento*

Dr. Ebony Williams will present the principles for building a culturally competent SUD prevention organization and share how cultural competence applies to each step of the SPF.

4:15 – 4:30 p.m. **Wrap-up and Closing** ***Gardenia Room***

Presenter Biographies

DeVone Boggan

Prior to founding Advance Peace, Mr. Boggan served as Neighborhood Safety Director and Director of the City of Richmond (California) Office of Neighborhood Safety (ONS). As Director of ONS, he was responsible for the development, implementation, and management of comprehensive approaches to reducing firearm assaults, preventing retaliation associated with firearm conflict, and transforming the lives of the city's most lethal young men. He is a national authority on urban gun violence prevention and intervention. Mr. Boggan also served as Executive Director of The Mentoring Center (TMC) in Oakland, California (1995-2004). He has extensive expertise and a passion for training and motivating mentors. While at The Mentoring Center, he trained more than 25,000 mentors nationwide. Programs included mentoring efforts that serve youth who have multiple contacts with the juvenile justice system, youth incarcerated in youth correctional facilities, youth in foster care, and youth in alternative education settings.

Nicole Bozzo

Ms. Bozzo is a Karuk Woman and the Behavioral Health Program Manager at Sacramento Native American Health Center (SNAHC). She is currently enrolled in the University of San Francisco – Marriage and Family Therapy Program. Nicole has been at SNAHC for a year, and is currently pursuing a master's degree to become an LMFT at SNAHC.

Jenny Castaldo

Hello, my name is Jenny Castaldo. I am 21 years old and from Chico, California. I'm currently a student at Butte College. I've been working as a Peer Advocate for the Butte County Behavioral Health - Prevention Unit for three years. I'm passionate about engaging youth to be influential members of our community. Currently, I work with Club Live at Bidwell Junior High School. I am also on the A-Team conference planning team and have had the opportunity to work with our Strengthening Families Program in childcare. I feel truly blessed and fortunate to work with so many amazing youth and to empower them to make change in their community. I strive for the greatness in others to see them grow to their highest potential. My motto in my work in prevention is by Mary Rose McGeady: "There is no greater joy nor greater reward than to make a fundamental difference in someone's life." I feel extremely fortunate for my position as Youth Advocate, as it has allowed me to make a meaningful impact on the lives of so many youth in our community.

Dr. C. Rocco Cheng

Dr. Cheng, a licensed clinical psychologist since 1996, has worked as a crisis counselor, team leader, project coordinator, program director, and corporate director at a large private non-profit behavior health agency for 22 years. He directed 10 federal Substance Abuse and Mental Health Service Agency (SAMHSA) demonstration programs on mentoring, parenting, and gang awareness, as well as several prevention projects aimed at reducing substance abuse, HIV, youth violence, and gang affiliation. Dr. Cheng founded a consulting firm, Rocco Cheng and Associates (RCA), in 2015, providing culturally and linguistically responsive training, consultation, and technical assistance to local and statewide projects. He has been actively involved with the implementation of Mental Health Service Act in California at the local and state level and has served on three of the five committees of the Mental Health Service Oversight and Accountability Commission (OAC). Dr. Cheng also directed the Asian Pacific Islander (API) Strategic Planning Workgroup (SPW) of the California Reducing Disparities Project (CRDP) from 2010 to 2015 and was appointed as an Advisory

Council Member for the California Department of Public Health's Office of Health Equity in 2013, where he was elected as the vice-chair for the next two years.

Daniel Domaguin, LCSW
Mr. Domaguin has been serving California's American Indian/Alaska Native communities as a behavioral health professional since 2009. Originally from South San Diego, he earned his Bachelor of Arts from Oberlin College and his Master of Social Work from the University of Michigan. He provides culturally aware behavioral health services that integrate knowledge of intergenerational and colonial trauma into treatment with community members, including those with histories of domestic or relational violence, substance use, incarceration, child abuse or neglect, and involvement with Child Protective Services. Mr. Domaguin is also versed in program development and administration, partner collaboration, outreach, and youth empowerment programming.

Rebecca "Maggie" Magdalena Escobedo-Steele
Maggie Steele is the founder of 7th Generation Warriors for Peace, an organization dedicated to working with youth and community to prevent substance abuse, violence, and gang conflict, and to promote healing and empowerment. She has implemented leadership, prevention programs, and community events throughout California and the U.S., and has been recognized by the Society of Professionals in Dispute Resolution for her excellence and innovation in working with youth and community. Ms. Steele specializes in working with community around Drug and Alcohol prevention and policy, youth violence, gang conflict, and promoting healing and wellness through grassroots projects and organizing. Her work is well known and respected in Native American communities. She has expertise working within and for all cultures, including African/American, Asian/American, Caucasian, elder, faith/clergy, Hispanic/Latino, multicultural, Native American, Pacific Islander, and refugee and migrant populations.

Denise Galvez
Denise Galvez has over 10 years' experience working in the substance use disorder (SUD) prevention field. Since April 2015, she has served in the capacity of Branch Chief of the Policy and Prevention Branch (PPB) at the Department of Health Care Services (DHCS). Ms. Galvez is primarily responsible for the management of program planning, evaluation, policy identification, development, design, maintenance, and continuous improvement of California's SUD prevention, perinatal, and youth treatment and recovery services. She provides leadership, direction, mentoring, and supervision to 58 counties. She oversees the branch responsible for multiple high-level projects, including two statewide technical assistance and training contracts; two data collection contracts; and the reporting and monitoring of all aspects of the Primary Prevention portion of the Substance Abuse Prevention and Treatment Block Grant. Ms. Galvez also leads interdisciplinary teams, including the Interagency Prevention Advisory Council and Youth Advisory Group, and is a Certified Prevention Specialist.

Erika Green, MS
Ms. Green has 20 years of experience providing direct service, management, guidance, training, and field support at the local, statewide, and national level in youth substance use disorder prevention. She is the Associate Executive Director at CARS and the Project Director for CPI. As CPI PD, she provides leadership and statewide support through the development of trainings, tools, and practical resources to enhance sustainability and capacity building for substance abuse prevention professionals. Working with consultants, Ms. Green assists in the provision of TA services, and in collaboration with State and Federal Departments, she provides guidance to inform

the field of best practices. Ms. Green is also responsible for providing vision and leadership on CPI, developing and managing project plans, supervising and managing program staff, and collaborating with consultants and experts to ensure successful delivery of services that align with DHCS priorities. She has provided direct substance abuse prevention services as a program coordinator and program director, has developed program strategies and evaluated outcomes, and has provided training and support to agency staff. At the state level, Ms. Green has managed training and TA projects including the California Mentoring TTA Project and the Community Prevention Initiative. Before joining the CARS team, Erika provided direct program services, including program and curriculum development, recruitment, training, implementation, and evaluation for substance abuse and violence prevention programs. She was integral in developing the award-winning Valley Hi Community Mobilization Project which integrated a multi-strategy program that was proven to enhance youth protective factors, thereby decreasing substance use over a seven-year time period. Based on the success of this strategy, Ms. Green has provided extensive training and technical assistance to inform the field of innovative best practices and strategies that positively impact youth.

Rachel Garcia Guerrero, LCSW

Ms. Guerrero has devoted her 38-year career in the mental health field to issues of social justice, including reducing disparities and improving services for Latinos and other multicultural communities. Her expansive career began as a child family therapist, hired as Yolo County's first Spanish-speaking mental health therapist, and concluded after 22 years as an administrator at the California State Department of Mental Health. This work included 12 years as the first Director of the Office of Multicultural Services. In 1999, Ms. Guerrero received a national leadership award for her pioneering work in multicultural mental health. In 2002, she received the California Statewide Mental Health Cultural Competence Leadership award. In 2008, under the voter-approved Mental Health Service Act, she secured support for the funding of the California Reducing Disparities Project. She retired in 2010 and currently manages her own national consulting and training practice, Guerrero Consulting, in Sacramento, CA.

Kathleen Jack, MPH

Kathleen Jack, MPH, is an enrolled member of the Shoshone-Paiute Tribe of Duck Valley. For over 21 years she has worked in California for American Indian non-profits on state and federally funded grants from the California Department of Public Health Services, U.S. Department of Education, Center for Disease Control, and Substance Abuse and Mental Health Services Administration. She began her career as a Youth Trainer, Health Educator, and Health Education Director, and currently serves as the Project Coordinator for the Research and Public Health Department's SAMHSA Native Connections suicide prevention grant at California Rural Indian Health Board, Inc. She had dedicated her career to work on improving the health and well-being of American Indian Tribal communities.

Kelsey Liou

Hello, my name is Kelsey Liou. I'm 21 years old and from Chico, California. I am a student at California State University, Chico. I've been working as a Peer Advocate for the Butte County Behavioral Health - Prevention Unit for three years. I'm passionate about positively influencing our community as a whole through intentional investment in youth. Currently, I work with our Impact Mentoring program, a one-on-one mentorship between a high school student and a junior high student that focuses on setting academic and personal goals, building skills, and preparing for high school. I am also on the A-Team conference planning team, and I work with our Strengthening

Families Program in childcare and the Club Live chapter at Chico Junior High School. My personal motto in work and in life is by Ralph Waldo Emerson: "It is one of the most beautiful compensations of this life that you cannot sincerely try to help another without helping yourself." My work in prevention is truly heartwarming and fulfilling, and I feel honored to work alongside leaders in my community to inspire a new generation of change.

Amanda Lipp

Amanda Lipp, 25, is a Technical Assistance Specialist for the Center for Applied Research Solutions (CARS), where she supports grantees' social marketing, curricula development, and multimedia needs. Ms. Lipp's passion for working in mental health and education began with experiencing her own crisis, after which she began innovating with others to improve individual wellness and collective impact. Since age 19, Ms. Lipp has given over 150 speeches across the U.S. and produced over 20 short films promoting health causes and individuals' stories. She owns a private consulting firm, Lipp & Associates, producing films and designing mental health resources and trainings for nonprofits around the nation Projects have included a narrative video series on psychosis with Columbia University Department of Psychiatry, a documentary narrative series with OnTrackNY, comic-education booklets on education-vocation rehabilitation with Felton Institute of San Francisco, and national training for President Obama's Now Is The Time (NITT) federal grantees. Ms. Lipp is a civil servant and passionate leader at heart; she currently serves as a board member for the National Alliance on Mental Illness (NAMI), and board advisor for Strong 365 and Art With Impact (AWI).

Mireya Munoz

Prior to joining PALS for Health in May of 2003, Ms. Munoz worked for 13 years in the health care sector as a Behavior Specialist. As Program Director at PALS for Health, Ms. Munoz works arduously to improve the quality of life for Limited English Proficiency (LEP) communities by providing an array of services that alleviate cultural and linguistic barriers to health care access; improving the health care system's understanding and support of LEP patients and families; increasing capacity to provide quality interpretation/translation services; and informing LEP patients and their families of their right to these services and how to access them. Ms. Munoz is an experienced health care interpreter, as well as a trainer of the State recognized curriculum Connecting World: Introduction to Health Care Interpretation Training held by PALS for Health. Ms. Munoz has been the recipient of numerous recognitions, including California State Legislature Recognition for collaboration in the Third Annual Southern California Partnership of Healthcare Advocates Conference (2006); Congressional Recognition from Hilda L. Solis for collaboration in the Fifth Annual Promotor/Community Health Worker Conference (2007); and Senate Recognition for leadership in the Dialogue on Access to Care: Advocating to Fight Cancer in Riverside and San Bernardino Counties (2008).

Alex Reale

Hello, my name is Alex Reale. I'm 17 years old and from Chico, California. I've recently graduated from Chico High School. I've been working as a Peer Advocate for the Butte County Behavioral Health Prevention Unit for three years. I'm passionate about empowering youth to live a better life through education, training, and programming. Currently, I work with our Youth Nexus program, a 501(c)(3) County-sponsored non-profit focused on grant writing, community service, and civic action. I am also on the A-Team conference planning team to plan our annual Youth Development Summit, Reach for the Future conference, and Athlete Committed conference. I have also had the opportunity to work with our Strengthening Families Program and the Friday Night

Live chapter at Chico High School. My position as Youth Advocate has given me the unique opportunity and resources to impact my peers to live positive, healthy lives.

Charlie Seltzer

Charlie Seltzer was introduced to the field of substance abuse prevention through his interest in HIV prevention. As an HIV educator for his county's public health department, Mr. Seltzer was struck by how often drugs and alcohol played a major role in HIV transmission. Halting the spread of HIV also meant reducing the impact of substances on people's health and choices. Mr. Seltzer retired after 10 years with the department, having served as its HIV Prevention Education Coordinator, Prevention Coordinator, and finally Substance Abuse Prevention Administrator. In retirement, Mr. Seltzer began consulting with the Center for Applied Research Solutions (CARS), providing SUD prevention education and technical assistance across the state of California. He is also on the faculty of Mendocino Community College, where he teaches SUD prevention.

Melissa Struzzo

Melissa Struzzo has been working in the social services field for over 20 years, with a focus on HIV/AIDS/HCV prevention, sexually transmitted disease prevention, homeless services, and substance use disorder prevention. Currently Ms. Struzzo works for the Marin County Department of Health and Human Services as a Senior Program Coordinator, where she oversees the SUD prevention programs. In addition, she is the statewide prevention coordinator for Marin County, focused on alcohol, marijuana, opioid, and other drug prevention. Before working for Marin County, Ms. Struzzo was working with the Sonoma County Department of Health Services in a similar SUD prevention role. Prior to moving to the North Bay in 2013, Ms. Struzzo was the principal investigator for multiple Alameda county-based research studies; these included an evaluation of HIV risk reduction interventions for HIV-serodiscordant couples, and geomapping of HIV incidence and mobile HIV testing sites. Ms. Struzzo holds a Master of Public Health from San Jose State University.

Daniel Toleran, MS

Mr. Toleran is respected for more than 20 years' experience advocating mental health, social services, and behavioral health prevention and treatment for both immigrant and US born Asian American and Pacific Islander, LGBTQ, and other health disparity populations. He has successfully directed several large, successful programs that provided integrated behavioral health, HIV/AIDS services, primary care, comprehensive social support, and community advocacy to historically underserved communities. His work has focused on building state and community linkages, systems development between health care and other agencies, and providing consultation and trainings. At CARS, he is Co-Project Director for the California Reducing Disparities Project Phase II LGBTQ TA Provider; subject matter expert in Cultural Competence, and health disparity for the California Prevention Initiative, and the Now Is The Time project.

Sandra Villanueva, PhD

Dr. Villanueva is a Community-Clinical Psychologist with over 20 years of experience in program evaluation and community-based participatory action research on a wide range of social justice issues and systems and policy change. She has worked on local, state, and national program evaluation initiatives with private foundations, governments at all levels, and a diverse range of community-based organizations and agencies. Dr. Villanueva has co-led more than 30 local, state, and national program evaluations. She is an expert in designing logic models and theories of change, mixed methods designs, and tools and strategies to capture policy and systems level

changes associated with a diverse set of health and mental health strategies in underserved communities of color. Her areas of expertise further include substance abuse prevention, root causes of childhood obesity (including food and recreation access), community organizing and leadership development training programs, education reform, juvenile justice, re-entry services, relative caregiver supports and services, multicultural health/mental health, and evaluation technical assistance.

Willy Wilkinson, MPH

Willy Wilkinson is an award-winning writer, public health consultant, cultural competency trainer, public speaker, and spoken word performer. He is the author of the Lambda Literary Award-winning book Born on the Edge of Race and Gender: A Voice for Cultural Competency, which illuminates trans experience from a Chinese American and mixed heritage perspective, and transforms the memoir genre into a cultural competency tool. Mr. Wilkinson has provided LGBTQ and trans-specific training for hundreds of community health organizations, educational institutions, and businesses. He is the recipient of a National Lesbian and Gay Journalists Association award and the Transgender Law Center Vanguard Award, and is recognized on the Trans 100. He lives in Oakland, California with his three vibrant young kids. Learn more at www.willywilkinson.com.

