Cori Cafaro:

Great. Let's go ahead and begin. I just want to thank everyone for joining us today. Good morning and afternoon, maybe evening, wherever you are in the world. And then fun fact, we realized today that in the participants who are joining us, we represent all of the United States time zones. So we really do have a wide spectrum in the audience and of presenters.

Cori Cafaro:

So I want to thank everyone today again for the presentation we'll be viewing. This is our first ever behavioral health equity challenge showcase. So today you'll be hearing from four organizations that were the first winners of this challenge. We'll have time at the end for Q&A, the four organizations presenting today. We're selected to showcase a wide range of populations and focus areas, though we ask everyone to stay tuned because we'll be featuring additional presentations and more showcases from the other winners later this month for Hispanic Heritage Month and other events throughout the year. So my name is Cori Cafaro, I'm a public health advisor with SAMHSA's Office of Behavioral Health Equity, or OBHE. I'm joined today by other members of SAMHSA's OBHE and the National Network to Eliminate Disparities National Facilitation Center.

Cori Cafaro:

Okay, before we begin, a few housekeeping logistics. Everyone, we encourage you to introduce yourself, your affiliation, maybe where you're from in the chat. You'll notice that there's the option to do a chat and a Q&A at the bottom of your panel. So Q&A is for the presenters. So if you have questions that come up during the presentations, we have a dedicated time to go through them or as many as possible at the end of the four presentations. We also have closed captioning, which is available through Zoom using the CC button in the full live transcription option. And again, resources and the recording will be available following this roundtable event at share.nned, N-N-E-D, .net. Okay. And now I'd like to introduce Dr. Larke Huang, director of OBHE, or the Office of Behavioral Health Equity at SAMHSA.

Dr. Larke Huang:

Okay. Thanks very much Cori for opening this session. As Cori mentioned, I'm Larke Huang and I direct the Office of Behavioral Health Equity at SAMHSA, and it was my office that conducted this first ever behavioral health equity challenge. I do want to acknowledge Perry Chan, who is the lead on this challenge, and Cori Cafaro, who is moderating this session today, who is the co-lead. While it sounds simpler than applying for a grant or a contract, it actually is a long arduous process for our staff, but we think it well worth the heavy lift. As we've worked with communities and community-based organizations, faith-based organizations, we often hear there are two things they really need from us, funding and recognition of the innovative and effective work they do in their communities.

Dr. Larke Huang:

So we designed a challenge to do exactly that. The goal of the Behavioral Health Equity Challenge outreach and engagement strategies for underserved racial and ethnic communities is to identify and highlight outreach and engagement strategies used by CBOs, or faith-based organizations, to increase access to behavioral health services for racial and ethnic underserved communities. The winners of the challenge each receive $50,000 and multiple opportunities for recognition. This being the first opportunity for recognition. According to GSA, which is our Government Services Administration, who hosts a challenge website and oversees some of the federal government challenges. Our challenge had more applications, more submissions than any other government challenge.

Dr. Larke Huang:

We received 427 submissions, so we had a particularly competitive challenge, and our applicants had to go through a complex two tiered judging process as well. From these submissions, we selected 10 winners and four of the winners focused primarily on mental health issues, three focused on substance use treatment, and three focused on prevention. And the winners you'll hear from today are from the Waianae Coast Comprehensive Health Center in Hawaii, focused on substance use treatment. The South Central Foundation in Alaska focused on substance use treatment. The North Carolina Youth Violence Prevention Center, focused on prevention. And the Mt Olive Baptist Church, also focusing on prevention.

Dr. Larke Huang:

And through this challenge, SAMHSA, we seek to learn more about the strategies used by community-based organizations to better connect and engage with populations and communities who don't always seek or trust what they're going to get in behavioral health services. As we recognize and publicize these winning strategies, we hope other CBOs will try these strategies, be in contact with our winners to test them out, to learn more about what they constructed in their organizations and to improve their own outreach and engagement efforts in their communities. We know that these organizations often serve on the front lines to address the needs of the community members.

