Prevention
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Mental Health & Addiction Services

Addressing Health Disparities Across the SPF Framework Including a Disparity Impact Statement and CLAS Standards in Your Prevention Efforts

Learning Objectives

SDOH	Gain an understanding of Social Determinants of Health
DIS	Learn what a Disparity Impact Statement is and how to incorporate a DIS into your Prevention Efforts
CLAS	Understand what the CLAS standards are
Matrix	Review a Health Equity Matrix Example and Template
SPF	Apply Health Equity Questions and Data Across the 5 Strategic Prevention Framework Steps
Resources	Be Provided Resources and Tools

Applying an Equity and Disparity Impact Lens Goal

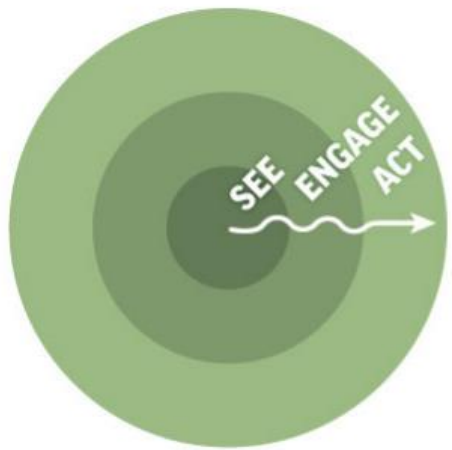
Ensure that community prevention efforts are inclusive of underserved racial and ethnic minority populations, and other underserved and at-risk populations, in their infrastructure, programs, and practices.

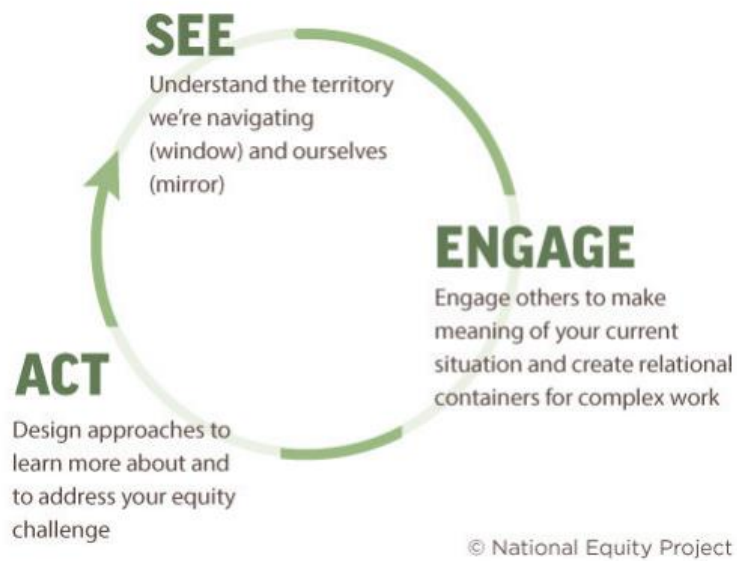
What is an equity lens?

*An equity lens is a process of answering the question **who** is experiencing the risks, prevalence or consequences of health and behavioral health disparities that increase the impact of the problem. .*

An Equity Leadership Stance: See, Engage, Act

Equity leadership moves from the "inside-out,"as different from traditional leadership which tends to move top-down. How we **See*** informs how we **Engage**, which informs how we **Act**.