Dr. Ebony M. Williams, PsyD

An Oakland, California native, Dr. Williams has worked extensively with LGBTQQIAA communities, people of color, individuals of low socioeconomic status, at-risk youth, and high-risk sexual offenders. She has a wide range of experiences, including working for the California Department of Corrections and Rehabilitation treating incarcerated male youth offenders. Dr. Williams has worked internationally in New Zealand as the sole psychologist of a 21-bed inpatient unit, where she incorporated NZ Maori practices and culture into the individual behavioral treatment plans of clients who were dually-diagnosed. Dr. Williams earned a Bachelor of Arts degree in Exercise Science from UC Davis; and two Master of Arts degrees in Sport Psychology and Clinical Psychology, as well as a Doctorate in Psychology (Psy.D.), from John F. Kennedy University in Pleasant Hill, CA. Currently, she is a Cultural Competency consultant for ONTRACK Program Resources and Center for Applied Research Solutions (CARS), and a professor at California State University, Sacramento. Occasionally, she is also a guest on the Wellness Radio Show based out of El Centro, CA.

Dr. Maureen Wimsatt

Dr. Wimsatt is the Program Director of the California Tribal Epidemiology Center within the California Rural Indian Health Board, Inc. Dr. Wimsatt has sixteen years of public health research and evaluation experience, including a research history with several academic institutions, community organizations, and independent consulting firms. Dr. Wimsatt has worked with community members and Tribal leaders to conduct American Indian- and Alaska Native-focused research and evaluation projects since 2008. Her work has been funded by the Indian Health Service, National Institutes of Health, Substance Abuse and Mental Health Services Administration, Robert Wood Johnson Foundation, Centers for Medicare and Medicaid Services, and National Science Foundation.

CENTER FOR APPLIED RESEARCH SOLUTIONS (CARS)

708 College Avenue
Santa Rosa, California 95404
707.568.3800 Phone
707.568.3810 Fax
www.cars-rp.org

More is Available for You!

Visit the CPI website for more no-cost resources, webinars, and trainings on prevention topics:
http://www.ca-cpi.org/

@CARSRP CARS.RP

Customized training is offered through the Community Prevention Initiative (CPI), which is funded by the California Department of Health Care Services and administered by the Center for Applied Research Solutions.

CPI Regional Training 2017

Keynote Speaker

Rachel Garcia Guerrero, LCSW

Community Prevention Initiative

CARS
Center for Applied Research Solutions

CPI Regional Training 2017

What's Culture Got to Do With It?
Culture and SUD Prevention Services

Presented by

C. Rocco Cheng, PhD

Community Prevention Initiative

CARS
CENTER FOR APPLIED RESEARCH SOLUTIONS

CPI Regional Training 2017

What's Culture Got to Do with It? Culture and SUD Prevention Services

Presented by

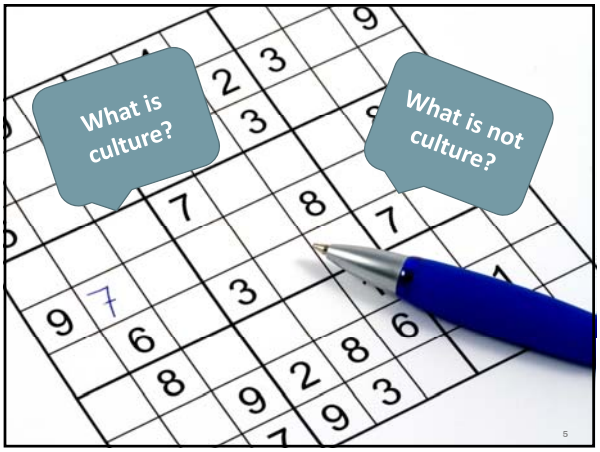
C. Rocco Cheng, PhD

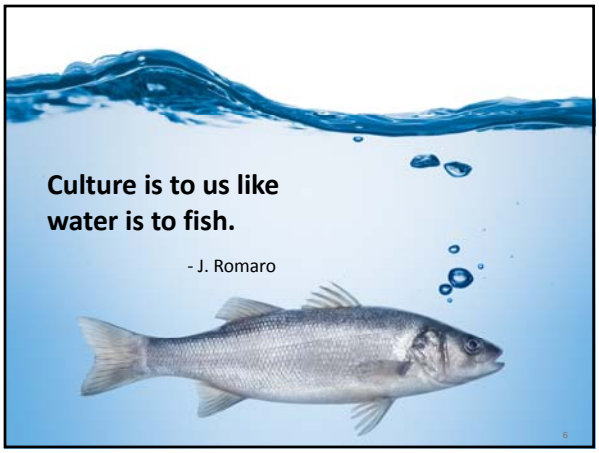
- Culture and Cultural Competence
- Health Disparities and Social Determinants of Health
- Risk and Protective Factors
- Designing a Culturally and Linguistically Responsive Program

Agenda

About Culture


What is culture?
What is not culture?
4


What is culture?
What is not culture?
5


Culture is to us like water is to fish.
- J. Romaro
6

"Culture refers to integrated patterns of human behavior that include the language, thoughts, communication styles, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups."

U.S. Department of Health and Human Services, Office of Minority Health, 2005

Elements of Culture

Culture includes the following elements:

- Norms
- Values
- Beliefs (what people think about something)
- Symbols
- Practices (customs or patterns of behavior that may not be connected to beliefs and values)

U.S. Department of Health and Human Services, Office of Minority Health, 2005; Griswold, W., *Cultures and Societies in a Changing World, third edition, 2008*

Cultural Diversity Beyond the Usual

- Beyond race and gender
- Generational
  - Sexual orientation
  - Religious / spiritual practices
  - Lifestyle
  - Social class
  - Immigration / refugee status
  - Illness
  - Occupation
  - AOD usage

- Views people holistically along multiple dimensions and elements of culture
- What is important to you may not be important to others

Generational Differences

10

Concepts to Remember

Cultural Competence	Acceptance and respect for culture is consistently demonstrated in policies, structures, practices, and attitudes.
Cultural Humility	The "ability to maintain an interpersonal stance that is other-oriented (or open to the other) in relation to aspects of cultural identity that are most important to the [person]" (p. 2). (Cook, Davis, Owen, Worthington, and Utsey, 2013)
Cultural Responsiveness	The ability to learn from and relate respectfully to people from your own and other cultures.
Health Disparities	Health disparities adversely affect groups of people who have systematically experienced greater social or economic obstacles to health based on their racial or ethnic group, religion, socioeconomic status, gender, age, or mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion.
Health Equity	Everyone has a fair and just opportunity to be as healthy as possible. This requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care.
Social Determinants of Health	Conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.
Trauma	Trauma results from an event, a series of events, or a set of circumstances that is experienced by an individual, group, or community as physically or emotionally harmful or life threatening and that has lasting adverse effects on their functioning and mental, physical, social, emotional, or spiritual well-being.

Watch Out for Ethnocentrism

- The belief that one's own culture is superior to other cultures.
- Uses a distorted version of one's culture as a foundation to view other cultures.

12

The Difference Culture Makes

Western culture in the U.S. places strong emphasis on the individual and focuses on the needs of **"I"** or the self.

However, many cultures are collective and place a strong emphasis on **"WE"** or the community.

www.strengtheningfamiliesprogram.org/index.html

13

What Cultural Competence Is and Is Not

IS NOT…	IS…
Something seen as a goal in itself	An ongoing process to be woven into the fabric of work at all stages of program development and implementation
Just something to check off a list	A guiding principle at every phase of program development and management

14

Positive Impact of Cultural Competence

- Cultural competence describes a level of skill and knowledge individuals possess to effectively interact and communicate in situations and environments with a diverse range of participants and stakeholders.
- Cultural competence helps to ensure that health care systems and providers identify and address the needs of all community members.

More About Cultural Competence…

Shape/modify services to meet the needs of the community:

- Cultural appropriateness
  - Examine if services are appropriate for the target community given its cultural context
- Cultural adaptation
  - Adapt to create a better fit between the needs of the community and available services
  - Tailor services to fit the cultural norm or practice of the community
- Cultural integration
  - Cultural exchange in which one group assumes the beliefs, practices and rituals of another group without sacrificing the characteristics of its own culture
  - Healthy intermingling of the beliefs and rituals of two unique cultures
  - Programs utilize cultural practices or strengths from the community to improve services provided

16

For Prevention Professionals

Culturally Competent Services

- Help alleviate health disparities associated with differences in race, ethnicity, gender, and other cultural factors
- Reduce the tendency to view communities through the lens of the dominant culture
- Facilitate better understanding to address the needs of marginalized and underserved populations

17

One Size Does Not Fit All

Cultural competence guides the development and implementation of effective prevention strategies to…

- expand community engagement;
- promote access; and
- increase the utilization of services that address the needs of **California's diverse populations.**

18

What Does SAMHSA Say About Cultural Competence and Evidence-Based Services?

- … the knowledge and sensitivity necessary to tailor interventions and services to reflect the norms and culture of the target population and avoid styles of behavior and communication that are inappropriate, marginalizing, or offensive to that population.
- … because of the changing nature of people and cultures, cultural competence is seen as a continual and evolving process of adaptation and refinement.

The National Registry of Evidence-based Programs and Practices (NREPP) Glossary (2013)

Caring Is Catching (Stir It Up)

- When I see you care … it ignites something in me.
- When you have a clean house and work in partnership with your spouse and hold your babies close to your chest … it ignites something in me.
- When you are fully present and not absent-minded about our people … it jars my memory and I catch a fire.
- When you see the beauty instead of the booty/bounty … it moves my mountain.
- When you sit still long enough for me to look inside your eyes … it settles my dust.
- When you speak tenderly and lovingly … it quickens my spirit
- When you stretch as you reach for us … it steadies (anchors) my racing heart.
- When you cry like rain for Our people … it refreshes the Whole atmosphere.
- When I see you care … it ignites something in me.
- When you care, I care … and we become uncompromised and revitalized.

Cheryl Taylor, written by participant of Consumers and Psychiatric Mental Health Nurses in Dialogue Meeting July 26–27, 1999, sponsored by SAMHSA (From CBMCS)

Health Disparities and Social Determinants of Health

Health Disparities and Social Determinants of Health

Health Disparities

- Difference or inequality in health conditions and outcomes that exist among specific or different groups.

Social Determinants of Health

- The conditions in which people are born, grow, live, work, and age. These circumstances are shaped by the distribution of money, power, and resources at global, national and local levels.

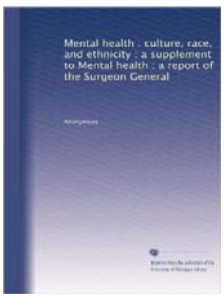
Who is Impacted by Health Disparities?

Health disparities adversely affect groups of people who have systematically experienced greater social or economic obstacles to health, based on their:

Race	Ethnicity	Religion	Socioeconomic Status
Gender	Mental Health	Cognitive, Sensory, or Physical Disability	Sexual Orientation
	Geographic Location	Other characteristics historically linked to discrimination or exclusion	

Warning from the Surgeon General's Report

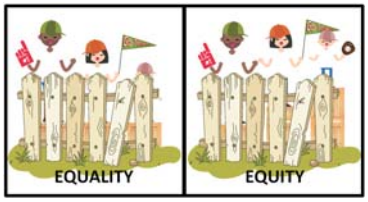
- Minorities have less access to and availability of services.
- Minorities are less likely to receive needed services.
- Minorities in treatment often receive a poorer quality of care.
- Minorities are underrepresented in research.



Mental Health: Culture, Race, and Ethnicity, A Supplement to Mental Health: a report of the Surgeon General, 2001

Health Equity vs. Health Inequities

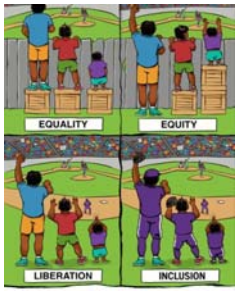
- **Health *equity*** is the attainment of the highest level of health for ALL people.
- **Health** and behavioral health ***inequities*** are differences in health and behavioral health or the factors that shape health that are **systemic** and **avoidable** and ***therefore considered unjust or unfair.***



Healthy People 2020, U.S. Office of Minority Health, HHS

Health Equity Is The Goal

- Achieving health equity requires valuing everyone equally through ongoing efforts:
  - To eliminate health and health care disparities
  - To address avoidable inequalities
  - To address historical and contemporary injustices
- Cultural competence is essential in achieving health equity.



Healthy People 2020, U.S. Office of Minority Health, HHS

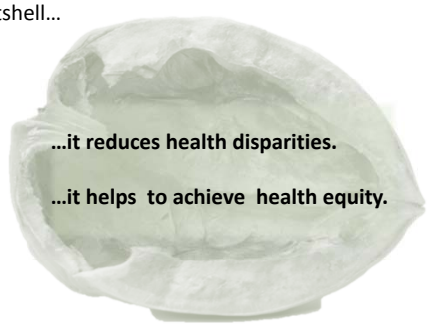
Examine Equity/Disparities with 5 A's

- Availability
- Accessibility
- Affordability
- Appropriateness
- Acceptability

Jackson, 2008

Why Cultural Competence?

In a nutshell…



…it reduces health disparities.

…it helps to achieve health equity.

Contributing Factors for Substance Use and Mental Health Disorders

Contributing Factors are the risk and protective factors that are predictive of substance abuse issues.

Contributing Factors

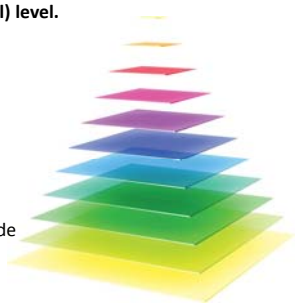
- Exposure to drugs
- Socio-Economic Status
- Quality of parenting
- Peer group influence
- Biologic/genetic factors
- History of traumatic experiences
- Historical/Intergenerational/Colonial Trauma

National Institute on Drug Abuse (NIDA), Preventing Drug Use Among Children and Adolescents: A Research Based Guide

Additional Contributing Factors

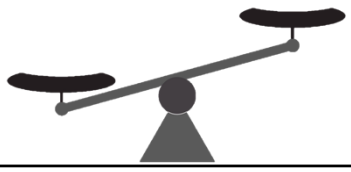
Let's go beyond one (individual) level.

- Family strengths
- Kinship support
- Culture
- Ethnic identity and ethnic pride
- Spirituality



Disproportionality of Contributing Factors

- Do you see these risk and protective factors manifest differently in different cultural and community groups?
- We need to consider the work from a holistic perspective considering individual, family, community, cultural, and other aspects of one's experience



Designing a Culturally and Linguistically Responsive Program

Putting these concepts together, it helps us design a program that is more culturally and linguistically responsive to the focus community. We should consider…

Principles of Cultural Competence

- Ensure focus community involvement.
- Use a population-based definition of community.
- Stress the importance of relevant, culturally-responsive prevention approaches.
- Promote cultural competence among program staff.
- Employ culturally-competent evaluators.

Integrating Cultural Competence Into the Strategic Prevention Framework

- SAMHSA's 5 Step Strategic Prevention Framework (SPF) is guided by the principles of sustainability and **CULTURAL COMPETENCE**
- **CULTURAL COMPETENCE is at the core of the SPF** and is intended to be infused throughout the 5 steps.