Dr. Larke Huang:

This challenge enabled their participants to share details about their successful strategies to help members of their communities engage and connect with culturally and linguistically responsive behavioral health services. So for SAMHSA, it was really critical that we learned from them and we hope to continue to showcase and learn more about their effective outreach and engagement strategies. So congratulations to all of your winners. We have six more that will present in yet another showcase. So now I'm going to let you start to hear from these winners, and I'd like to turn it over first to Pastor Carlton Williams of Mt Olive Baptist Church in Dayton, Ohio. Carlton?

Carlton Williams:

Well, thank you Dr. Huang. Certainly appreciate it. Certainly appreciate Dawn and I want to thank you and SAMHSA for the recognition. We are a Mt Olive Baptist Church, so we do want to thank God for this opportunity to present and share what we believe are some unique strategies, certainly to our population as we try to address many of the issues that are plaguing our communities. And also as we celebrate recovery month with over 60 million people declared in recovery, we want to acknowledge those individuals and certainly do what we can to assist them in their recovery. So if we can get the next slide, we can get started.

Carlton Williams:

Now, let me start by saying this, of all the strategies that we've been given by SAMHSA to implement all of the help, all of the implementations, all of the best practices, I think the one that was most impactful for our community was an intervention called Community Promise. Community Promise is decades old, but it set the foundation for a strategy that we would move forward because what it does is it aligns partners throughout the community. It gives voice to the community in part to their resolution for what's plaguing the community. So what we found is it's been very helpful that as we partner with other CBOs and community organizations, that we also partner with the community and lend voice to what their concerns are. Because what we've done at Mt Olive is simply address the needs. So know many

times in grant work what we do is we apply for what the organization does, but Mt Olive has pretty much addressed the needs and the needs of the community have driven our focus in terms of what we endeavor to do.

Carlton Williams:

Now we are located in 45417, of the largest zip codes in the Dayton area. We do a combination of a lot of things that you've heard. We do prevention, we do connection to treatment and a lot of other things. So we do mental health, substance abuse, hepatitis and HIV screening, prevention, case management, referral for treatment and recovery for services to community for over two decades. So speaking of our partnership, if you would bring up the next slide, I want to say that most of this started in our relationship with Wright State University sorority in their commitment to community to get a lot of this work done and partnering with the community. So it's been a combination of a grassroots professional effort with everybody lending their expertise to make a difference in what's been ailing our communities. Now, I was really blessed to be a part of SARDI for a number of years, met some of the most wonderful committed people you'll ever have the pleasure to work with.

Carlton Williams:

And through that engagement, I've had three directors, Dr. Dennis Moore, Dr. Josephine Wilson, and the current director Joann Moore. Now what I love about the three of these people is their consistency in their commitment to reinvest dollars in the community to make a voice, but also giving credence to the grassroot efforts of the CBOs who have partnered with them to not only hear their expertise but be guided by their expertise. So what I love is the consistency that we've been able to maintain for decades with Wright State and the SARDI entity along with some of the other people I'm going to mention, public health. We are currently in collaboration with UMADAOP and other agencies as we move throughout the community. Now, the one-stop center, which we created based on a model one-stop simply means for us is that if you come to Mt Olive for service and we can't provide the service, we make sure that before you leave the building, we'll connect you with that service.

Carlton Williams:

And we will do direct referrals to make the transition a lot easier as you try to navigate sometimes the sophistication and the nuances of governmental systems. So we do health education, evidence-based interventions, peer support, linkage. I'm not going to go through all of these things, there's certain time constraints that we have. But many of these things you can see, I think some of the vital services that we provide as we look at this strategically is the premise of a quote that was given by then President Teddy Roosevelt, who said, "People don't care how much you know until they know how much you care."

Carlton Williams:

So what we do is we create a caring, compassionate atmosphere where we're able to let people know that regardless of their social economic status or their plight in life, you'll find a welcoming atmosphere at Mt Olive. And in that way, people know that once we establish these relationships, then they can get what they need. We do NA, AA, we do testing. Most of the staff provides the testing. So we create an atmosphere where there's a lot of relationship building as we move through this next slide, please. All right. Now as we look at the barriers that have plagued us, high percentage of single parent households, higher unemployment, stigma. All of these things that are associated with socially economic depressed neighborhoods and communities.