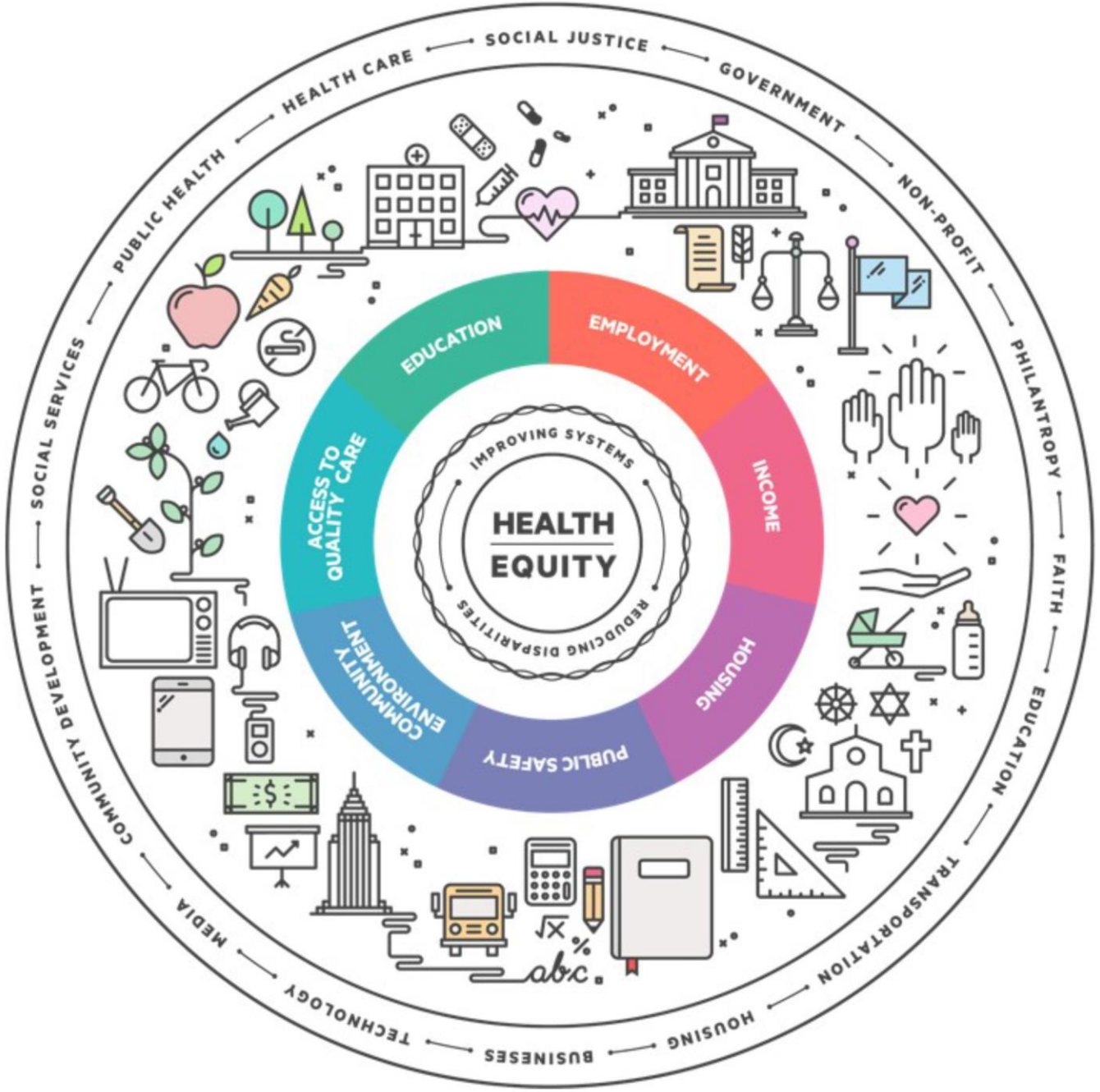




Why Health Equity?

What do we expect to be true for all people?

We all have dreams for ourselves and our families. But we don't all have the same opportunities to make those dreams come true. If we are to create communities where health is truly for everyone and not just for the few, we must embrace new ways of learning, working, and acting.



An Example of Health Equity

EQUALITY:
Everyone gets the same – regardless if it's needed or right for them.

EQUITY:
Everyone gets what they need – understanding the barriers, circumstances, and conditions.

Equity Terms and Definitions

Equity: In a general sense, equity refers to fairness and justice in treatment, access, and opportunity. In the context of health, equity means ensuring that everyone has the opportunity to achieve their full health potential, by addressing systemic barriers that contribute to health disparities.

Health Disparities: These are differences in health outcomes or access to healthcare services that are closely linked with social, economic, or environmental disadvantages. Health disparities often affect groups that have historically been marginalized, such as racial or ethnic minorities, low-income individuals, or rural populations.

Social Determinants of Health: These are the conditions in the environments where people are born, live, learn, work, play, and age that affect a wide range of health risks and outcomes. Examples include socioeconomic status, education, neighborhood and physical environment, employment, social support networks, and access to healthcare.

Equity Terms and Definitions

CLAS Standards: CLAS (Culturally and Linguistically Appropriate Services) standards are a set of guidelines designed to improve the quality of healthcare services provided to people from diverse cultural and linguistic backgrounds. They emphasize culturally competent care, effective communication, and organizational policies that promote inclusivity and reduce health disparities.

Health Equity: Health equity refers to the principle that everyone should have a fair opportunity to attain their highest level of health. It involves addressing and eliminating health disparities by recognizing and removing obstacles related to social, economic, and environmental factors. Achieving health equity requires efforts to ensure that all people have access to the resources and opportunities needed to live healthy lives.

Social Determinates of Health

Social Determinants of Health

What are social determinants of health?

- Social determinants of health (SDOH) are the non-medical conditions in the environments where 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.