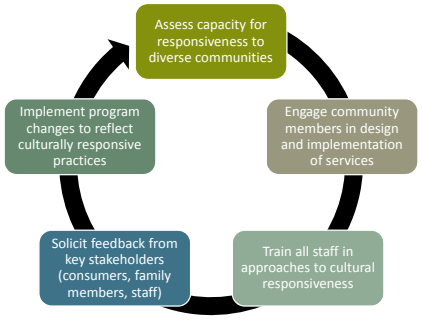
37

Joint Efforts Between The Organization And The Individual

Organizational	Individual
• Valuing diversity • Cultural self-assessment • Managing the dynamics of difference • Institutionalization of cultural knowledge • Adaptation to diversity • Policies, structure, values, services	• Awareness and acceptance of difference • Awareness of own cultural values • Understanding dynamics of difference • Development of cultural knowledge • Ability to adapt practice to the cultural context of client

Cross, Bazron, Dennis, & Isaacs, 1989; Isaacs & Benjamin, 1991; see also Arredondo & Arciniega, 2001, for strategies and techniques) From CBMCS

Cultural Competence in Action



Taylor, 2014

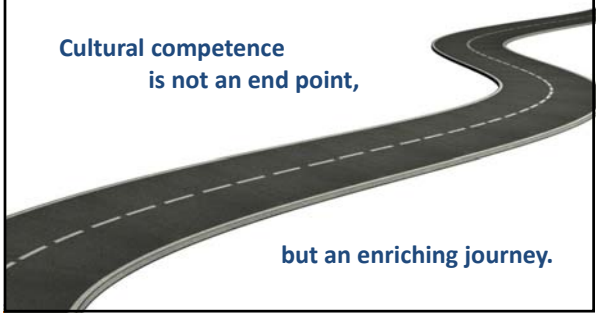
The Hearing Hand

Now let's look at how empowering it is for someone who is hearing impaired to enter an environment where people have been trained in American Sign Language (ASL), and using ASL is the norm and not a barrier to community engagement.

Click on icon to connect to video.

40

Final Thoughts



Cultural competence is not an end point,

but an enriching journey.

Questions?

Presenter Information

C. Rocco Cheng, Ph.D.
Rocco Cheng and Associates
RoccoAssocaites@Gmail.com

CPI Regional Training 2017

Cultural Competence in Action: Examples of Culturally Competent Prevention Services

Moderated by

Daniel Toleran, MS

Community Prevention Initiative

CARS
Center for Applied Research Solutions

CPI Regional Training 2017

Cultural Humility and the CLAS Standards in Student Assistance Programs for Sonoma County

Presented by

Melissa Struzzo, MPH

Community Prevention Initiative

CARS
CENTER FOR APPLIED RESEARCH SOLUTIONS

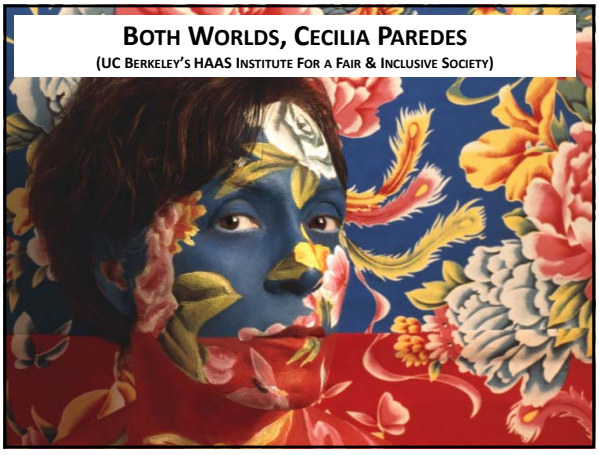
CPI Regional Training 2017

Cultural Humility and the CLAS Standards in Student Assistance Programs For Sonoma County

Presented by
Melissa Struzzo, MPH

Topics Covered

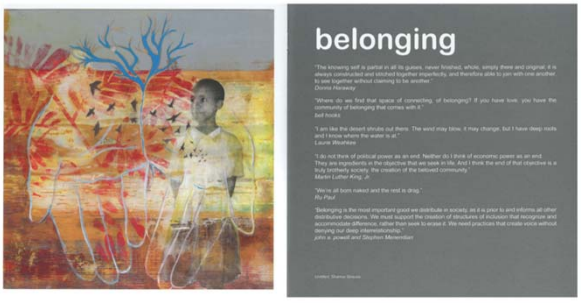
- Cultural framework and philosophy
- Culturally and Linguistically Appropriate Services (CLAS) Standards
- Student Assistance Programs – Project SUCCESS+ (PS+)
- PS+ Activities
- Strategies used to engage stakeholders
- Recommendations for implementation



The Cultural Lens and Frameworks

Need to understand and incorporate:

- Social Justice
- Concept of Culture
- Cultural Humility
- Power and Privilege
- Bias
- Trauma Informed and Adverse Childhood Experiences (ACEs)
- Harm Reduction

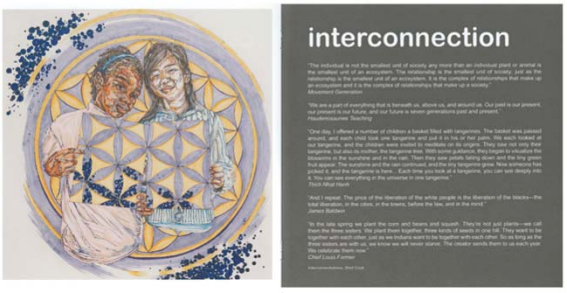


Untitled artwork created by Shanna Strauss

WHY INCLUDE CLAS WITH SAPS?

CLAS Standards

- Increase communication through cultural awareness
- Reflect cultural backgrounds
- Improve client/student/parent understanding and consent
- Provide improved care and services



Interconnectedness by Brett Cook

PROJECT SUCCESS+ BACKGROUND

Project SUCCESS+

Project Success

Schools
Using
Coordinated
Community
Efforts to
Strengthen
Students

PS+ Core Components

- Community coalitions
- Prevention Education Series
- Individual- and group-level interventions
- Parent engagement activities
- Faculty and staff engagement activities and trainings
- School-wide prevention activities
- Friday Night Live and student clubs
- Systems change and school policies
- Partnerships with community-based organizations

Incorporating CLAS

- Provide bilingual services
  - Parent engagement activities
  - Translation and interpreting
- Discuss privilege, bias, and historical trauma
- Mix it Up at Lunch Day
  - SPLC Teaching Tolerance Project

Engaging Stakeholders to Incorporate CLAS

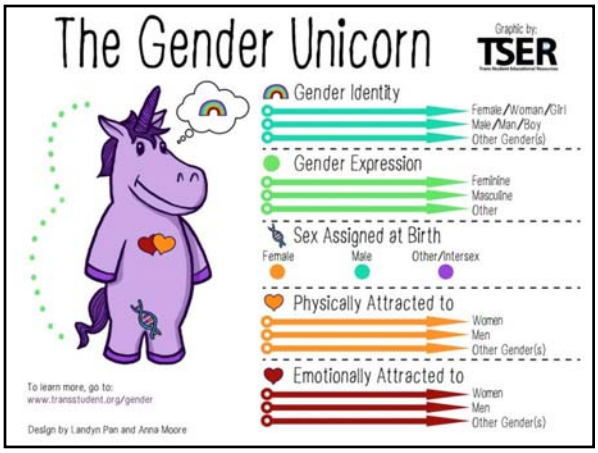
- Who are the PS+ stakeholders?
- Ways we are engaging the stakeholders:
  - Trainings – individual, organizational, community
  - Leveraging partnerships at the national, statewide, and local levels by incorporating health promotion campaigns and awareness months, weeks, and days
  - Community coalitions
  - POLICY

TRAININGS

- Who receives trainings?
  - PS+ Program – students, staff, faculty, parents, and family members
  - School administrators, school counseling staff, and PS+ staff from the contracted agencies, districts, office of education
- What trainings?
  - Gender Identity and Expression
  - ACEs
  - Harm Reduction
  - Cultural Humility
  - Privilege, Bias and Historical Trauma
  - Motivational Interviewing
  - Underage Marijuana Use

TRAINING TOOLS

1) TV2 Denmark Commercial - All that we share – Part of Privilege and Bias Training (https://youtu.be/jD8tjhVO1Tc)
2) Gender Unicorn – Part of the Gender Expression Training
3) Cultural Humility vs. Competency Table



Cultural Humility	Cultural Competence
▪ Learner's Stance - learning about other's culture	▪ Implies complete knowledge and mastery of other cultures
▪ Says you are the expert	▪ Says I'm the expert
▪ Equips you with the right questions	▪ Equips you with the right answers
▪ Lifelong process	▪ Seen more as an endpoint
▪ Curiosity	▪ Set of finite skills
▪ Acknowledging differences	▪ Understanding differences
▪ Self-reflection and critique	▪ Evaluating others
▪ Implies subjective set of best practices	▪ Implies objective set of best practices

LEVERAGING PARTNERSHIPS

- Partnerships with local community-based organizations
  - National Alliance on Mental Illness (NAMI)
  - Positive Images – Youth LGBTQ+ Organization
- National, statewide, and local SUD prevention and mental health promotion campaigns
  - Each Mind Matters, Directing Change, What I Be Project
- Awareness months, weeks, and days
  - Substance Abuse Awareness Month in October

DIRECTING CHANGE

What I Be Project – Steve Rosenfield

"I am not my gender identity"

"I am not my color"

http://www.whatibeproject.com

Awareness Months, Weeks, and Days

- Suicide Prevention Week – September 10-16, 2017
- Substance Abuse Awareness Month – October 2017
- Mental Illness Awareness Week – October 2-6, 2017
- Red Ribbon Week (Drug-Free America) – October 23-31, 2017
- Mix It Up at Lunch Day – October 31, 2017. A national campaign launched in 2002 by Teaching Tolerance, a project of the Southern Poverty Law Center, and held the last Tuesday in October each school year. This event encourages students to identify, question, and cross social boundaries.
- National Drug and Alcohol Facts Week – January 22-28, 2018
- National Youth Violence Prevention Week – April 3-7, 2017, and March 19-23, 2018
- National Mental Health Awareness Month – May 2018

Community Coalitions

- PS+ Collaborative
- Teen Health Advocacy Coalition
- Sonoma County ACEs Connection
- Sonoma County Prevention Partnership
- Petaluma Parents Against Drugs

Policy

- State, County, and City
  - AB 2246 – suicide prevention policies that incorporate CLAS
  - Transgender laws – AB 1266 (School Success & Opportunity Act), AB 1732 (Single-user Restrooms)
- School-based policies that:
  - Mandate cultural humility trainings for all staff
  - Incorporate trauma-informed practices
  - Create an inclusive and affirming school culture and environment that honors, respects, and values diversity in theory and in practice
  - Require restorative justice, suspension reduction practices and programs

Recommendations for Implementation

- Determine capacity
- Conduct trainings
- Add the trauma-informed and cultural humility lens
- Authentic community engagement – include the community voice as often as possible
- Review of materials, practices, etc.
- Create partnerships
- Leverage CBOs, community collaborations, community coalitions
- Environmental and systems changes and policies
- Learn about your referral agencies before making the referral
- Evaluation, regularly reassess, and make modifications

Questions?

Presenter Information

Melissa Struzzo, MPH
mstruzzo@gmail.com

CPI Regional Training 2017

Sacramento Native American Health Center
Behavioral Health Department
Culturally Competent Services

Presented by

Nicole Bozzo

Community Prevention Initiative

CARS
Center for Applied Research Solutions

CPI Regional Training 2017

Keynote Speaker

DeVone Boggan

Community Prevention Initiative

CARS
Center for Applied Research Solutions

CPI Regional Training 2017

Youth Culture & Substance Use Disorder

Youth Panel

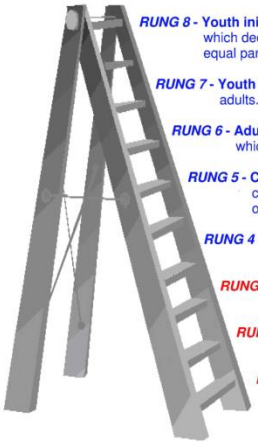
Moderated by
Amanda Lipp

Community Prevention Initiative

CARS
Center for Applied Research Solutions

What is Youth Culture?

- Interests, attitudes, behaviors, norms, beliefs, "lingo"
- Youth development is identity-centric:
  - "Who am I?"
- New Media/Information Age is widely considered a "youth culture"
  - Virtual and physical community bonds
  - Youth self-expression is the negotiation of self and social boundaries:
- "What is normal", and "What is MY normal"
  - The process of validation to and from peers
- To understand "youth culture" is to understand "adult culture" as well.
  - What defines age-based cultures, and how do they partner?



***RUNG 8* - Youth initiated shared decisions with adults**: Youth-led activities, in which decision making is shared between youth and adults working as equal partners.

***RUNG 7* - Youth initiated and directed**: Youth-led activities with little input from adults.

***RUNG 6* - Adult initiated shared decisions with youth**: Adult-led activities, in which **decision** making is shared with youth.

***RUNG 5* - Consulted and informed**: Adult-led activities, in which youth are consulted and informed about how their input will be used and the outcomes of adult decisions.

***RUNG 4* - Assigned, but informed**: Adult-led activities, in which youth understand purpose, decision-making process, and have a role.

***RUNG 3* - Tokenism**: Adult-led activities, in which youth may be consulted with minimal opportunities for feedback.

***RUNG 2* - Decoration**: Adult-led activities, in which youth understand purpose, but have no input in how they are planned.

***RUNG 1* - Manipulation**: Adult-led activities, in which youth do as directed without understanding of the purpose for the activities.