Carlton Williams:

I think the biggest issue that we struggle with, as probably with most of my colleagues here, is stigma. Next slide. Mistrust of health systems and belief that a significant amount of information is withheld from the community. This has plagued us. Not only from the community in general, but from a wide margin of beliefs. Whether it be faith-based or non-faith based, there is a mistrust. And we can date this back to Tuskegee and all of the things that have come out of that unfortunate incident in America's history where there is little mistrust. So we were very meticulous working with public health and how we designed even our mobile unit where we put different things on.

Carlton Williams:

When we started to test for HIV, one of our inaugural programs, we made sure that we couch other services on the mobile unit as we moved out the community so it would not be identified as the AIDS wagon as it had been in other communities. So couching, other services without effort kind of disguised some of the treatments and it doesn't attach the stigma that would normally apply in other situations where you kind of single focus. Next slide. Our targeted efforts, reaching out to adults with SUD, mental health disorders, adolescents, college age students. Particularly the whole gamut. And I'll just give you a synopsis of this, is that what we've done is that when we try to serve people, we not only serve people, but we serve the people that are around people. The families, the grandmas, the grandpas, the aunties, the aunts. All of those people who surround them, who provide the intimate support system, they need to be educated as well and we try to make sure that we incorporate that facet in all of our programming. Next slide.

Carlton Williams:

All right. Now, we work with Wright State, we work with public health, we work with UMADAOP, one of our newest partners. We do a succession intervention designed to create awareness, increase knowledge prevention skills, and train peer advocates on substance abuse, HIV and Hep C. And this is critical because a lot of the stigma comes from a lack of information and a lack of understanding the information. And then we work very hard with our curriculum and our interventions to make sure that the information is palatable for the people who need to receive it. We have to put the information at a level where they can get it and then they can transfer it and then they're encouraged to share.

Carlton Williams:

We create ambassadors for all of our programs who subsequently share our information throughout the community because they are our best voices. And again, as I talked about Community Promise, one of the strategies of Community Promise is to make sure that you talk with the gatekeepers, the captains of the block, the influential people in the community who have voice in the community so that they can share and give credence to what you're doing. So we met with the pastors, we met with the gatekeepers, we met with the people of influence so that they could help spread our message. Now, some of the innovative strategies continued are we deal with youth mental health, but we deal with youth mental health from the perspective of we're teaching this mental health first aid to anybody that impacts youth.

Carlton Williams:

Because of the lack of access in our communities we saturated 45417, we train at least one youth mental health first-aider for every eight young people so that when those people are in crisis, they have a familiar face and a familiar voice to help them sustain them until the appropriate professional help is

provided. Next slide. Now again, our work with Wright State, you'll find this continuous in our work. We have built a relationship with SARDI, specifically at Wright State, that has lasted decades. It's uncommon, but is very fruitful for maintaining sustainability in the community. One of the things that you'll find in some of our programming is we have people, I'm happy to say on one hand and then sad on the other, where they're multi-generational recipients of some of our programming. We have support groups now where we have mothers and daughters in the same support group. Now it's sad that they're still suffering from that plight. However, it's a good thing that the resources that are provided are generational as it addresses some of the generational issues. Next slide please.

Carlton Williams:

Now, this 2000 and SAMHSA 7 grant that we talked about that supported the needs of those formerly incarcerated, returning citizens. One of the things that we found that drove the rates was the returning citizens were returning to situations where their families were not aware of what they had gone through. So we educate the families on how to receive those returning citizens in addition to providing the services to help support them in their re-acclamation. Next slide, please. Our goal was to supply, enhance the substance abuse treatment. So to that end, we work with a lot of women. We have SAMHSA programming, we have interventions, specifically Jermaine, in this case SISTA, African-American women. One of the phenomenal programs where we've created ambassadors that have last generations because of the community connection, because of the community promise where we talked about what we would do and then we've continued to do it.

Carlton Williams:

A lot of things emerge out of this group, such as the 12 step recovery programs that are currently going on and it's currently one of our longest longstanding recovery programs. Next slide please. Innovation strategies where we address disparities, retention for treatment and co-occurring disorders. One of the strategies implemented is that when a person comes through our initial process, we set up a process initially through the wonderful work of our case managers and peer support workers where they establish and maintain contact throughout the process so that the person knows that there's always somebody available to them that they can reach out to.