SDOH can be grouped into 5 domains:

- Economic Stability
- Education Access and Quality
- Health Care Access and Quality
- Neighborhood and Built Environment
- Social and Community Context

Social Determinants of Health

Economic Stability

- Help people earn steady incomes that allow them to meet their health needs

Education access and quality

- Increase educational opportunities and help children and adolescents do well in school

Health care access and quality

- Increase access to comprehensive, high-quality health care services

Neighborhood and built environment

- Create neighborhoods and environments that promote health and safety

Social and community context

- Increase social and community support

Social Determinants of Health and Youth

Healthcare Access and Quality

- Increase the number of community organizations that provide prevention services

Social and community context

- Increase the proportion of adolescents who have an adult they can talk to about serious problems
- Increase the proportion of children and adolescents who communicate positively with their parents
- Increase the proportion of children and adolescents who show resilience to challenges and stress

Economic stability

- Decrease the proportion of youth who are not in school or working (disengaged)

Education access and quality

- Increase the proportion of high school students who graduate in four years
- Decrease the proportion of students who are chronically absent or truant

Neighborhood and built environment

- Increase the proportion of schools with policies and practices that promote health and safety
- Reduce deaths from motor vehicle crashes

Disparity Impact Statements

Disparity Impact Statements

The Disparity Impact Statement (DIS) is a data-driven, quality improvement approach to advance equity using grant programs. The DIS helps grantees identify underserved populations at risk of experiencing behavioral health disparities. The aim is to increase inclusion of underserved populations in funded grants, achieve behavioral health equity for disparity-vulnerable populations, and help systems better meet the needs of these population.

The Purpose of the DIS is to:

- Identify, contextualize, and address health disparities
- Develop and implement a disparity reduction quality improvement plan to address/close the identified gap(s)
- Achieve targeted behavioral health equity for disparate populations and improve systems addressing the needs of these populations

Why is a Disparity Impact Statement (DIS) important?

A DIS is a way of focusing thinking around identification of and service to underserved and higher risk populations. A focus on disparities and approaches to addressing them can help close the gap in personal and community resources that differentially affect quality of life for individuals and groups. All SAMHSA grants require that a DIS be developed by grantees as an initial step in their post-award process.

Identifying Health Disparities You Are Seeking to Address

Use data to identify the disparity/problem/gap you are seeking to address

Who experiences disparities in access, use or health outcomes in your area of focus?

What groups of people within the populations your program aims to serve/reach/train might have a harder time accessing or using the services or trainings offered by the grant?

What data leads you to believe this disparity exists?

Consider demographic characteristics that might contribute to the disparity (e.g. race, ethnicity, gender, sexual orientation)

Describe the scope of the problem

Create a table that breaks out the subpopulations you aim to serve/reach/train based on the demographic characteristics that are relevant to the identified disparity.

Decide how you will address the disparity/problem/gap so that everyone you aim to serve/reach/train is able to access and use services/trainings achieve better outcomes.

- How can the disparity be addressed?
- What social determinants of health can be addressed to improved in the environment in which the disparity-vulnerable was born, lives, learns, works, plays, and worships that could help to reduce the disparity?
- Can services/trainings be improved so that they are more culturally and linguistically appropriate for the disparity-vulnerable to help address the problem?

Developing a Disparity Reduction Quality Improvement Plan

- Develop a quality improvement plan that will allow for reduction of disparities
- Describe implementation using SMART goals/objectives
- Describe intended outcomes and impact expected with disparate population after implementation of activities
- Describe client, peer, and stakeholder involvement with addressing disparities)
- Describe the projected timeline needed to implement activities
- Describe how you will measure the process, progress, and outcomes of improving disparities
- Describe how the organization will sustain improvements made to continue improving disparities

- What activities will you implement?
- Who will be involved in the activities?
- What will be your timeline for implementing activities?
- What will result from your activities?
- How will you know if you are making progress towards outcomes?
- What data will you use to measure this?
- How will you keep the work going?
- Who will be involved?
- What processes will need to be in place?

Example of a Disparity Reduction Plan

CLAS Standards

NATIONAL CULTURALLY AND LINGUISTICALLY APPROPRIATE SERVICES STANDARDS: CLAS

The National CLAS Standards are intended to advance health equity, improve quality, and help eliminate health care disparities by establishing a blueprint for health and health care organizations to:

Principal Standard

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

Governance, Leadership and Workforce

2. Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices, and allocated resources.

3. Recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce that are responsive to the population in the service area.

4. Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.

Communication and Language Assistance

5. Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.

6. Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.

7. Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.

8. Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.

Engagement, Continuous Improvement, and Accountability

9. Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organization's planning and operations.

10. Conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities.

11. Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery.

12. Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.

13. Partner with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness.

14. Create conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints.

15. Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents, and the general public.

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Examples of Activities:

- Continuous learning about and sharing of CLAS Standards
- Create and implement a formal CLAS implementation plan
- Increase the recruitment of culturally and linguistically diverse individuals
- Continuous CLAS-related training and technical assistance to leadership and all staff.
- Incorporate assessment of CLAS competencies (e.g., bilingual communication, cross-cultural communication, cultural and linguistic knowledge) on an ongoing basis into staff performance reviews/rating.