Adapted from Hart, R. (1992). Children's Participation from Tokenism to Citizenship. Florence: UNICEF Innocenti Research Centre, as cited in www.freechild.org/ladder.htm

CPI Regional Training 2017

Gathering Culturally Competent Data

Moderated by

Daniel Toleran, MS

Community Prevention Initiative

CARS
Center for Applied Research Solutions

CPI Regional Training 2017

Culturally Competent Evaluation

Presented by

Sandra Villanueva, PhD

Community Prevention Initiative

CARS
Center for Applied Research Solutions

CPI Regional Training 2017

Strategies for Gathering Culturally Competent Data for American Indian/Alaska Native Populations

Presented by
Maureen A. Wimsatt, PhD, MSW

Community Prevention Initiative

CARS
Center for Applied Research Solutions

CPI Regional Training 2017

Strategies for Gathering Culturally Competent Data for American Indian/Alaska Native Populations

Presented by
Maureen A. Wimsatt, PhD, MSW

- Identify the location of Tribal and Urban Indian populations in California
- Discuss potential successes and challenges in collecting needs or outcome data for American Indian/ Alaska Native (AIAN) populations
- Identify protocols for approaching Tribal communities and Tribal and Urban Indian Health Programs for data collection
- Learn about existing tools and resources to assist with culturally competent data collection

Session Goals

- Location of Tribal and Urban Indian populations in California
- Potential successes and challenges in data collection for AIAN populations
- Protocols for approaching Tribal communities and Health Programs for data collection
- Tools and resources to assist with culturally competent data collection

Agenda

Location of Tribal and Urban Indian Populations in California

California has one of the largest population of American Indians and Alaska Natives (AIAN) in the United States

- 109 federally recognized Tribes
  - Approximately 75 Tribes currently petitioning for federal recognition
- Many AIAN in California do not live on reservations
  - Urban AIAN, Rancheria lands
- AIAN in California are diverse
  - Not linked by dominant Tribal affiliation
    - Linguistic diversity
  - AIAN "alone" and "mixed race" Census classifications

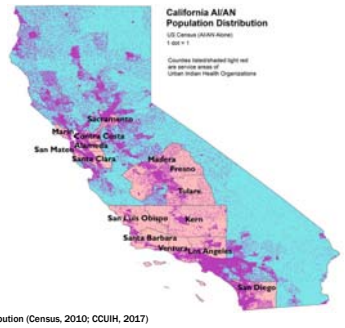
Location of Tribal and Urban Indian Populations in California

Tribal Lands (EPA, 2011)

Location of Tribal and Urban Indian Populations in California

Urban Indian Health Organization Service Areas (CCUIH, 2017)

Location of Tribal and Urban Indian Populations in California



AIAN Population Distribution (Census, 2010; CCUIH, 2017)

Potential Successes of Data Collection for AIAN Communities

- Opportunities for prevention/intervention are available
  - Rural Tribal Health Programs with limited access to resources, Urban Indian Health Programs with limited funding
  - Tribal leaders are invested in improving the health of their people
  - Example: Community-based participatory research project
- Native culture emphasizes oral traditions which are in line with story sharing and in-person data collection
  - Interviews, focus group, discussion of needs or outcomes
  - Example: Research study on experiences of cross-jurisdictional sharing of emergency management services
- Opportunities for partnership and cross-jurisdictional work
  - Example: Teen pregnancy prevention program evaluation
- Greater understanding of Native population
  - Example: Health priorities survey

Challenges of Data Collection for AIAN Communities

- Historical context of Tribal data collection
  - Misuse of data
  - Researchers collecting information then leaving communities
- Lack of knowledge about Tribal sovereignty by non-Native peoples
  - Only a Tribe as a sovereign governing body can choose to enter into a formal arrangement for data collection
- Limited Tribal infrastructure for data collection
  - Recent elections
  - Tribal officials and staff wear many hats
  - Limited funding for programs
- Cultural differences
  - Non-Native researchers
  - Members of other Tribes

Approaching Tribal Communities and Health Programs for Data Collection

- Discuss your project with Tribal leaders
  - Present benefits to the Tribe or Indian community
  - Understand that the project may not be a good fit at that time
- Consider a Data Sharing Arrangement to protect both parties and determine who should hold the data when the project ends
- Ask if the project will need to be approved by Tribal Council, a health board, or an Institutional Review Board
  - Prepare to spend time gaining all approvals required by the Tribe, Tribal Health Program, or Urban Indian Health Program.
  - Get buy-in early and as directed by leadership
- Form an advisory council/group or workgroup with stakeholders from the community
- Adapt methods to be culturally responsive
  - Review survey or data collection items with Advisory Council members or other stakeholders prior to data collection
    - Review for cultural appropriateness
    - Add items to be relevant to AIAN
  - Modify data collection approach for Tribes, even if it makes for "messy" data
    - If appropriate, consider an in-person interview versus a survey

Approaching Tribal Communities and Health Programs for Data Collection

- Be comfortable not being an expert
  - Assume that every AIAN Tribe, community, or Health Program is unique
  - Ask questions
    - "What would your Tribal Council/Chairman prefer?"
    - "How does your Tribal Council/organization approve this type of work?"
    - "Does Tribal Council need to approve this survey or should I work with Tribal staff to finalize it?"
    - "Does your Tribal/Urban Indian Health Program have a board that reviews this type of project?"
  - Have local stakeholders and community members help you
    - Example: Recruiting participants to a focus group
  - Be careful with language
    - Example: Some Tribes prefer different words for "data collection" or "evaluation" (data gathering, story sharing, sharing barriers and lessons learned, etc.). Describe Tribes as sovereigns, for example: "Tribes in California" instead of "California Tribes"
- Throughout the project, be willing to meet in-person with community partners
- After the project ends, make a presentation of findings for AI/AN stakeholders and/or give a summary of data back to Tribes

Existing Tools and Resources to Help with Culturally Competent Data Collection

- Tribal Epidemiology Centers (TECs)
  - Established in 1996 by Congress through reauthorization of the Indian Health Care Improvement Act.
  - Funded by IHS Division of Epidemiology and Disease Prevention (core) with supplemental funding through grants.
  - Established to assist in collecting and interpreting health information for AIAN.
  - Unique because TECs rely on the guidance of Tribal leaders to direct priorities and efforts.
  - TECs are legislated public health authorities.

Existing Tools and Resources to Help with Culturally Competent Data Collection

Map of TECs (TEC-C, 2017)

Existing Tools and Resources to Help with Culturally Competent Data Collection

- Activities of all TECs
  - Collect and disseminate health data
  - Produce regional and Indian Health Program specific health status reports
    - Community Health Profiles
  - Support public health emergency response
  - Provide technical assistance to Tribes and Indian Health Programs
    - Survey development
    - Health statistic data analysis
- California TEC
  - Founded in 2005
  - Housed within the California Rural Indian Health Board in Sacramento, California
  - Staff roles: Program Director, Epidemiologists, Program Evaluators, Research Associate, Outreach Coordinator, and other support staff for projects
  - Work guided by Advisory Council

Existing Tools and Resources to Help with Culturally Competent Data Collection

- Other California Indian Health resources and organizations
  - California Rural Indian Health Board, Inc.
    - Institutional Review Board
  - California Consortium of Urban Indian Health
  - Regional Health Councils and Tribal and Urban Indian Programs
    - Examples: Indian Health Council, Sonoma County Indian Health Project, Inc., Southern Indian Health Council, Toiyabe Indian Health Project, Inc., Sacramento Native American Health Center
  - Inter-Tribal Council of California
  - Tribal Advisors or Divisions
    - California Office of Emergency Services Tribal Advisor
    - California Tribal Advisor to the Governor
    - California Department of Health Care Services Primary, Rural, and Indian Health Division

Existing Tools and Resources to Help with Culturally Competent Data Collection

- Professional and academic resources
  - Example: Dr. Joan LaFrance article on culturally competent evaluation in Indian Country

    http://www.betterevaluation.org/sites/default/files/CCevalinidancountry.pdf
- Webinars
  - Example: National Partnership for Action to End Health Disparities, Mountain States Regional Health Equity Council, Native American cultural competency webinars

    http://region8.npa-rhec.org/

Questions?

Presenter Information

Maureen A. Wimsatt, PhD, MSW
Director, California Tribal Epidemiology Center
California Rural Indian Health Board, Inc.
mwimsatt@crihb.org

CPI Regional Training 2017

Strategies to Build Organizational Cultural Competence

Presented by
Ebony M. Williams, PsyD

Community Prevention Initiative

CARS
Center for Applied Research Solutions

CPI Regional Training 2017

Strategies To Build Organizational Cultural Competence

Presented by

Ebony M. Williams, PsyD

Training Goals

- Understand principles for building a culturally competent organization
- Understand how to apply cultural competence at each step of the Strategic Prevention Framework (SPF)

Organizational Cultural Competence

- A set of congruent behaviors, attitudes, and policies that come together in a system, agency, or amongst professionals and consumer providers that enables that system, agency, or those professionals and consumers to work effectively in cross-cultural situations.
- Cultural competence is a developmental process, one that occurs over time.

Cross, T. L. et al. , 1989

Benefits of Organizational Cultural Competence

- Increases respect and mutual understanding among those involved
- Increases creativity in problem-solving through new perspectives, ideas, and strategies
- Decreases unwanted surprises that might slow progress

Community Tool Box, Ch. 27, 2014

Benefits of Organizational Cultural Competence

- Increases participation and involvement of other cultural groups
- Increases trust and cooperation
- Helps overcome fear of mistakes, competition, or conflict
- Promotes inclusion and equality

Community Tool Box, Ch. 27, 2014

Culturally Competent Prevention Organizations…

- Conduct an organizational assessment
- Value diversity
- Have an attitude of "openness" and reciprocity
- Are aware of the "Dynamic of Differences"
- Can adapt to diversity as conditions and communities change
- Incorporate new practice around cultural competence
- Institutionalize cultural knowledge in organizations and programs

How to Build a Culturally Competent Organization

1. Develop culturally competent health services.
2. Collect race, ethnicity, and language preference data.
3. Provide culturally and linguistically competent care.
4. Make cultural competency an institutional priority.
5. Increase diversity and minority workforce.
6. Identify and report disparities.
7. Involve the community.

Health Research & Education Trust, 2011

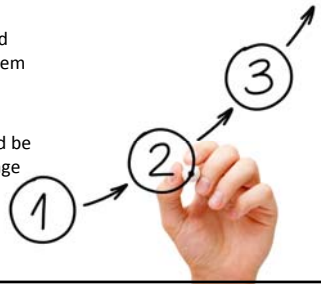
Action Steps to Organizational Cultural Competence

- Develop support for change throughout the organization
- Identify the cultural groups to be involved within the organization
- Identify barriers within the organization
- Assess your current level of cultural competence

Community Tool Box, Ch. 27, 2014

Action Steps to Organizational Cultural Competence

- Identify necessary resources
- Develop goals, implementation steps, and deadlines for achieving them
- Commit to an ongoing evaluation of progress and be willing to respond to change



Community Tool Box, Ch. 27, 2014

How to Begin

How to Begin

Indicators of Organizational Cultural Competence

- Recognizing the power and influence of culture
- Understanding how each of our backgrounds affects our responses to others
- Not assuming that all members of cultural groups share the same beliefs and practices
- Acknowledging how past experiences affect present interactions
- Building on the strengths and resources of each culture in an organization

Indicators of Organizational Cultural Competence

- Allocating resources for leadership and staff development in the area of cultural awareness, responsiveness, and humility
- Actively eliminating prejudice in policies and practices
- Willing to share power among leaders of different cultural backgrounds
- Evaluating the organization's cultural competence on a regular basis

Community Tool Box, Ch. 27, 2014

Using the SPF to Operationalize Organizational Cultural Competence

Strategic Prevention Framework (SPF)

A planning process for substance use disorder prevention.

Steps of the SPF

Assess Needs
- What is the problem and how can I learn more about it?

Build Capacity
- What do I have to work with? What are the gaps?

Plan
- What should I do and how should I do it?

Implement
- How can I put the plan into action?

Evaluate
- Is the plan succeeding?

Two Guiding Principles of the SPF

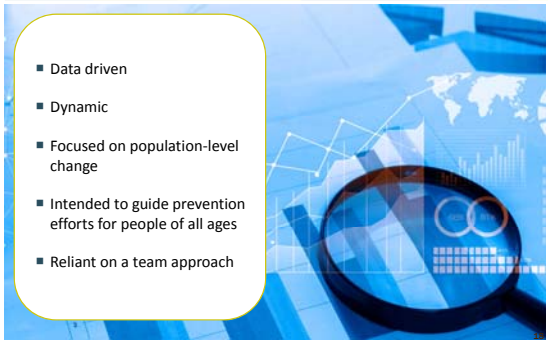
Cultural Competence

The ability to interact effectively with members of diverse populations.

Sustainability

The process of achieving and maintaining long-term results.

Distinctive Features of the SPF



- Data driven
- Dynamic
- Focused on population-level change
- Intended to guide prevention efforts for people of all ages
- Reliant on a team approach

CULTURAL COMPETENCE IN SPF

Step 1: Assess Needs

- Use data to target disparities.
- Identify and use a culturally-competent program evaluator.
- Decide how to measure cultural competence and collect cultural competence-related information and data.
- Identify change from a community perspective.
- Gain community approval for data collection methods, analysis, and the final product.
- Create a process for identifying culturally relevant **risk and protective factors and underlying conditions.**

19

CULTURAL COMPETENCE IN SPF

Step 2: Build Capacity

- **Assess community resources and readiness in the community.**
- Provide a safe and supportive environment for all participants.
- Ensure cultural representation (language, gender, age).
- Develop policies to improve cultural competence through staff recruitment, retention, and training.
- Seek community input on problems and possible solutions.
- Identify mutually acceptable program goals and objectives.

20

CULTURAL COMPETENCE IN SPF

Step 3: Plan

- Make community representation in the planning process a priority.
- Consider how the program will fit into the community culture, what existing prevention efforts are in place, and the community's past history when selecting programs and strategies.
- Prioritize risk and protective factors associated with identified prevention problems (see Step 1: Assess Needs).
- Select effective interventions to address priority risk factors.
- Build a logic model that links problems, factors, interventions, and outcomes.

21

CULTURAL COMPETENCE IN SPF

Step 4: Implement

- Develop a clear action plan.
- Balance fidelity and adaptation.
  - Involve the community in the implementation of the prevention services.

CULTURAL COMPETENCE IN SPF

Step 5: Evaluate

- Include the community service groups in the evaluation and data collection process.
- Develop performance outcomes to evaluate and monitor health disparities.
- Report data reflecting diversity and cultural relevance.
- Evaluate the community's role in the SPF process.
  - How successful was the community in selecting and implementing appropriate strategies?
  - Were these the "right" strategies, given the **risk and protective factors the community identified?**
  - Were representatives from across the community involved in program planning, selection, and implementation? In what ways were they involved?
  - What was the quality of the data used in decision making?

CULTURAL COMPETENCE IN SPF

Step 6: Be Respectful and Responsive

- Be Respectful
  - Recognize and value cultural differences such as the health beliefs, practices, and linguistic needs of diverse populations.
- Be Responsive
  - Know something about the culture of the group to which the interventions will be provided.
  - Customize prevention services in a way that respects and fits within the group's culture.
  - Involve members from cultural groups served in assessing needs, developing resources, planning and implementing interventions, and evaluating their effectiveness.

"Platinum Rule"

"Treat others how
THEY want to be treated."



Goal… To Build a Better World

Questions?

Presenter Information

Dr. Ebony M. Williams, PsyD
drwilliams1055@gmail.com

CPI Regional Training 2017

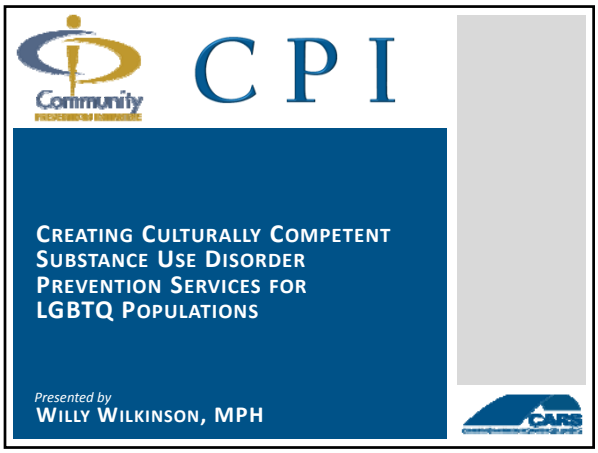
Creating Culturally Competent Substance Use Disorder Prevention Services for LGBTQ Populations

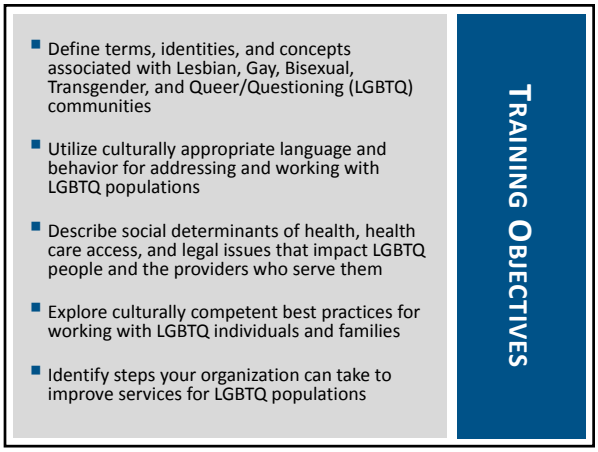
Presented by

Willy Wilkinson, MPH

Community Prevention Initiative

CARS
Center for Applied Research Solutions


Community
CPI
Creating Culturally Competent Substance Use Disorder Prevention Services for LGBTQ Populations
Presented by
Willy Wilkinson, MPH
CARS


Define terms, identities, and concepts associated with Lesbian, Gay, Bisexual, Transgender, and Queer/Questioning (LGBTQ) communities
Utilize culturally appropriate language and behavior for addressing and working with LGBTQ populations
Describe social determinants of health, health care access, and legal issues that impact LGBTQ people and the providers who serve them
Explore culturally competent best practices for working with LGBTQ individuals and families
Identify steps your organization can take to improve services for LGBTQ populations
Training Objectives


Terms and Identities
Social Determinants of Health
Health Care Access and Legal Issues
Best Practices
Action Steps
Agenda

Welcome

- What role do you represent?
- What do you hope to get out of this session?