Carlton Williams:

One of the things that was shared in one of our focus groups upon the initial concept was when we asked them what did they need when we were talking to the citizens in recovery, they said, "Well, we know what you need. So what we need, we'll tell you. But what we need is for you to be consistent in your application of services. You don't need to come around only when you need something or when the numbers are being counted or when you doing reports, because if you treat us that way, we'll make sure when you look for us, we'll make sure you won't find us." So we found out that maintaining contact was very fruitful in maintaining the appropriate SAMHSA GPRA rate, of which we are all familiar with, I'm sure. Next slide.

Carlton Williams:

Prevention to treatment and recovery, social networking, peer to peer. Our peer support workers were excellent. Our drug support screening, you can see the different interventions that we use. One of the most interesting interventions over the last decade has been the shield intervention where it addressed the onset of a lot of infection in people 50 and older. I think it was a population that not many people thought was very viable sexually, but there are a lot of things that have occurred in the last decade that

has changed that dynamic in terms of the sexuality of seniors. If you know what I mean, and I'm sure most of you do. Certainly we have to address those issues and it's a program that we're still addressing today. Next slide.

Carlton Williams:

Next slide? Okay. Equity. Our policies and guidelines created to address diversity and sensitivity. Our client paperwork is culturally and linguistically appropriate, which is very critical for these diverse populations that we serve. Our referral system in place to address social determinants of health are absolutely necessary. Direct referrals are critical. The agency collaboration is mandated by what we do. Our staff culturally, cultural humility trainings for staff is absolutely a must. Again, we operate from a mantra that people must be treated with dignity and respect. If that can't be accomplished through employment, then you probably should seek other employment. We use name tags to identify preferred pronouns to reduce the chances of misgendering when you're doing certain intake work. There's nothing more embarrassing than misgendering when you're doing certain types of paperwork. We find these things very critical in establishing the initial contacts and respect so that people will be willing to be more forthcoming with information that's needed to help serve them. Next slide.

Carlton Williams:

Well, our challenges are the same as probably a lot of folk. Director Huang mentioned this, keeping up with unexpected services when funding runs dry. One of the things that I'm most proud of is our ability to have been able to maintain services in the absence of funding. And sometimes those things have been rewarded. SAMHSA has taken notice of some of those things that we have done in the absence of funding, and so maybe not at the same level, but it's important that we continue to maintain those contacts that we've established in the community to make sure that we are not a one-shot wonder that we will continue to be there for them as they continue to work through their addictions and their struggles. Geographic limitations. Sometimes I don't know that geographic locations are as much an issue as they are on the funding stream.

Carlton Williams:

There are certain prohibitions that you cannot do because of geographic limitations, but what we have to do is serve everybody that walks through the door. So we find a way to serve everybody that walks through the door, whether they're with funding dollars or not. I can't tell you the countless number of times staff has taken money out of their pockets or we've called on staff to do certain things. We recently participated in a community event where our current director, Joanne Ford's son, has a nonprofit where tennis shoes were donated for kids going back to school. So it's establishing those contacts with the resources that are necessary to keep you afloat, whether you are getting funding or not. And then the deeply rooted trust issues, and this is a two-prong problem for us. It's not only the community, but it's the church. We're in a day and a time when the receptivity of the church or faith entities is not as well received as it used to be. There are people who have issues about that.

Carlton Williams:

So Mt Olive has done some things that help itself in terms of creating an atmosphere conducive for folk to come express and be themselves. I'm proud to say that we have not proselytized not one person that has come through those doors talking about Jesus. We show them the love... Well, we don't have to say it, we show it to them. And then once they see the love, then they know. But the point is that we educate the church, not only Mt Olive Church, but churches... We have special curriculums that we have

put together for faith entities so that they can help where they can. I think the misnomer that people don't understand about faith communities, that they're willing to help, but they'll help where they can.

Carlton Williams:

And I'll take this back to our HIV inception where we had one church that didn't want to help because they had some issues with HIV, but what they were willing to do was provide housing for people. Because our biggest issue was moving people from the streets through crisis care into treatment and there used to be such a gap that by the time they got a bed and treatment, we lost the individuals. Well, by them providing a place for people to stay. They provided housing, they provided food, they provided clothing. So I think sometimes we have to understand that they're organizations that are willing to help, but we can't be so demanding on what they must do, we must accept the help where we can find it and then find other organizations to do some of the other things.