Communication and Language Assistance Standards

5. Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.

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7. Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.

8. Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area

Examples of Activities:

- Complete an organizational assessment specific to language assistance services
- Standardize procedures for staff members and train staff in those procedures.
- Provide individuals with notification that describes what communication and language assistance is available, in what languages the assistance is available, and to whom they are available.
- Require that all individuals serving as interpreters complete certification or other formal assessments of linguistic and health care terminology skills to demonstrate competency.
- Build organizational capacity to provide competent language assistance.
- Formalize processes for translating materials into languages other than English and for evaluating the quality of these translations

Engagement, Continuous Improvement, and Accountability Standards

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14. Create conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints.

15. Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents, and the general public.

Examples of Activities:

- Incorporate CLAS into mission, vision, and/or strategic plans
- Tailor existing evaluation efforts to include measures of CLAS implementation
- Complete a CLAS-related organizational assessment of the cultural and linguistic needs of populations served and of organizational resources to address these needs
- Collect race, ethnicity, and language (REAL) data (at a minimum) from all individuals receiving services, either by tailoring existing data collection approaches or creating a new data collection process
- Include community members in the process of planning programs and developing policies to ensure cultural and linguistic appropriateness
- Partner with community organizations to lead discussions to create advisory boards on issues affecting diverse populations and how best to serve and reach them.

You don’t have to do it all!

- Pick 2 or 3 items that you think your organization could implement.
- Jot down some concrete action steps on what resources your organization would need to be successful.
- Set a timeline.
- Consider your objectives, challenges, and staff and resources that can support you.

Checklist of National CLAS Standards Implementation Practices

Theme 1: Governance, Leadership, and Workforce			
Select your organization's stage of implemention for each practice	Currently implementing	Planning to implement	Not planning to implement at this time
Identify and designate a CLAS champion or champions, who are supported by the organization's leadership, and whose specific responsibilities include (at a minimum) continuous learning about, promoting, and identifying and sharing educational resources about CLAS and the National CLAS Standards throughout the organization.			
Create and implement a formal CLAS implementation plan that is (at a minimum) endorsed and supported by the organization's leadership, that describes how each Standard is understood, how each Standard will be implemented and assessed, and who in the organization is responsible for overseeing implementation.			
Target recruitment efforts to the populations served to increase the recruitment of culturally and linguistically diverse individuals, through actions such as: posting job descriptions in multiple languages in local community media, holding job fairs in the community(ies) served, and/or working with leaders of local community institutions to create mentorship and training programs targeting populations served.			

Checklist of National CLAS Standards Implementation Practices and Action Plan

Currently implementing	Planning to implement	Not planning to implement at this time

- Theme 1: Governance, Leadership, and Workforce
- Theme 2: Communication and Language Assistance
- Theme 3: Engagement, Continuous Improvement, and Accountability

Your CLAS Action Worksheet

Review the practices you checked as "planning to implement." We suggest choosing three practices that your organization or department will focus on implementing next. Write these three practices down, along with timeframes for their implementation.

How will you help your organization implement these National CLAS Standards? Write down a few concrete action steps. Consider your objectives, challenges, and staff and resources that can support you.

How will you help your organization implement these National CLAS Standards? Write down a few concrete action steps. Consider your objectives, challenges, and staff and resources that can support you.

Congratulations! You now have a CLAS implementation action plan!

Strategic Prevention Framework

The five steps and two guiding principles of the SPF offer prevention practitioners a comprehensive approach to understanding and addressing the substance misuse and related behavioral health problems facing their communities, and to developing and sustaining programs and practices that reduce behavioral health inequities.

The SPF includes these five steps:

1. **Assessment:** Identify local prevention needs based on data (e.g., *What is the problem?*)
2. **Capacity:** Build local resources and readiness to address prevention needs (e.g., *What do you have to work with? How can you facilitate the communication of prevention science?*)
3. **Planning:** Find out what works to address prevention needs and how to do it (e.g., *What should you do and how should you do it?*)
4. **Implementation:** Deliver evidence-based programs and practices as intended (e.g., *How can you and your coalition put your plan into action?*)
5. **Evaluation:** Examine the process and outcomes of programs and practices (e.g., *Is your plan succeeding?*)

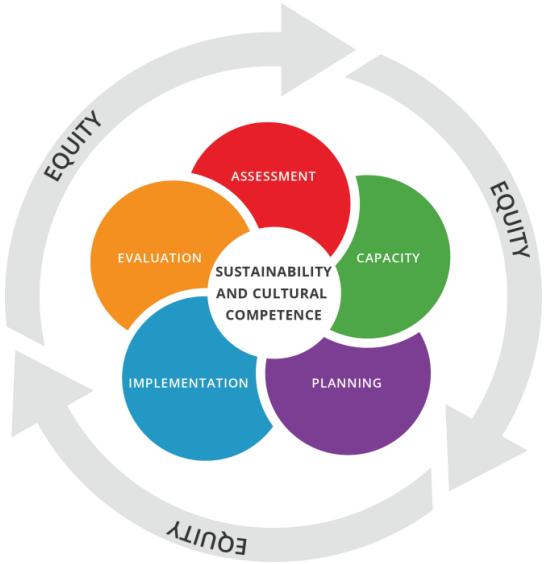
The SPF is also guided by two cross-cutting principles that should be integrated into each of its five steps:

- **Cultural competence**: The ability of an individual or organization to understand, interact, and engage with people who have different values, culture, languages, lifestyles, and traditions based on their distinctive heritage and social relationships.
- **Sustainability**: The process of building an adaptive and effective system that achieves and maintains desired long-term results.

Prevention Framework

Assessment
1. Define and Describe the Community
2. Collect Comprehensive Data
3. Identify Priority Substance(s) and Population(s)
4. Create Logic Model

Evaluation
1. Assess short term and long-term changes to your goals
2. Document and Present Successes and Challenges
3. Use Evaluation Data to Guide Programming
4. Use both Qualitative and Quantitative Methods of Evaluation



Build Coalition Capacity
1. Build Coalition Membership
2. Develop Coalition Structure
3. Cultivate Coalition
4. Identify Resources and Readiness

Implementation
1. Prioritize Strategies and Action Plan Timeliness
2. Utilize Coalition Resources to Deliver Programming
3. Ensure Implementation Fidelity
4. Share Messaging with Sectors Partners and the Community

Sustainability
- Create Sustainability Plan
- Engage Stakeholders
- Best Fit Strategies
- Human and Fiscal Resources

Cultural Competence
- Identify Subgroup Populations
- Address Disparities
- Ensure broad community representation
- Evaluate Impact

Planning
1. Create a Vision and Mission
2. Identify Objectives to Meet Local Needs
3. Plan Strategies and Activities
4. Develop Action Plans for each strategy

Step 1: Assessment

Assessment involves identifying local prevention needs based on data.

To conduct a comprehensive assessment of prevention needs, you will gather data about:

- Substance abuse problems and related behaviors.
- Risk and protective factors for priority substances and populations.
- Capacity, including resources and readiness to address identified problems.
- Sources of the data will vary based on each community but may include information from each of the 12 Sectors: School, Law Enforcement, Hospital/Health, Youth, Community/Population Demographics, Parents, etc.

Once you have completed this assessment, it is important to share key findings with diverse prevention stakeholders

Applying A Health Equity and Disparity Lens to Assessment

Are certain communities experiencing greater health disparities?

What data have you collected to determine community disparities?

Are certain subgroup populations in your community experiencing a greater variance in social determinants of health around housing, education, employment, safe neighborhoods, and access to healthcare?

Use various sources of health, education, community profiles, and national data sets to assist in identifying subgroup and populations of focus to focus your prevention efforts to decrease disparities, increase protective factors, and positively meet your goals.

- Assess existing behavioral health disparities and gaps in data at the individual (e.g., race, ethnicity, gender or sexual identity) and social (e.g., access to services) levels
- Nothing About Us Without Us: get the community involved early
- Have staff representation that fits the communities in which you are working
- Be inclusive and culturally sensitive in the way you are asking questions and interpreting responses
- Share the results of your needs assessment with your community

Step 2: Capacity

Capacity involves building and mobilizing local resources and readiness to address identified prevention needs

- ***Resources***: A community needs both human resources and structural resources to establish and maintain a prevention system that can respond effectively to local problems.
- ***Readiness*** describes the motivation and willingness of a community to commit local resources to address identified prevention needs. Prevention programs, policies, and strategies are always more likely to be successful and sustained if they are well supported.
- The following are some strategies for building local capacity for prevention:
  1. Engage diverse community stakeholders
  2. Develop and strengthen a prevention team or coalition
  3. Raise community awareness of the issue to increase readiness
  4. Identify resources to support the coalitions activities

Applying A Health Equity and Disparity Lens to Capacity Building

- Does your coalition or organization reflect the diverse populations and cultures present in the community?
- What strategies have you engaged in to bring diverse representation to your work?
- Have you raised awareness and educated the community about health disparities that are present in the community between subgroup populations on topics pertaining to substance misuse, social determinants of health, and mental health matters?
- Is the work you engaged in viewed differently by different segments of the population?

- Ensure your materials and messages are culturally responsive- languages, literacy accessibility, use CLAS standards- that will reach across populations
- Noting About Us Without Us: continue to recruit and involve diverse stakeholders to your community efforts with their voice and perspectives
- Establish a safe and trusting environment for discussions and actions.
- Continue your own education and sense of cultural humility while navigating tough topics with the community on sensitive topics.