What is some of the language that you hear to describe LGBTQ people?

Gender Identity vs. Sexual Orientation

- **Sexual Orientation** describes the type of sexual, romantic, physical, and/or emotional attraction one feels for others.
- **Gender Identity** describes a person's innate, deeply felt, psychological identification of their gender, which may or may not correspond with the sex they were assigned at birth or their appearance.

Gender identity is distinct and separate from sexual orientation.

Queer

Queer
- Prideful, affirming term used to refer to people with a same-sex orientation
- Umbrella term that describes the larger LGBTQ population
- Has a sociopolitical context
- Some LGBTQ people do not identify with this term
- Some people experience the word queer as a pejorative term

Pansexual
- Sexual, romantic, and/or physical attraction to all gender identities regardless of whether or not individuals fit into the gender binary

Dyke
- Reclaimed word that is considered by many to be a positive term for lesbian, though it can be used in a derogatory way

Fag
- Generally considered a negative term for gay men, though sometimes used as an "in-house" word in the LGBTQ community

Transgender (Trans)

- Describes people who have a gender identification that is different from the sex they were assigned at birth
- An umbrella term that includes a diverse group of people who experience and express their gender in ways not limited by the expectations of family, community, and society
- Social expectations of gender vary by culture, geographic location, and generation

Trans-related Language

Transsexual	Transfeminine	Transmasculine	Tranny
People who are living 24/7 in a gender identity that is different from the sex they were assigned at birth	People on the male-to-female spectrum (MTFs), trans women	People on the female-to-male spectrum (FTMs), trans men	Considered a negative, disrespectful term

Binary Gender System

The **Binary Gender System** refers to the traditional framework for describing gender, where there are only two genders (men and women), and that gender must conform to biological sex (male and female).

Whether gender is understood to be strictly binary or not varies by culture and is influenced by social expectations.

Non-Binary Gender Identities

Non-Binary describes people whose gender identity or expression does not correspond with either the sex they were assigned at birth, or an exclusively male or female cross-gender identity.

The term **genderqueer** came into common use in the early 21st century in youth culture, and is often used as an umbrella term to describe gender identities or expressions that are outside the gender binary.

Gender Expansive, Gender Nonconforming

- People who are **gender nonconforming** or **gender expansive** live beyond gender boundaries and may or may not identify as transgender.
- Gender expansive individuals can include masculine females and feminine males.
- Gender expansive individuals have a gender presentation that differs from widely accepted and prescribed gender expectations (e.g., pink and blue).

Cisgender

- Refers to people whose gender identity and expression corresponds with the sex they were assigned at birth.
- Often shortened to "cis," i.e., cis man, cis woman.
- Alternatively, the term **non-trans** is used.

Misgender

Verb: To refer to someone, especially a transgender person, using a word, especially a pronoun or form of address, that does not correctly reflect the person's gender identity.

"Various media outlets have continued to misgender her."

Cultural Competency Considerations for LGBTQ Populations

Cultural Competency

- Cultural Competence implies having the capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviors, and needs presented by the individuals and communities being served.
- Acceptance and respect for culture is consistently demonstrated in policies, structures, practices, and attitudes. Shows acceptance of and respect for differences.

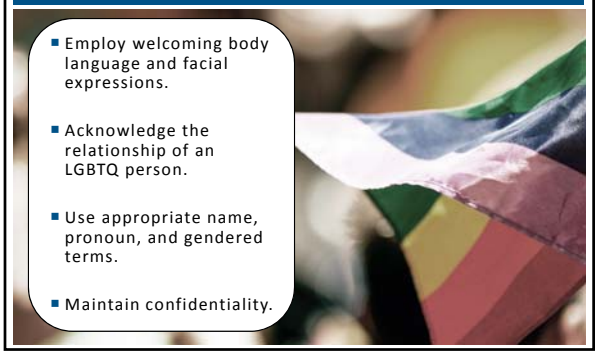
Cultural Competency

"It is fundamentally about holding another human being's cultural framework as authentic to them and accepting their perspective without question, judgment, or revision."

Source: Born on the Edge of Race and Gender: A Voice for Cultural Competency, Willy Wilkinson

How Do You Show Respect to LGBTQ People?

How to Show Respect



- Employ welcoming body language and facial expressions.
- Acknowledge the relationship of an LGBTQ person.
- Use appropriate name, pronoun, and gendered terms.
- Maintain confidentiality.

What do you do when you don't know what pronoun or gendered terms are appropriate?

Appropriate Name and Pronoun Use

- Ask politely and privately for clarification.
- You can say, "What pronoun is appropriate?" "What pronouns do you use?" "How would you like to be addressed?" "How would you like me to refer to you?"
- Use the appropriate name and pronoun in all paperwork and conversations, even when the person isn't present.
- Develop organizational systems for documenting appropriate names and pronouns.

Systemic Barriers and Risk Factors for LGBTQ People

Heightened Survival Issues

Many LGBTQ people struggle with heightened survival issues in their daily lives:

- Discrimination in education, employment, housing, health care, public accommodations, and social services
- Public humiliation, harassment, and ridicule
- Being kicked out of their homes or otherwise isolated from their families because of their LGBTQ status
- Limited access to education
- Hate violence
- Abusive treatment by law enforcement personnel
- Criminalization and incarceration
- Discrimination compounded by racism, classism, sexism and other oppressions

Family Rejection

- LGBTQ people come from varied racial, ethnic, and cultural backgrounds.
- Many experience family rejection, which impacts their ability to access education, employment, housing, and health care.
- Family rejection interferes with the connection to community and culture.
- **Many LGBTQ people develop families of choice.**

Discrimination in Education

LGBTQ high school students hear 26 anti-LGBTQ slurs a day.

Trans/gender nonconforming K-12 students:

- Harassment (78%)
- Physical assault (35%)
- Sexual violence (12%)

Source: GLSEN and National Transgender Discrimination Survey

Discrimination in Employment

1 in 10

LGB workers report being **fired** because of their sexual orientation

90%

of trans workers have experienced **harassment** in the workplace

47%

of trans workers report being **fired**, **not hired**, or **denied a promotion**, because of their gender identity

Source: Center for American Progress: "We the People" and Transgender Law Center

Discrimination in Housing

24%

of older LGBTQ people of color report **housing discrimination**

1 in 5

trans people has experienced **homelessness** at some point in their lifetime

20-40% of 1.6 million

homeless youth in the U.S. are LGBTQ-identified

Source: Center for American Progress: "We the People" and Transgender Law Center

UNDOCUQUEERS

- Of 11 million undocumented adults in the US, 267,000 are LGBTQ
- That's 30% of the 904,000 LGBTQ people in the US, which mirrors general population of US immigrants
- Male, young, more likely Asian than Latinx
  - "Latinx" is a gender-neutral term for a Latino individual

Daniela Vargas

LGBTQ IMMIGRANT DISPARITIES

- Employment insecurity
- Income insecurity
- Health insurance coverage gaps
- Greater health care access barriers for trans and bisexual undocumented people
- Loss of talented Americans and immigrants
- Family separation: Kids of LGBTQ immigrant parents more likely to end up in foster care

SYSTEMIC INJUSTICES FOR LGBTQ IN DETENTION

- Discrimination, harassment, and violence
- Trans women are 13 times more likely to be sexually assaulted by a detention official or detainee than the general population
- Trans women are placed in isolation for protection because of who they are
- Isolation (solitary confinement) is considered torture
- HIV+ detainees are denied health care
- Trans detainees are denied medically necessary care

Hate Violence

90%	72%	67%
of LGBTQ homicide victims are people of color	are trans women	are trans women of color

2015: 22 documented trans people murdered in the US
2016: 29 documented trans people murdered in the US

Police Harassment

- 38% of Black, 36% of multiracial, and 29% of Asian trans people
  - ↑ Trans women
  - ↑ Trans men
  - ↑ Visually gender nonconforming
- 15% of Black trans people reported physical assault and 7% reported sexual assault
- 51% of the black transgender community feels unsafe seeking police assistance

Police Harassment
Monica Jones, Juan Evans, Cece McDonald, & Jim Howley

LGBTQ Health Disparities

LGBTQ Health Disparities

- ↑ Tobacco use
- ↑ Depression and suicidality
- ↑ Breast cancer, anal cancer
- ↑ Experiences of violence and discrimination
- ↑ HIV/AIDS infection
- ↑ Substance abuse
- ↓ Insurance coverage

Source: The Health of Lesbian, Gay, Bisexual and Transgender People (Institute of Medicine, 2011), Healthy People 2020

Disparities for Questioning Youth

Seventh and eighth graders who are questioning their sexual orientation report higher incidences of bullying, homophobic victimization, unexcused absences from school, drug use, depression, and suicidal behaviors than non-LGB youth.

Source: The Trevor Project

LGBTQ Youth Suicide

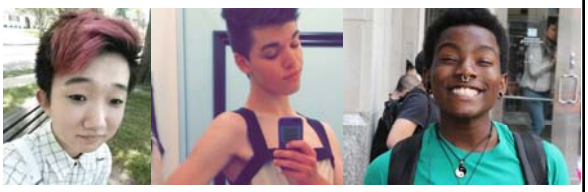
- LGB youth: 4 times as many suicide attempts as the general population
- Questioning youth: 3 times as many suicide attempts
- LGB youth who experience family rejection are 8.4 times more likely to die by suicide than the general population.
- Each episode of physical/verbal harassment or abuse increases the likelihood of self-harming behavior by 2.5 times.

Ronin Shimizu

Source: The Trevor Project

Transgender Suicide

- 41% of trans people have attempted suicide
- 9 times more likely than the general population



Skylar Lee ~ Leelah Alcorn ~ Blake Brockington

Source: National Transgender Discrimination Survey

Health Disparities: Gynecological Issues

- Lesbians and bisexual women are four times less likely to get Pap smears than the general population of women.
- Lesbians are at higher risk for breast cancer and gynecological cancers than the general population of women.

Bisexual Health Disparities

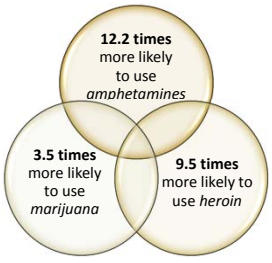
- Bisexual identity and behavior is strongly and persistently associated with heightened mood and anxiety disorders for both men and women over the lifetime and past-year time frames.
- Bisexual people have poorer health outcomes than lesbians, gay men, and heterosexual women and men.
- 40% of LGBTQ people of color identify as bisexual.
- Half of trans people identify as bisexual or queer.
- 39% of bisexual men and 33% of bisexual women report not disclosing their sexual orientation to any provider, as compared to 13% of gay men and 10% of lesbians.

LGBTQ Health Disparities: HIV

- According to the World Health Organization, trans women are 49 times more likely to have HIV than the general population.
- In 2014, gay and bisexual men aged 13-24 accounted for 92% of new HIV diagnoses among all men in their age group and 27% of new diagnoses among all gay and bisexual men.
- 1 in 7 gay and bisexual men who are living with HIV are unaware they have it.
- Even though PrEP (pre-exposure prophylaxis) is a highly effective method to avoid contracting HIV
  - Gay men of color are less likely to access PrEP than their white counterparts.
  - Trans people are less likely to access PrEP than non-trans people.

Disparities in Substance Use, Misuse, and Abuse

Men who have sex with men are



than men who do not have sex with men.

Disparities in Substance Use, Misuse, and Abuse

- 26% of transgender people report using or having used alcohol and other drugs to cope with the stress of discrimination they face based on gender identity and expression.
- Transgender people who participate in sex work, drug sales, and other underground survival economies have double the risk for substance abuse.
- Transgender people who have lost a job because of discrimination also have elevated risk of substance use.

Source: National Transgender Discrimination Survey

Disparities in Substance Use, Misuse, and Abuse

- 32% of trans people who experienced family rejection reported using alcohol and drugs to deal with the mistreatment they experienced as a trans person.

"My parents threatened to disown me. 'It was a sin.' 'I was sick.' 'I wanted to mutilate my body.' etc. I drank fairly heavily from the time I was 14 on. And I just kept drinking."

Source: National Transgender Discrimination Survey

Disparities in Health Care Access

- Many LGBTQ people have had multiple negative experiences in substance use disorder treatment, mental health, public health, health care, and social service settings because of ignorance and insensitivity on the part of providers and office staff.
- Discrimination in health-related settings causes LGBTQ people to delay or avoid necessary services, which can put overall health at severe risk.
- Culturally competent services improve quality of care and treatment outcomes.

Systemic Barriers to Health Insurance

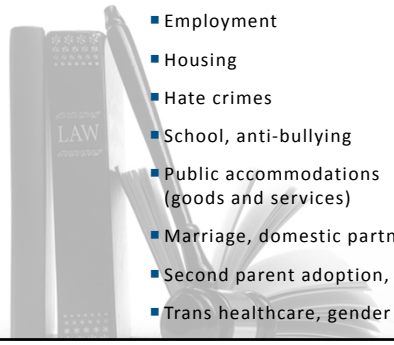
- Historically, many same sex couples—whether legally married or not—had difficulty accessing health insurance coverage for themselves and their children.
- Transgender people are frequently denied health insurance coverage and health care because of who they are.
- Transgender people experience difficulty getting coverage for HIV infection and gender transition because of exclusions for pre-existing conditions.

Systemic Barriers to Health Insurance

- Denial of health insurance coverage because being transgender is considered a pre-existing condition
- Denial of coverage for medical care related to gender transition
- Denial of coverage for sex-specific care (i.e., a male-to-female individual not getting covered for a prostate exam, or a female-to-male individual not getting covered for gynecological services)
- Denial of coverage for services that are unrelated to gender transition because the insurer claims that the medical issue is a result of transition-related care, such as hormones
- California is one of 18 states and the District of Columbia that requires insurance issued in the state to remove transgender exclusions, with some exceptions

What do LGBTQ-affirming services look like?

Legal Protections for LGBTQ People in CA



- Employment
- Housing
- Hate crimes
- School, anti-bullying
- Public accommodations (goods and services)
- Marriage, domestic partnership
- Second parent adoption, joint adoption
- Trans healthcare, gender marker change

Legal Protections for Trans People: Title IX and AB 1266

"No person in the US shall, on the basis of sex, be excluded from participation in, or denied the benefits of, or be subject to discrimination under any educational program or activity receiving Federal aid."

The US Dept. of Justice and Dept. of Education's Office for Civil Rights have both affirmed that Title IX prohibits discrimination based on gender identity and expression. **Protections were gutted in February 2017.**

AB 1266, the CA school Success and Opportunity Act, which took effect in 2014, requires that a pupil be permitted to participate in sex-segregated school programs and activities, including athletic teams and competitions, and use facilities consistent with his or her gender identity, regardless of the gender listed on the pupil's records. **Effective in K-12 schools and all publicly funded colleges in California.**

Non-Discriminatory Services

- People have the legal right to equal access to services.
- Create a non-discriminatory environment by being respectful in all interactions.
- You can have your own beliefs, but at work you must treat everyone equally and equitably.
- Use your resources to train staff to de-escalate conflicts.
- Everyone can be an ally.