Cori Cafaro:

Pastor Williams, I apologize. People are really responding well in the chat to the words you're sharing, but I want to make sure that the other participants are ready to go. So just last point, thank you.

Carlton Williams:

Okay, last point is keeping the community motivated and buy-in. We're a grassroots operation and we beat the brakes. I'm done.

Cori Cafaro:

Thank you so much. That was a wonderful presentation. And again, if you have a chance to look at the chat, folks really responded well to the things you were saying. I would like to introduce our next organization and presenters, Waianae Coast Comprehensive Health Center, and we'll hear from multiple presenters from this organization and I will hand it off to Niki, Tina, and Makani.

Makani Tabura:

[Hawaiian 00:27:52] With that, my friends who say [Hawaiian 00:27:55] all the way from the islands of Hawaii. Whenever we get together for things like this, we all make sure we're of the same breath. I know you folks are familiar with the word aloha. Aloha means hello and goodbye, but most importantly, it means love. Aloha is actually two words. Alo means to stand face to face with one another, and ha is our breath of life. So we're not actually exchanging a high and hello, we're actually exchanging the true essence of our being. So really quickly, whenever we get together like this, we want to make sure we're of the same breath. So if everybody can take three deep breaths, your first breath, I want you to connect to whoever your creator is. Your second breath. I want you to connect to the land and the aina that you are on. And the last breath, I want you to connect to the people around you.

Makani Tabura:

So Hawaiians believe that everything that goes into our nose, we breathe through our nose, we inhale is clean and [foreign language 00:28:44]. Things that come out of our mouth have the potential to be harmful. So if everybody can inhale and ha, inhale and ha, inhale and ha. The ultimate gift you can give somebody in thanks and gratitude and appreciation and healing is your breath. With that, my friends, we share our breath with you and we introduce our team.

Dr. Niki Wright:

Aloha. My name is Niki Wright and I'm a licensed clinical psychologist and director of Malama Recovery Services and Ho'okuola Hale. Our health center is the oldest and largest of the 15 federally qualified health centers in the state of Hawaii. It is my tremendous honor to introduce the rockstar of our departments, Dr. Tina Liu-Tom, who prepared and submitted our application to SAMHSA's Behavioral Health Equity Challenge.

Dr. Hsin-Tine (Tina) Liu-Tom:

Thank you so much, Dr. Wright. First of all, I'd like to just say thank you very much and humbly express our gratitude to SAMHSA, to Dr. Delphin-Rittmon and the office of the Assistant Secretary. And to especially Dr. Larke Huang and the team at the Office of Behavioral Health Equity for the honor of receiving this prestigious Behavioral Health Equity Challenge award. Thank you so much also for this uniquely outstanding opportunity to showcase Waianae Coast Comprehensive Health Center's engagement strategies in servicing racially and ethnically underserved communities. And special thanks to Cori, today's facilitator, and Cheyenne at Change Matrix for working so closely and tirelessly with us to put this showcase together. Again, I'm Tina Luis-Tom, a staff psychologist and the director of training of the joint programs, Malama Recovery Services, our intensive outpatient substance use disorders program, and Ho'okuola Hale, the integrated chronic pain management department. So I think we're going to also have Makani Tabura, who is our cultural educator, say a little bit more about himself and introduce himself.

Makani Tabura:

Hello, [Hawaiian 00:31:21] one more time. Thank you very much everybody for letting us hang out. I'm just going to get right into it. I'm going to share with you a really quick history of Waianae Coast Comprehensive Health Center. About 50 years ago, about 1970... Where we are, we're located on the west side of the island of Oahu. It's very rural. It's the largest population of native Hawaiians in the world. Within the Native Hawaiian population we have many, many other cultures and races. So we're all there. Back in 1970, our elders from the community brought... We didn't have a hospital, we didn't have anywhere. We didn't have a clinic. They brought two truckloads of sick Hawaiians all the way to the other side of the island to a medical center there. And when they got to the entrance of the medical center, they brought these Hawaiians in to be treated and the administrators came out and said, "We're sorry, we don't treat your people anymore." And we said, "Well, that was the will of the queen." And they said, "Well, it's different now."