Step 3: Planning

Planning involves how to best address identified prevention needs and associated factors

To develop a solid prevention plan:

- Prioritize risk and protective factors identified for your community
- Select appropriate interventions to address each priority factor
- Combine interventions to ensure a comprehensive approach. Interventions should reinforce each other. Interventions can target more than one risk or protective factor.
- Build and share a logic model with stakeholders

To prioritize factors, it's helpful to consider a factor's importance and changeability.

Importance describes how a specific risk or protective factor affects a problem.

To determine a factor's importance, ask yourself the following questions:

How much does this factor contribute to our priority problem?

Is this factor relevant, given the developmental stage of our focus population?

Is this factor associated with other behavioral health issues?

Changeability describes a community's capacity to influence a specific risk or protective factor..

To determine a factor's changeability, ask yourself the following:

Do we have the resources and readiness to address this factor?

Does a suitable intervention exist to address this factor?

Can we produce outcomes within a reasonable timeframe?.

When developing a prevention plan, it is best to prioritize risk and protective factors that are high for both importance.

Applying A Health Equity and Disparity Lens to Planning

- How are you involving members of the subgroup population/POF in the planning process?
- Are there community readiness concerns that need to be addressed before Implementation?
- Are the prevention strategies you are selecting a good match culturally for the community and populations of focus?

- Ensure you have recruited diverse membership to the coalition and of the subgroup populations that are reflective of the community
- Nothing About Us Without Us: Continue to engage your community sectors and segments of the population in your prevention efforts
- If there are data gaps, consider qualitative data sources such a focus groups or key informant interviews
- Ensure strategies selected during the planning phase are a cultural fit with the community and target populations

Step 4: Implementation

***Implementation** involves putting your plan into action by delivering evidence-based interventions as intended.*

Implementation Partners: You will have already identified and connected with key implementation partners, sectors and stakeholders during the previous steps of the SPF. These are the individuals and organizations that will be responsible for and involved in the delivery of your selected interventions, activities and strategies.

- ***Fidelity and Adaptation***
- As you prepare to implement your selected prevention interventions, it is important to fidelity and adaptation with your implementation partners
- ***Fidelity****:* Describes the degree to which a program or practice is implemented as intended. Evidence-based programs are defined as such because they consistently achieve positive outcomes. The greater your fidelity to the original program design, the more likely you are to reproduce those positive results
- ***Adaptation***: Describes how much, and in what ways, a program or practice is changed to meet local circumstances.

- The following implementation activities can help to ensure that your prevention efforts will be culturally competent:

- Identify interventions with documented effectiveness for your focus population
- Involve focus population members, including potential intervention participants and cultural leaders, in the process
- Ensure that interventions are evidence-based and part of a comprehensive prevention plan
- Work closely with implementation partners to build capacity for prevention and evaluation
- Engage in continuous feedback collection and adjust strategies where warranted.

Applying A Health Equity and Disparity Lens to Implementation

- Do you need to make any adaptions of the selected strategies for and if so, how will you maintain their fidelity?
- How ill you assess if strategies are working towards your identified goals or if you need to adjust?
- Have you verified that selected strategies are a good cultural match with your population(s) of focus?
- What is your communications plan to provide information to the community and to receive input and feedback?
- Are you prepared to collect data to report and share with the community in your implementation plan?

- Ensure the strategies you are implementing are a good match to your identified goals and outcomes measures
- Select strategies that area good fit for your community readiness and culturally relevant to your subgroup and populations of focus
- If you need to make adaptations to your selected strategies, will the changes maintain fidelity?
- Create a culturally relevant communications plan and adjust as needed
- Collect data as you progress for your reporting, to demonstrate impact, and to justify updates where warranted.

Step 5: Evaluation
Evaluation involves examining both the process and outcomes of prevention interventions

- *Evaluation* is the systematic collection and analysis of information about prevention activities to assess goal achievement, improve effectiveness, and make decisions on adaptations.
    - ***Process evaluation***, documents the implementation of an intervention, can be used to improve intervention delivery and make mid-course corrections, and enhance understanding of prevention outcomes.
    - ***Outcome evaluation***, measures the effects of an intervention following its implementation, can reveal whether the intervention produced the anticipated short- and long-term prevention outcomes and helped build support for those interventions that worked.

- Evaluation methods can be used to identify if strategies and activities are having the intended effect on the target population(s) and disparities.
- Schedule follow up meetings with priority population groups, coalition members and community partners to share and discuss evaluation findings.
- Use evaluation results to guide future programming, set goals, secure funding, and to allocate resources.
- Celebrate successes and note areas that remain areas of focus for improvement!

Applying A Health Equity and Disparity Lens to Evaluation

- Do you have community diversity represented in your data collection and evaluation efforts?
- Have you identified missing gaps of data?
- Have you included both quantitative and qualitative data sources in your evaluation plan?
- When sharing evaluation results, have you applied cultural awareness to your presentations and graphics?
- How will you use the evaluation results to adjust the previous steps of the SPF?