Creating an LGBTQ-Affirming Environment

- Maintain confidentiality.
- Demonstrate consistency in service delivery.
- Keep questions relevant to services.
- Respect privacy.
- Be respectful in all communications with individuals and their families.
- Demonstrate comfort with name, pronoun, and family relationships.

Creating an LGBTQ-Affirming Environment

- Address transphobic and homophobic comments from staff and clients as they occur.
- Adopt a non-discrimination policy that includes both sexual orientation and gender identity, and have a system for addressing inappropriate conduct.
- Provide opportunities for LGBTQ and trans-specific cultural competency **training** for all staff, board members, and volunteers.

Equal Access

- **Mission** - Develop a clear mission statement that is inclusive of LGBTQ people. This is particularly important in services that have been traditionally gender-specific.
- Provide access regardless of sexual orientation.
- Provide equal access for transgender participants based on gender identity and expression, not biological status or legal name and gender.
- **Data collection process -** Maintain consistency.
- Ask questions that are inclusive of the range of sexual orientation and relationships.

Gender-Specific Settings

Gender-specific environments: Develop policies and procedures that specifically provide equal access regardless of sexual orientation, or gender identity and expression.

- Support groups
- Restroom Access
- Residential placement
- Urinalysis
- Handle residential placement and urinalysis on a case-by-case basis

Restroom Access

- People have the legal right to use the restroom in accordance with their gender identity and expression, regardless of the name and gender on their ID or their appearance.
- All single-occupancy restrooms in CA are designated as all-gender restrooms.

Restroom Access

- In a recent study of 28,000 trans and gender nonconforming people nationwide, 59% avoided a public restroom in the past year out of fear of confrontation.
  - 24% said someone questioned their presence
  - 9% were denied access
  - 12% were verbally harassed, physically attacked, or sexually assaulted
  - 32% limited food and liquid intake
  - 8% had a urinary tract infection, kidney infection, or other kidney problem as a result of avoiding restrooms

Source: U.S. Trans Survey

Participant Education

Work to educate participants without violating the confidentiality of LGBTQ people or putting them on the spot. Strive to create a service environment where all can participate comfortably.

Organizational Assessment

- Do LGBTQ participants receive ample cues that they are welcome at your organization?
- Do program applications and other data collected by your organization identify client gender identity as well as sex at birth?
- Do applications and data collection efforts identify client sexual orientation?
- Does your organization manage data on LGBTQ people appropriately?
- Do participants access gender-specific settings at your organization in accordance with their gender identity and without regard for their sexual orientation?

Organizational Assessment

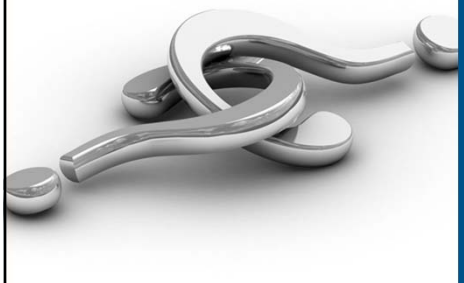
Does your organization…

- Have a welcoming attitude in interactions with LGBTQ people?
- Provide equal access to restrooms and other gender-specific settings?
- Have visible signs of LGBTQ competency?
- Provide LGBTQ-competent referrals?
- Have LGBTQ staff?

Organizational Assessment

Does your organization…

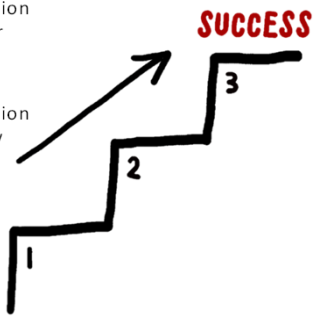
- Build effective partnerships with organizations that serve LGBTQ people?
- Partner with LGBTQ community members?
- Regularly assess the needs of LGBTQ people?
- Have a clear, written non-discrimination policy?
- Communicate effectively with stakeholders, constituents, and the public?



Questions

Action Steps

- What can your organization do to increase access for LGBTQ populations?
- What can your organization do to augment culturally competent services and systems?



Presenter Information

Willy Wilkinson, MPH
willy@willywilkinson.com
510.531.5710
www.willywilkinson.com

CPI Regional Training 2017

Cultural Competency in Working with Immigrant and Refugee Populations

Presented by
Mireya Munoz

Community Prevention Initiative

CARS
Center for Applied Research Solutions

CPI Regional Training 2017

Cultural Competency in Working with Immigrant and Refugee Populations

Presented by
Mireya Muñoz
Program Director
PALS (Pacific Asian Language Services) for Health

Training Goals

- **Increase awareness of linguistic and cultural issues when working with immigrant and refugee populations**
- **Understand the impact of language and culture on service seeking behaviors**
- **Apply knowledge to promote culturally and linguistically competent interactions with immigrant and refugee populations**

Agenda

- **Culture**
  - Definition of culture, make up of culture systems, subcultures, diversity within cultures
- **CLAS Standards –Language/Communication**
  - What is LEP?
  - Oral interpretation
  - Written translation
- **Cultural and linguistic context and it's impact on SUD prevention**
- **Effective communication in working with immigrants and refugees**

Culturally Competent SUD Services for English as a Second Language and Refugee Populations

National CLAS Standards: Principle Standard

" 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."

"You may know someone's language, but that doesn't mean that you know their culture."

– Betty Cheng, LCSW

Culture

Whatever helps a group express it's sense of *group-ness*.

The learned and shared knowledge, beliefs, and norms that people use to interpret their day to day experiences and to generate social behavior.

-PODSDT: Dr. Melissa Welch

SUBCULTURES

SUD Culture

Gay Culture

Goth Culture

60's Culture

Culture is transmitted, through language, material objects, ritual, institutions, and art, from one generation to the next.

Culture and Society are NOT the same thing; societies are groups of interacting organisms that can be similar or diverse.

Culture is also NOT static; it often evolves over generations and can be transmitted between peers as well as from one generation to the next.

Latino Culture

Political Culture

Victorian Culture

Urban Culture

Pop Culture

DIVERSITY WITHIN THE SAME CULTURE

Within the same culture, attitudes and behaviors can be influenced by some of the following issues: *(which may have an effect on the way individuals perceive substance use disorders or prevention programs)*

- Religion/Spiritual Beliefs
- Education
- Social Class
- Age
- Gender
- Language
- Birthplace
- Health Status
- Age at Time of Immigration
- Years in the U. S.
- Sexual Orientation and Gender Identity
- Immigration Experience
- Status/Generation

Who are the Two Largest Groups of Immigrants Currently in the U.S?



Asians and Pacific Islanders



Asian and Pacific Islanders

- Approximately 35 Asian ethnic subpopulations
- Approximately 25 Pacific Islander subpopulations
- Greater than 1,000 distinct languages and dialects
- Over 100 spoken in the U.S.
- 63% are foreign born

U.S Census, 1990, 2000, 2010



Latinos and Hispanics



Latino and Hispanic

- Latino: Ethnic group comprised of a mix of European, African, and Native Indian backgrounds.
- Hispanic: Term invented for the 1970 census referring to ethnic group whose derivation is from Spain.
- 289 languages spoken in Mexico
  - 280 of the living languages are indigenous, 3 are non-indigenous
- All Latinos are not the same. Latinos are a diverse collection of people from 20 countries in the Western hemisphere.

Adapted from Niall McCarthy, October 2015, and Marisa Alicea, The Immigrant Experience



Immigrants and Refugees



Immigrants and Refugees

- **Immigrants** are "pulled" to this country while **Refugees** are "pushed" from their country of origin.
- This difference often has varying effects in adapting to a new culture in a new country.

A Refugee's Experience

"It's hard to tell someone who you really are. I have to hide who I am. I don't get to be myself. The hardest part about being here is finding people to talk freely with."

-Central African Asylee,
describing the challenges in forming a community

Barriers for Immigrant and Refugee Populations

- Language
  - Limited English-speaking proficiency
- Stigma
  - Seeking help may be uncomfortable
  - Talking about your problems with a stranger may be embarrassing or shameful-foreign concept
- Fear
  - Disclosing information may affect their asylum status or claim
- Social Isolation
  - Discrimination and Racism

Barriers for Immigrant and Refugee Populations

- Conditions of Country of Origin
  - Community violence
  - Victims of torture
  - PTSD

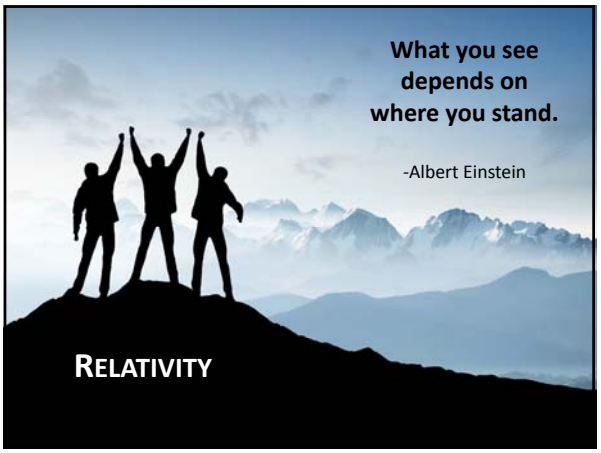
Immigrants and Refugees may not volunteer information about their experience due to feelings of guilt, shame, or mistrust.

Factors that May Impact Effective Utilization of Prevention Services

- Acculturation
  - Length of residency in the US
- Family Structure
  - Size of family or extended family
  - Support system
- Environmental Context
  - Housing conditions
  - Neighborhood safety

Cultural Values and Approaches to Health

Western	Sample Non-Western
Internally Controlled *"I determine my health."*	**Externally Controlled** *"Fate determines my health."*
Focus on Future *"Prevention is important."*	**Focus on Past and Present** *"I am not sick. Why worry?"*
Low Power Distance *"I am free to ask questions."*	**High Power Distance** *"Questioning isn't respectful."*



IMPACT OF CULTURE AND LANGUAGE ON THE UTILIZATION OF PREVENTION SERVICES

- It affects the relationship between program participants and program staff
- Culture accounts for variation in how program participants communicate their needs
- Culture influences motivation to participate in prevention programs and also impacts how programming is experienced
- Culture relates to how people cope with everyday problems and types of adversity
- Culture influences what type of coping styles and social supports people have

IMPACT OF CULTURE AND LANGUAGE ON THE UTILIZATION OF PREVENTION SERVICES

- Culture influences expectations between program staff and participants (different assumptions about what program staff are supposed to do, how participants should act, and what prevention strategies are available)
- Everyone – not just those from minority cultural communities – has "culture." Therefore prevention program providers must be mindful of their own perspectives and how these interplay with those of your program participants and their families (as relevant)

Impact of Language on Prevention Services

- Effective communication is at the core of SUD prevention service providers' efforts to reduce and eliminate disparities in substance use disorders.
- Any prevention program, no matter how effective with English-speaking populations, will not be effective with limited English speaking populations if their communication needs are not addressed by program staff.

Limited English Proficient Persons

United States Residents

- 52 million spoke a language other than English
- 25.2 million considered Limited English Proficient

California Residents

- 15.3 million spoke a language other than English
- 6.9 million considered Limited English Proficient

Census 2010

Who is Limited English Proficient?

A person who is unable to speak, read, write, or understand the English language at a level that permits him/her to interact effectively with health and social service agencies and providers.

Adapted from OCR, LEP Guidance

What Does the LEP Guidance Say About Interpreting (Spoken)?

- Providers should make sure program participants know that an interpreter is **available for free**.
- Possible options for interpreting services include
  - Bilingual Staff
  - Staff Interpreters
  - Contract Interpreters
  - Volunteer Interpreters
  - Telephonic Interpretation Services
- Providers **must not** require a program participant to use friends or family members for interpretation

HHS OCR LEP Guidance – Competence of Interpreters

Interpreters should…

- Be proficient in English and the non-English language
- Know special terms (such as substance use disorder jargon), as necessary
- Respect the program participant's rights to confidentiality and to impartial interpreters
- Understand the role of interpreter (such as ethics and practices)

Language Assistance in Prevention Program Settings - FACTS

- Interpreting is a complex skill.
- Language proficiency may be inadequate unless raised and educated in the non-English language.
- Interpreters must understand different world views and cultural perspectives with regards to the participant's perceptions of wellness and health practices/beliefs.
- Interpreters must be tested and trained.
- Interpreters must have strong command of substance use disorder terminology in English and the target language.
- Interpreters must possess excellent memorization skills.

Choosing an Interpreter

- Do your research.
- Learn about and understand the basics of interpretation.
- Meet with interpretation agencies.
- Ask about qualifications of interpreters.
- Ask about proficiency assessment methods. Look at evaluation tools.
- Don't assume that the interpreter is a "language machine".

The Role of an Interpreter

- An interpreter is a tool for communication between prevention program providers and participants.
- An interpreter will stay to assist you throughout the entire program activity, i.e., enrollment, engagement, and evaluation unless you request otherwise.
- An interpreter
  - Will not speak on your behalf
  - Will not make judgments or decisions for you
  - Will not voice his/her opinions
  - Will keep all information confidential

Utilizing an Interpreter Effectively

- Be aware that interpreting services may lengthen program sessions. Allocate twice the amount of time for the engagement.
- Meet with the interpreter before a session (pre-session)
- Stand or sit across from the participant; the interpreter will stand or sit next to and slightly behind the participant.
- Talk at a normal pace. Pause frequently and speak in short sentences so the interpreter can interpret accurately and completely.

Utilizing an Interpreter Effectively

- Maintain eye contact with the participant, not the interpreter.

Note: Appropriate eye contact varies by culture. While it is considered essential to communication in Western cultures, many non-Western cultures consider direct eye contact a sign of disrespect, especially between people of different social status. In other cultures and religious groups, sustained eye contact between men and women is considered inappropriate and either threatening or flirtatious.

Utilizing an Interpreter Effectively

- Speak directly to the program participant in a first person voice. Avoid using phrases such as "Tell her" or "Tell him".
- The interpreter will interpret everything you say accurately and completely. Say only what you want interpreted.
  - Allow the interpreter to intervene for clarification.
  - Use simple language. Avoid usage of slang.
  - When sight translation is involved, stay with the interpreter to summarize the document and answer questions.

Note: The role of the interpreter is to facilitate communication and understanding between limited English proficient (LEP) participants and prevention program providers.

Translated Written Materials

- Written materials routinely available in English should be translated into regularly encountered non-English languages.
- Information in "essential documents" must be translated or communicated in easy-to-understand language
  - "Essential documents" are those which affect program participation, such as:
    - Application and enrollment forms
    - Letters or notices regarding program eligibility
    - Anything requiring a response
    - Participant consent forms

Adapted from Karin Wang, Deputy Regional Manager, Region IX, Title VI and Limited English Proficiency

Considerations for Providing SUD Prevention to Immigrant and ESL Populations

1. Listen to and learn from your program participants and let them teach you about their culture – focus on what you don't know.
2. Identify a cultural guide: Someone from the culture who is willing to discuss the culture, introduce you to new experiences, and help you understand what you're seeing.
3. Spend time with the literature. Reading articles by and for persons of the culture is most helpful. Along with professional literature, read the fiction.
4. Attend cultural events and meetings of leaders from within the culture. Events allow you to observe people interacting in their community and see values in action.

Terry Cross, Developing a Knowledge Base to Support Cultural Competence

Considerations for Providing SUD Prevention to Immigrant and ESL Populations

5. Learn to ask questions in sensitive ways. Most individuals are willing to answer questions, if the questioner is sincere and motivated by the desire to learn.
6. Be aware of your assumptions, stereotyping, and interpretation of a persons' cultural context.
7. Reach out to the immigrant and refugee communities you work with to determine their needs.
8. Offer viable and effective services to address their unique needs.
9. Tailor services accordingly.

Terry Cross, Developing a Knowledge Base to Support Cultural Competence

Considerations for Providing SUD Prevention to Immigrant and ESL Populations

10. Make an action plan.
    - Areas of strength
    - Areas of growth
    - Identify resources
11. Provide interpretation services.
    - Utilize trained interpreters
    - Make sure the participant does not know the interpreter
12. Create a safe space.

Terry Cross, Developing a Knowledge Base to Support Cultural Competence

Considerations for Providing SUD Prevention to Immigrant and ESL Populations

13. Develop trust.
    - Encourage participant to express his/her concerns or needs
14. Review outreach, educational or program materials to ensure they are culturally and linguistically appropriate.
    - Language used is acceptable in that community
    - Adjust for readability
15. Create formal partnerships with culturally competent providers.

Terry Cross, Developing a Knowledge Base to Support Cultural Competence

Platinum Rule

"Treat patients as they would like to be treated, not as providers would like to be treated."

Take Home Messages

Cultural Competence = Relationship Building

- **INDIVIDUAL** - Get to know yourself (worldview, values, cultural identities) so you can better explore the uniqueness of others.
- **ORGANIZATION** - Get to know your community (traditions, cultures, norms, practices, beliefs) so your agency can be more in tune with their assets and needs.
- **SYSTEMS** – Get to know your agency (culture, mission, values, staff, services, polices, practices, philosophies) so you can better serve the community.

Do not interpret the behavior of others through the eyes of your own culture.

QUESTIONS?

PRESENTER INFORMATION

MIREYA MUÑOZ
mireyam@palsforhealth.org
213-553-1818

CPI Regional Training 2017

Cultural Competency SUD Prevention Services for Native Populations

Presented by

Daniel Domaguin and Kathleen Jack, MPH

Community Prevention Initiative

CARS
CENTER FOR APPLIED RESEARCH SOLUTIONS

CPI Regional Training 2017

Culturally Competent SUD Prevention Services for Native Populations

Presented by
Daniel Domaguin, LCSW
Kathleen Jack, MPH

- Recognize the diversity in histories, cultures, languages, and needs in California Indian communities
- Pinpoint general protective and risk factors
- Understand how historical trauma contributes to substance use and other health disparities
- Have familiarity with how SUD prevention can be culturally responsive

Session Goals

- Introduction
- Diversity of California Indian Communities
- Protective and Risk Factors
- Introduction to Historical/Intergenerational Trauma
- Culturally Responsive Prevention

Agenda

INTRODUCTION

CALIFORNIA RURAL INDIAN HEALTH BOARD, INC.

- CRIHB is a network of Tribal Health Programs, which are controlled and sanctioned by Indian people and their Tribal Governments.
- We are committed to the needs and interests that elevate and promote the health status and social conditions of the Indian People of California.
- CRIHB does this by providing advocacy, shared resources, training, and technical assistance that enhances the delivery of quality comprehensive health-related services.

CRIHB Member Tribal Health Programs and their Member Tribes 2017

Retrieved from: https://www.census.gov/geo/maps-data/maps/aian_wall_maps.html

Diversity of California Indian Communities

California: Indian Country

http://www.parks.ca.gov/pages/22491/images/cal_indians_languages_map.jpg

8

Diversity of Cultures and Languages

Photos credit: CRIHB and Daniel Domaguin

9

Diversity of Cultures and Languages

10

Protective & Risk Factors

Culture as Protective Factor for Native Communities

- Culture "acts in combination with family, personality, or peer influences" and strong identification with culture "makes adolescents less vulnerable to risk factors" for SUD
- Having a "stake" in society
- Participating in culture: the importance of relationships
  - Connectedness to others; not feeling "alone"
  - Strong familial ties
  - Mentors and friends in the community
  - Relationships with spiritual and cultural leaders/healers
  - Elders serving as community educators has been seen as a protective factor, as they "assist families in setting healthy behavior goals."

Zickler, 1999/Sanchez-Way & Johnson, 2000/LaRowe et. al., 2007

12

Protective Factors

Positive relationships: family, friends, school, community	High self-esteem and self-worth	Spiritual or religious involvement
Education	Employment	Good physical health

Spiritual or Religious Involvement

Photo credits: Daniel Domaguin

Education and Employment

- Education
  - Language immersion
  - Cultural groups and gatherings
  - Native American studies programs at colleges/universities
- Employment
  - Tribal employment programs
  - Vocational education and rehabilitation

Good Physical Health

- Nutrition
  - Traditional foods
  - Seasonal
- Exercise
  - Traditional and intertribal dance
  - Traditional fitness games and sports
  - Native-specific exercise initiatives

Risk Factors

- Lack of cultural involvement or connection
- Few positive relationships
- Low self-esteem and self-worth
- Disconnect from spirituality
- No/low education
- Unemployment
- Isolation/remoteness
- Health disparities
  - Physical health
  - Mental health

Introduction to Historical/ Intergenerational Trauma

Psychological Trauma

- Exposure to actual or threatened
  - Death
  - Serious injury
  - Sexual violence
- Direct experience
- Witnessing
- Learning the events occurred to a loved one
- Repeated or extreme exposure

Biological Effects of Psychological Trauma

- Alters the brain
- Trauma is stored in the genes (methylation)
  - "Molecular scars in the DNA"
  - This is passed on to future generations if trauma is unhealed

Retrieved from http://discovermagazine.com/2013/may/13-grandmas-experiences-leave-epigenetic-mark-on-your-genes

Hurley, 2015

Intergenerational Trauma

- Intergenerational trauma
  - Trauma that is passed from one generation to the next
- When an individual or their ancestor(s) experienced a trauma, their responses may not be "logical" because the trauma affected the emotional and physical centers of the brain.
  - Addiction
  - Substance use
  - Violence
  - Withdrawal from others
  - Dysregulation of emotions
  - Constant physical health issues

Robertson, 1999

Historical Trauma

- The historical trauma response is a myriad of features which are seen amongst groups of people—including Native Americans, Jewish Holocaust survivors, Japanese American internment camp survivors, and their descendants—who have experienced substantial group trauma.
- African Americans, whose ancestors were survivors of chattel slavery
- Genocide and war survivors and refugees (Hmong, Vietnamese, Khmer, Armenians, Bosnian, Cuban, etc.)
  - Mental health symptoms (depression, PTSD, anxiety)
  - Suicidality
  - Violence
  - Hypervigilance
  - Dreams of traumatic experiences of ancestors
  - Dysregulation of emotions
  - Self-destructing behavior
    - Over-eating
    - Self-neglect
    - Self-harm
    - Substance use

Brave Heart & De Bruyn, 1998

Sources of Historical Trauma

Moments of substantial group trauma for California Indians

- California missions
- Forced removal
- Massacres
- Boarding schools

California Missions

Photo retrieved from https://www.tes.com/lessons/vxUWmAMqa7z-Vw/california-missions

Photo retrieved from http://www.californiapioneer.org/images

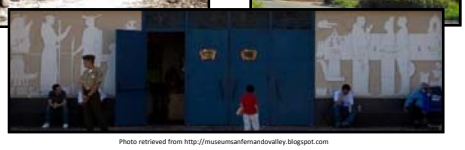
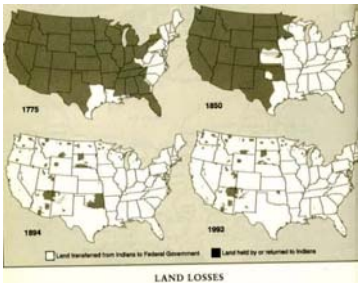


Photo retrieved from http://museumsanfernandovalley.blogspot.com

Forced Removal



LAND LOSSES

Retrieved from: http://usuncut.com/news/native-land-bundy-gang-irony-lost/

Massacres

Photo credit: Daniel Domaguin

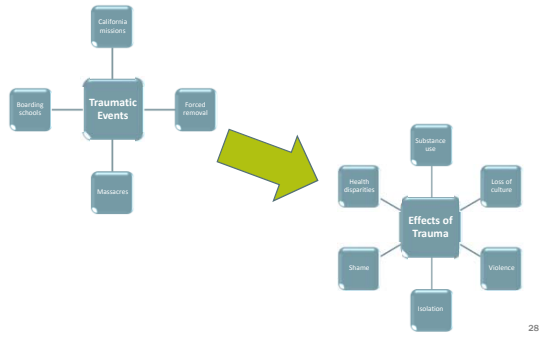
Boarding Schools

Photo retrieved from http://www.accmuseum.org/Boarding-School-Sports

Photo retrieved from https://lindquist.cul.columbia.edu/catalog/burke_lindq_037_0143

Photo retrieved from http://home.epix.net/~landis/histry.html

Cumulative Effects of Historical Trauma



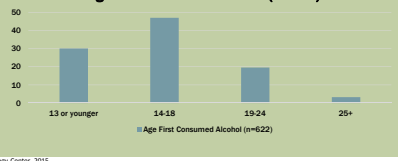
28

Substance Use in California Native Communities

Ever Used Drugs

Drug	Yes (%)	Preferred Not to Answer (%)
Marijuana (n=921)	56.6%	4.9%
Cocaine (n=927)	33.3%	3.9%
Methamphetamine (n=927)	29.4%	3.5%
Speed (n=923)	30.3%	3.6%
Inhalants (n=925)	17.9%	3.5%

Age First Consumed Alcohol (n=622)



California Tribal Epidemiology Center, 2015

Intergenerational Substance Use

- Children raised in household with substance use present from 1+ parent learn to be compliant, and when they are adults, they have difficulty with decision-making.
  - Do well in structure, but when structure is not present (i.e., no one to be compliant to, except one's self), they don't have an internal structure to discern what to do
  - Don't know what to do when a mistake is made; no tolerance for frustration
- Attachment theory
  - Primary relationship(s) are hindered due to substance use
    - Disorganized attachment with caregivers→disorganized attachment with others
- If no intervention, cycle continues

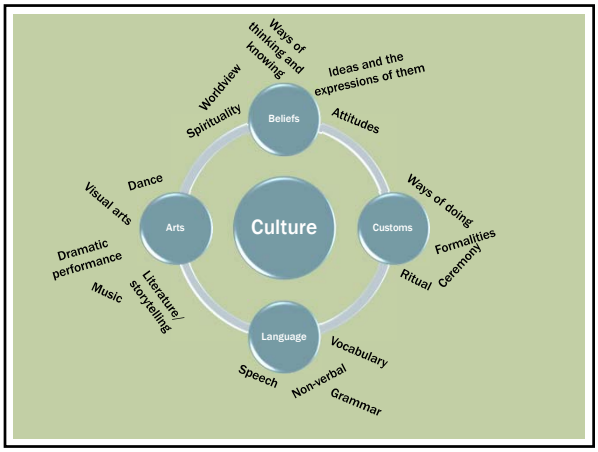
Vimont, 2012

Culturally Responsive Prevention

Surviving from intergenerational trauma requires intergenerational ***resilience***

Integration of Native Cultures with Prevention Efforts

- Central and integral, not "tacked on" and ancillary
- Family as part of the programming
- Traditional, tribe-specific and intertribal practices
- Spirituality
- Help to build self-identity and self-esteem



Providing Culturally Competent Services

Being "culturally competent" is necessary prior to integrating cultural values and concepts

- Understand and appreciate diversity among and within Native American populations
- Know the history, culture, and contemporary realities of specific Native American clients
- Have good general social work skills and strong skills in patience, listening, and tolerance of silence
- Be aware of his or her own biases and need for wellness
- Display humility and a willingness to learn
- Be respectful, nonjudgmental, and open-minded
- Value social justice and decolonize his or her own thought processes

Weaver, 1999

Why Emphasize Culture?

- "A sense of belonging and a strong cultural identity supports [a person's] mental health and wellbeing"
- Non-compartmentalization of experience
  - Harmony of existence with creation vs. domination/exploitation of creation
    - Including domination over illness
- "The role of culture is central to healing and is of great significance as a protective factor for many indigenous people."

Kids Matter Australian Early Childhood Mental Health Initiative/Duran & Duran, 1995/California Reducing Disparities Project, 2012

Cultural Activities Known to Contribute to Resilience

Kinship/Family/Gender Roles

- Participating in extended family culture
- Learning about family structure and traditions
- Maintaining strong family ties
- Hearing or telling family stories (knowing their family/cultural history)
- Participating in traditional male and female cultural roles
- Searching for a connection with relatives or Native ancestry

Cross, 2009

Cultural Activities Known to Contribute to Resilience

- Tribal Arts and Crafts
  - Making cradleboards and dream catchers
  - Making shawls, sewing quilts, carving
  - Weaving baskets, making flints
  - Making jewelry, beading, doing quill work
- Tribal Clothing
  - Making traditional attire/regalia for pow-wows and other ceremonies
  - Making ribbon shirts
  - Making moccasins, tanning hides, working with animal skins

Cross, 2009

Cultural Activities Known to Contribute to Resilience

- Subsistence/Food/Medicines
  - Gathering, harvesting, planting, growing, preserving, or cooking traditional foods
  - Hunting, fishing, exercising treaty rights
  - Knowing or participating in hunting/gathering-related ceremony
  - Knowing plants, bark, roots, herbs, medicines
  - Learning the teaching about plants, animals, foods, and medicines
- Music/Dance/Pow-wows
  - Attending a pow-wow, dancing, drumming, singing
  - Learning lyrics or specific dances and the history behind songs and dances
  - Learning song etiquette: where and when a song can be sung
- Games/sports
  - Playing culture-specific games such as hand/stick games
  - Playing indigenous sports such as lacrosse

Cross, 2009

Cultural Activities Known to Contribute to Resilience

- Ceremony, Rituals, and Protocol
  - Participating in rituals, knowing how to act, how to prepare
  - Participating in smudging, mediation, sacred dance, fasting, visioning
  - Paying attention to dreams
  - Participating in a talking circle
  - Practicing Native protocol for showing respect and honor
  - Developing communication skills with elders
  - Practicing spirituality
  - Knowing and practicing protocols for handling sacred or traditional items
  - Showing respect for beliefs at ceremony
  - Seeing traditional healers for help
  - Learning rules for who can attend ceremonies
  - Knowing passing away (death) ceremonies
  - Knowing sacred animals
  - Understanding people's interconnectedness with the natural world

Cross, 2009

Cultural Activities Known to Contribute to Resilience

- History/Cultural Knowledge/Cultural Skills
  - Knowing tribal history, laws, treaty rights, reservations, clans
  - Knowing the meaning of sovereignty
  - Learning Indian names for places
  - Speaking a Native language
  - Knowing sacred places—protecting them as cultural monuments
  - Learning about traditional living houses/buildings/lodges
  - Understanding the impact of colonialism—genocide, blankets to spread diseases
  - Understanding the history of activism, importance of protesting
  - Understanding sport mascots and their negative impact
- Traditional Forms of Living
  - Learning to tell tribal stories and legends
  - Learning about canoe journey/families
  - Learning horsemanship
  - Learning about the birds and what they do
  - Camping and participating in survival retreats
  - Taking care of Mother Earth

Cross, 2009

Caution of Appropriation

Photo credit: Daniel Domaguin

Caution of Appropriation

- Be aware of interventions that are being used
  - Does this work with the client?
    - Individual, family, group, community
  - Is it appropriate culturally?
- Do not fall into the trap of stereotypes
  - Understand generalizations that may be made when using interventions
  - Share the origins of interventions if they are culture- or region-specific

Breaking the Cycles

Healing Journey: Breaking the Cycles of Violence/Harm

What Happens If We Don't Address Historical Trauma?