- Recruit diverse community representation to your evaluation efforts, especially those of your target subgroup populations/populations of focus.
- Consider national, state, regional data sources if local sources are not available
- Apply CLAS standards to presentations, graphics, and messages.
- Share successes and use challenges to refine and adjust strategies!

Example Risk Factors and Evidenced Based Strategies

Risk Factor	Strategies
• Low Perceived Risk of Harm Communications	Awareness Raising/Education
• Social Access	Social Marketing
• Peer and Family Norms	Education/Training
• Retail Availability	Compliance Checks
• Social Host	Enforcement of Laws/Social Marketing
• Low Commitment to School	Coalition Capacity Building

Health Equity Matrix Template and Example

Substance: (insert prioirty substance(s)		Subpopulations: (insert subpopulation/Populations of Focus POF)		
Evaluation Area of Focus	**Data Collection of Measurement Tool/Type**	**Will you involve members of your identified subpopulations/Populations of focus in development of the insructments and data collection protocols? If so, how?**	**How will you ensure that members of your identified subpopulations/Population of Focus are adequately represented in the data you collect?**	**How will you involve members of your identified subpopulations/Populations of focus in sharing and interpretation of the results?**
	SEARCH Institute Survey	Youth from POF will develop a video to explain the survey and encourage peers to participate	Survey will be provided in Spanish or other languages, as needed.	Members of POF will participate on coaltion. Evaluation findings will be unpacked with coalition members.
Prevalence and Risk Factors	Town-level student survey	Will gather input from POF on items, and pilot survey with them	A community survey using the SEARCH Institute items will be implemented in alterntive school programs and community settings where high risk youth are present, to reach those who are not in school.	Listening sessions with POF will be held to share findings.

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Applying an Equity and Disparity Impact Lens Goal

Ensure that community prevention efforts are inclusive of underserved racial and ethnic minority populations, and other underserved and at-risk populations, in their infrastructure, programs, and practices.

Data Sources

DMHAS Regional Data Stories are a set of interactive comparative prevention data resources developed by CPES, and housed in the CT SEOW Prevention Data Portal. These data visualizations contain both regional and town-level data, detailed below.

Regional-level data

- **Substance Use by region (NSDUH, 2016-2018):** past month by substance; alcohol and substance use disorder; needing but not receiving treatment;
- **Perception of great risk of harm by region (NSDUH, 2016-18):** marijuana, cocaine, heroin, alcohol, cigarettes, age groups 12-17, 18-25, 26 and older;
- **Substance/issue of greatest community concern for region (Community Readiness Survey, 2020):** substances, problem gambling, mental health, for age groups 12-17, 18-25, 26-65, 66+;
- **Regional and regional subgroup mental health and suicide data.**

Town-level data

- **Towns by community type** (5 Connecticuts: wealthy, suburban, urban periphery, urban core, and rural)
- **Demographics and SES data by town:** age, race/Ethnicity, median household income
- **Motor vehicle crashes by town, 2021:** all crashes, DUI crashes, % of crashes DUI-involved
- **Drug-involved overdose deaths by town:** any opioid, heroin/fentanyl, cocaine, benzodiazepine, prescription opioid-involved deaths, 2021 (number, r.p. 100,000)
- **School data by school district:** absenteeism, disengaged youth, ATOD incidents (by demographics)
- **DMHAS treatment admissions by town (2021 FY):** substance abuse, mental health, SA/MH

Existing Data Sources

Existing Database	Type of Data	Step(s) in the Enhancement Process
United States Census Bureau	Population/Community Characteristics: Age, Race, Ethnicity, Economy, Education, Employment, Living Arrangements, Government, Housing, Income, Poverty	Assessment Capacity Building Strategic Planning Evaluation
State Epidemiological Outcomes Workgroup (SEOW) Prevention Data Portal	Prevalence of Substance Use, Perception of Harm, Substance Use Behaviors, Mental Health, Mental Health Treatment Usage	Assessment Strategic Planning
Regional Behavioral Health Action Organizations (RBHAOs)	Rates of substance use, problem gambling, mental health problems (including suicide)	Assessment Strategic Planning Evaluation

E.G. SEOW Prevention Data Portal

- An interactive repository for behavioral health and related data.
- **Goal: Increase accessibility and utility of CT's epidemiological data in support of a comprehensive public health approach to substance abuse prevention and health promotion.**
- SEOW is developed with support from several state funded agencies and local non-profits, including:
- Department of Mental Health and Addiction Services (DMHAS)
- Center for Prevention Evaluation and Statistics (CPES)
- CT Data Collaborative


SEOW Prevention
HOME
INDICATORS
DATA SETS
RESOURCES
EPIDEMIOLOGICAL PROFILES
PRODUCTS
DATA STORIES
ABOUT
Connecticut SEOW Prevention Data Portal
Bringing together Connecticut's epidemiological data in support of a comprehensive public health approach to substance abuse prevention and health promotion.