- Allow for loss of historical memory
- Allow for denial of history's impact on ancestors, their offspring, and every generation after
- Perpetuate cycle of violence/harm, and disallow the ability to "break out," as feelings of confusion, sadness, fear, shame, guilt, anger, revenge, etc. are allowed to fester

How Can Cultural Competence Promote Healing?

- EDUCATE OURSELVES! Nothing says "perpetual genocide" like continuing the lack of historical knowledge when working with colonized peoples!
- Facilitate healing process via expressing thoughts and feelings related to historical impact of genocide. However, recognition must come first.
- Just as we conduct intake assessments to determine how client's personal and familial histories affect symptoms, we must similarly take into account broader history to acknowledge violence/harm done.

Works Cited

- Brave Heart, M.Y.H., & De Bruyn, L. (1998). The American holocaust: Historical unresolved grief among native American Indians. *National Center for American Indian and Alaska Native Mental Health Research Journal*, *8*(2), 56-78.
- California Reducing Disparities Project (2012). Native vision: A focus on improving behavioral health wellness for California Native Americans. Retrieved from http://nativehealth.org/sites/dev.nh.edeloa.net/files/native_vision_report_compressed.pdf
- California Tribal Epidemiology Center, California Rural Indian Health Board. (2015). California Tribal Behavioral Risk Factor Community Survey (CTBRFCS) Summary Report. Sacramento, CA.
- Cross, T. (2009). The role of Native culture in preventing suicide. In *Ensuring the Seventh Generation: A youth suicide prevention toolkit for tribal child welfare programs.* Retrieved from http://www.nicwa.org/YouthSuicidePreventionToolkit/YSPToolkit.pdf
- Duran, E. & Duran, B. (1995). *Native American postcolonial psychology*. Albany: SUNY Press.
- Hurley, D. (2015). Grandma's experiences leave a mark on your genes. *Discover Magazine*. Retrieved from http://discovermagazine.com/2013/may/13-grandmas-experiences-leave-epigenetic-mark-on-your-genes
- Kids Matter Australian Early Childhood Mental Health Initiative (n.d.). Cultural diversity: Suggestions for families and educators. Retrieved from https://www.kidsmatter.edu.au/sites/default/files/public/KM%20C1_Cultural%20Diversity_Suggestions%20for%20Families%20and%20Educators.pdf
- LaRowe, T.L., Wubben, D.P., Cronin, K.A., Vannatter, S.M., Adams, A.K. (2007). Development of a culturally appropriate, home-based nutrition and physical activity curriculum for Wisconsin American Indian families. *Preventing Chronic Disease. 4*(4)
- Mohatt, Dennis (date unknown). Rural mental health: Challenges and opportunities caring for the country. Powerpoint retrieved from http://govinfo.library.unt.edu/mentalhealthcommission/presentations/rural.ppt.
- Robertson, B. (1999). The Aboriginal and Torres Strait Islander women's task force on violence report. Retrieved from the Department of the Premier and Cabinet, Queensland government website. http://www.premiers.qld.gov.au/library/other/default/atsiviolence.htm
- Sanchez-Way, R. & Johnson, S. (2000). Cultural practices in American Indian prevention programs. Retrieved from https://www.ncjrs.gov/html/ojjdp/jjnl_2000_12/cult.html
- Singh G.K., & Siahpush M. (2003) The increasing rural urban gradient in US suicide mortality, 1970,-1997 Am J Public Health. 1161-1167
- Urban Indian Health Institute (2014). *Supporting sobriety among American Indians and Alaska Natives: A literature review.* Retrieved from http://www.uihi.org/download/Supporting-Sobriety_A-Literature-Review_WEB.pdf
- Weaver, H. (1999). Indigenous people and the social work profession: Defining culturally competent services. *Social Work. 44(3)*
- Vimont, C. (2012). Breaking the intergenerational cycle of substance abuse. Retrieved from http://www.drugfree.org/join-together/breaking-the-intergenerational-cycle-of-substance-abuse/
- Zickler P. (1999). Ethnic identification and cultural ties may help prevent drug use. *National Institute on Drug Abuse Notes*. 14:7–9

Questions?

CPI Regional Training 2017

Preventing Substance Use Disorders in Rural California

Presented by

Charlie Seltzer

Community Prevention Initiative

CARS
Center for Applied Research Solutions

CPI Regional Training 2017

Preventing Substance Use Disorders in Rural California

Presented by

Charlie Seltzer

Session Goals

By the end of this session, participants should:

- Understand the unique cultures and concerns of rural populations.
- Identify the challenges of providing/accessing SUD prevention services in rural areas.
- Be familiar with risk and protective factors impacting rural substance abuse.
- Know some of the best practices in providing rural SUD prevention services.

Agenda

- Define "rural"
- Discuss rural risk and protective factors
- Discuss what makes providing and accessing SUD prevention services so challenging in rural areas
- Discuss how we can improve our ability to provide SUD prevention in rural areas

What is "Rural"?

What is "Rural"?

What is "Rural"?

What is "Rural"?

Defining Rural and Urban

- There is no universally agreed upon definition of "urban" and "rural."
- "Urban" is defined by the following federal departments:
  - US Census Bureau
  - US Department of Agriculture
  - US Department of Commerce
  - US Department of Health and Human Services
  - US Department of Veteran Affairs
  - White House Office of Management and Budget
- Anything that is not "urban" is "rural" by elimination.

Defining Rural and Urban

U.S. Census Bureau

- Defines two types of urban areas
  - Urbanized Areas of 50,000 or more people
  - Urban Clusters of between 2,500 and 50,000 people
- "Areas" can be an entire county, can be within a county, or can be spread out over more than one county.
- Anything that isn't "urban" is "rural" by elimination.

Defining Rural and Urban

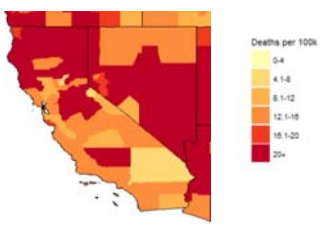
Office of Management and Budget (OMB)

- Does not use terms "urban" and "rural" and instead classifies by county.
  - Metropolitan counties – have an "urban core" of at least 50,000
  - Micropolitan counties – have urban cores of 10,000-49,999 people
  - Neither – no urban cores; populations less than 10,000
- Anything that isn't "urban" is "rural" by elimination.

OMB's View of Rural California

Alpine
Amador
Butte
Calaveras
Colusa
Del Norte
El Dorado
Glenn
Humboldt
Imperial
Inyo
Lake
Lassen
Madera
Mariposa
Mendocino
Merced
Modoc
Mono
Napa
Nevada
Placer
Plumas
San Benito
San Luis Obispo
Shasta
Sierra
Siskiyou
Sutter
Tehama
Trinity
Tulare
Tuolumne
Yolo
Yuba

Opioid Overdose Deaths in 2014



California Terrain

Most of the rural counties are located in the mountainous north and east sides of the state or in the Mojave desert in the southern half of the state. Some are also located in the agricultural northern half of the Central Valley.

Rural California

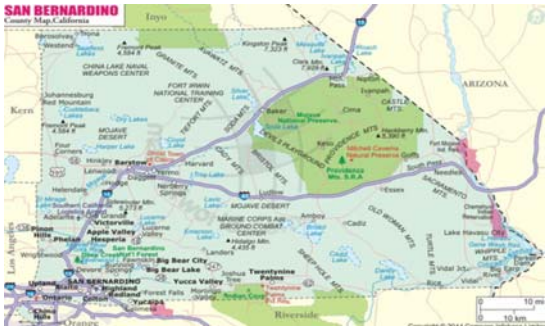
- 35 rural counties have a total population of 3,800,000
- 39,000,000 people live in CA
- 10% of CA's population is rural
- Total land area of rural counties = 52% of CA
- 4 counties are entirely rural: Alpine, Mariposa, Sierra, Trinity
- 7 counties are predominantly rural: Plumas, Calaveras, Modoc, Siskiyou, Amador, Lassen, Mono

Source: US Census 2010

San Bernardino County

- "Rural" and "urban" are not so neatly categorized and do not reveal the whole picture.
- Many urban counties have large rural populations.

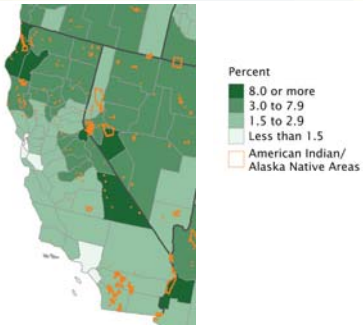
San Bernardino County



Native Americans

- US population in 2010 = 308.7 million
- Of this, 2.9 million (=0.9%) identify as Native American
- Of these 2.9 million, 406,000 (=14%) live in CA
- About 1.7% of CA's population identifies as Native American
- More Native Americans live in CA than any other state.

Native Americans in California



The map of where Native Americans live in CA looks just like the map of where rural Californians live.

Reservations and Rancherias

- Almost always rural; sometimes, the nearest "big" towns with services are many miles away
- Many tribes were relocated from their traditional homelands to their current reservations and Rancherias
- Sometimes a reservation or Rancheria will have Native Americans relocated from more than one tribe – sometimes from tribes that didn't get along in their original territories, now – forced to live in close proximity
- Today's tribal areas are often a small segment of their traditional territory
- Sovereign land: Tribal law followed

Who here is from a rural area?

Rural Risk Factors

- Tend to be poorer
- Have lower educational attainment
- Are frequently geographically isolated; have to travel further to access services
- Live where drugs are often embedded in the local economy
- Have poorer health outcomes
- Have fewer services to chose among; services that do exist may not be comprehensive or of high quality
- Live where elected officials may be happy to approve any new business – even one that contributes to SUD complain that "there's nothing to do"
- Are more likely to be unemployed

OTHERS?

Native American Risk Factor

- **Historical Trauma** = cumulative emotional, psychological, and spiritual wounding over a person's lifespan and across generations.
- Can lead to disenfranchisement, depression, self destructive behaviors, anxiety, low self esteem, anger…
- Substance use as a coping mechanism

A Case Study: Mendocino County

- Population
  - 2010: 87,841
  - 2016: 87,628
  - Change: -0.2%
- Income
  - County, per capita: $24,000
  - State, per capita : $30,000
  - County, per household: $43,000
  - State: per household: $62,000
- Poverty
  - County: 20.3%
  - State: 15.3%

Source: Mendocino County Community Health Status Report 2016

A Case Study: Mendocino County

- Cost of Housing
  - Average income/per person: $24,000 or $2000/month
  - Average rent: $960/month
  - Rent as a share of income: 48%
- 4-year Degree or Higher
  - County: 23.7%
  - State: 31.4%

Source: Mendocino County Community Health Status Report 2016

A Case Study: Mendocino County

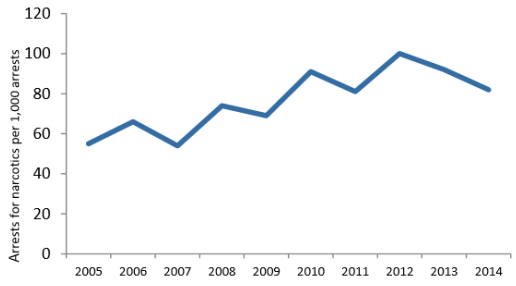
- Health
  - County: 12% of population is disabled
  - State: 6.8%
- Employment
  - County: 22,779 working = 26% of population
  - State: 14,325,377 working = 37% of population

Source: Mendocino County Community Health Status Report 2016

Substance Abuse in Mendocino County

Adult Arrests for Narcotics

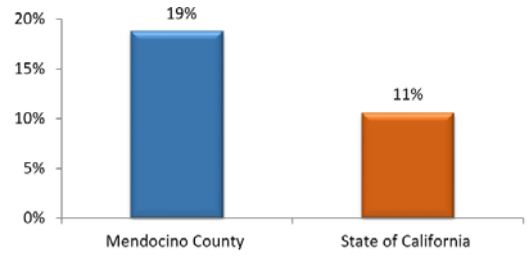
Mendocino County, 2005 - 2014



Source: US Department of Justice

Percent of Deaths Due to Drug Poisoning

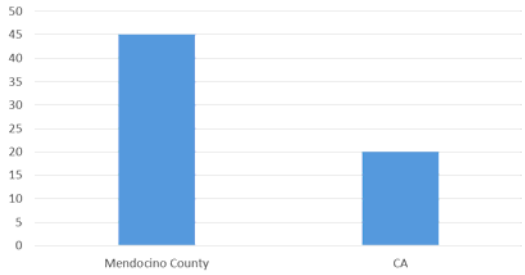
2012-2014



Source: County Health Rankings

Hospitalizations Due to Overdoses

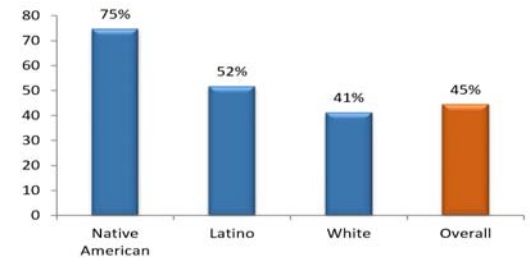
2012-2014



Source: Mendocino County Community Health Status Report 2016

Binge Drinking Among Adults by Ethnicity

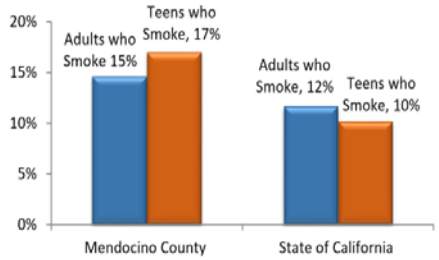
Mendocino County, 2014



Source: California Health Interview Survey, 2014

Adults and Teens Who Smoke Tobacco

Mendocino County, 2013

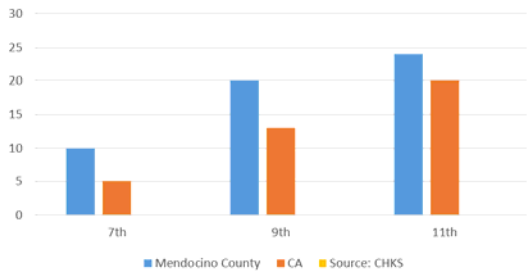


Teens who smoke tobacco are likely to become adults who smoke tobacco.

Source: California Health Interview Survey, 2013

Past 30-Day Marijuana Use

2013-2015



Source: California Healthy Kids Survey, 2013-2015

Rural Protective Factors

- Are often self reliant
- Know how to get by on little
- Are often positively bonded to family, school, community and nature
- Frequently know and socialize with their neighbors
- Are often multi-generational residents
- Appreciate the beauty of their surroundings

OTHERS?

Challenges Providing and Accessing Rural SUD Prevention Services

- Geographical isolation; "pocket" communities
- Distances are large; getting anywhere takes a long time and costs a lot in gas money
- Public transportation connects only the main cities
- Service triage is often necessary
- "Leave me alone" mentality

OTHERS?

Best Practices for Rural SUD Prevention

- Promote engagement with family, school and community
- Provide alternative activities to counter "there's nothing to do"
- Reveal truth about social norms
- Promote, support, and cooperate with existing social networks including faith based, granges, school and community service clubs, and others
- Teach refusal skills

OTHERS?

RECOMMENDATIONS

- Build the capacity of the rural workforce
  - Hire people from rural backgrounds
  - Train staff and providers on rural best practices
- When quantitative data is not available or is insufficient, use qualitative data
  - Build relationships to get best qualitative data
  - Follow leads – people living in rural areas often know where "hot spots" are or can identify new trends before they show up in data sets

OTHERS?

QUESTIONS?

PRESENTER INFORMATION

Charlie Seltzer
Grandview Consulting
grandview.charlie@gmail.com