E.G. RBHAO Regional Priority Reports

RBHAOs develop regional priority reports to highlight recommendations for prevention, treatment, and recovery services.

Profile and data can be used to:

- Provide a basis for determining emerging needs, projecting future needs, and identifying health disparities;
- Increase community awareness of substance use and other behavioral health problems
- Respond to public needs
- Enhance membership of planning or advisory groups to be more demographically representative and/or more responsive to the priority needs of the region

Regional Priority Reports:

- Region 1: The Hub
- Region 2: Alliance for Prevention Wellness - BHCare
- Region 3: SERAC
- Region 4: Amplify, Inc.
- Region 5: Western CT Coalition

Regional Prioritization & Report

Data Collection Resource: Key Informant Questions for Needs Assessment

To assess *this*...	And *this*...	You can ask *this*...	Of *these* individuals
Key informant sector/area of focus	Key informant perspective	What **community** do you **represent**?	School/community representatives, parents/guardians, youth
		What is your **role** and **organization?**	School/community representatives
		How old are your **children?**	parents/guardians
		What is your **connection** to this community? **How long** have you **lived/worked** in this community?	School/community representatives, parents/guardians, youth
Prevalence/Magnitude		**What** substance use problems are occurring most in your community?	School/community representatives, parents/guardians, youth
		What is the **biggest substance use issue** for youth? **Why do you say this?**	
		How do you know this?	
		How often are these problems occurring?	
Severity/Impact		**What problems** are associated with underage drinking?	School/community representatives, parents/guardians, youth
		What consequences of underage drinking are you seeing?	

To assess *this*...	And *this*...	You can ask *this*...	Of *these* individuals
Risk Factor(s)	Retail/social access	**How easy** is it for youth to get alcohol?	School/community representatives, parents/guardians, youth
		Where are youth **getting** alcohol?	
	Peer/family norms	**Where** are youth **using** alcohol?	
		Who are youth **drinking with**?	
	Parental disapproval	**How wrong** do **you/parents feel** it is/would be for youth to use alcohol?	parents/guardians
		How wrong do **parents feel** it is for youth to use alcohol?	School/community representatives, youth
	Peer disapproval	**How wrong** do **you/your friends feel** it is for kids to use alcohol?	youth
		How wrong do **kids feel** it is for youth to use alcohol?	School/community representatives, parents/guardians
	Perception of risk/harm	**How risky or harmful** do youth in your community think it is for youth to drink alcohol? **How risky or harmful** do parents in your community feel it is for youth to drink alcohol?	School/community representatives, parents/guardians
		How risky or harmful do you, your friends, and kids in your community think it is for youth to drink alcohol?	youth
	Other risk factors	**Why** do youth use alcohol?	School/community representatives, parents/guardians
			youth

Resources and Tools

Social Determinants of Health– CDC:
https://health.gov/healthypeople/priority-areas/social-determinants-health

DIS Training– Disparity Impact Statement 101 training video:
https://www.youtube.com/watch?v=GC65r_YbQdM

Disparity Impact Statement Worksheet:
https://www.samhsa.gov/sites/default/files/disparity-impact-statement.pdf

Disparity Impact Statement Services Example:
https://www.samhsa.gov/sites/default/files/disparity-impact-statement-servicesexample.pdf

National CLAS Standards: https://thinkculturalhealth.hhs.gov/clas/standards

A Guide to SAMSHA's Strategic Prevention Framework:
https://www.samhsa.gov/sites/default/files/20190620-samhsa-strategic-prevention-framework-guide.pdf

Connecticut SEOW Prevention Data Portal:
https://preventionportal.ctdata.org/about.html

EdSight: Data on CT Districts, Schools, and Students: https://public-edsight.ct.gov/

An Implementation Plan Checklist for the National CLAS Standards:
https://thinkculturalhealth.hhs.gov/assets/pdfs/AnImplementationChecklistfortheNationalCLASStandards.pdf

Resources

- PTTC: Building Health Equity and Inclusion. Extensive list of resources, trainings, webinars, and sub-group populations
- Guide to Equity Terminology: Promoting Behavioral Health Equity through the Words We Use | SAMHSA
- Race_Equity_Crosswalk_Tool.pdf
- The Spectrum of Community Engagement to Ownership
- Robert Wood Johnson Foundation | RWJF
- Racial Equity Tools | Home
  - Glossary | Racial Equity Tools

Questions?

Thank you!

- Evaluation Link:
- https://www.surveymonkey.com/r/J8YNYXN

- Contact: Jennifer Jacobsen, jacobsen@xsector.com