Makani Tabura:

So that truckload of Hawaiians, we had to turn around and we went to another hospital located on the south side of the island of Oahu. We got the same welcome when we went there. And the welcome was that we did not work for the plantation, so we're not going to be serviced. So these two truckloads of Hawaiians that our elders brought over, we had nothing to do. So we went back to Waianae, and what we did is we got together with other elders in the community. And with zero money, but with aloha and the passion to help our people, we just reached out in grassroots like we do, and we created Waianae Coast Comprehensive Health Center. We went to the Department of Hawaiian Homes and they said, "We got a site of land that is just rock and dirt and you can do whatever you want with it."

Makani Tabura:

So they gave it to us. Fast-forward in 1971, Waianae Coast Comprehensive was created with one building, six employees, one nurse practitioner. Fast-forward 20 years, we realized we're working with a native population, so why are we not using our native traditional practices? The thought is that if I go to your house, I don't tell you how to clean your house, you tell me how to clean it and let me help you. So we created a traditional Hawaiian Healing Center. So today we are the only health facility or health center that has traditional Hawaiian healing, or traditional healing, and western medicine on the same campus. And I'm really, really blessed and lucky that I can be part of that cultural side of that.

Makani Tabura:

So that gives you a little bit of an idea of the health equity that we've created. Sometimes you just have to do it yourself. You can't depend on anybody but your community. With that said, I can go on and on, but I'll let Dr. Liu-Tom get into a little bit more of... I want you guys to keep in mind that just this idea of, "It takes a village. It takes a village." So with that said, Dr. Liu-Tom.

Dr. Hsin-Tine (Tina) Liu-Tom:

Okay, and we're going to now have Dr. Wright, who is the director, again, of both our Malama Recovery services and Ho'okuola Hale departments talk a little about the history of these two departments and the joint activities that the departments present.

Dr. Niki Wright:

Thank you, Dr. Liu-Tom. We work in a community with some of the most beautiful beaches in all of Hawaii, but the beauty of our lands hides the sickness, pain, and suffering of the residents of our coast. Among the top issues that the Waianae community faces, are poverty, homelessness, and substance use disorders. Over one in five individuals have an annual income less than 100% of the federal poverty level, and 7.2% of our residents aged 25 years and older do not have a high school diploma. Our community ranks among the highest in the state related to infant fatalities and teen pregnancies, and at one point we ranked the highest in methamphetamine use per capita in the entire nation. Addressing health inequities in our community has been a primary goal of our health center for the last 51 years.

Dr. Niki Wright:

Both of our departments where Makani, Dr. Liu-Tom, and I work, are a true testament to our health center's commitment to provide behavioral health equity to the community. In 1994, our Kupuna Council, or our council of wise elders, approached our executive leadership team and they asked for help for the increasing number of people, especially native Hawaiians who were suffering from addiction. They told stories of people in severe emotional pain from losing their jobs, their homes, their relationships, children being raised by grandparents and great-grandparents because their parents were drug addicted and intergenerational patterns of substance use. The nearest treatment program at that time was over an hour's drive away and many in the community were experiencing transportation issues, as is still the case today. The health center created an intensive outpatient SUD treatment program, Malama Recovery Services. And since 1994, we have helped thousands of individuals and families recover from the devastating effects of substance use disorders.

Dr. Niki Wright:

Makani and Kuku, who is not on the call today, joined our team about six years ago and incorporated cultural education and activities into our curriculum and we've seen even greater client outcomes since. Our main philosophy is that we love our clients until they love themselves. In 2017, the health center

opened Ho'okuola Hale, the integrated chronic pain management department in response to the growing opioid crisis that was affecting our state. We like to not share this fact too much, not that we're superstitious, but since we opened our doors we have had zero fatalities from opioid overdoses by working together with our integrated team, including our cultural educators. We have learned through five decades that to address behavioral health inequities, it truly does take a village, like Makani mentioned.

Dr. Niki Wright:

It requires comprehensive efforts including incorporating culturally sensitive mental health services and addressing the underlying social determinants of health such as poverty and housing instability. And Dr. Liu-Tom is here to speak more about the services our health center offers to address the behavioral health inequities in our community. And thank you so much for such a warm welcome and the prayers for Maui from the audience. Thank you, so much.

Dr. Hsin-Tine (Tina) Liu-Tom:

Thank you, Dr. Wright. And that was a very comprehensive introduction to our center and at Waianae Coast Comprehensive Health Center, improving the overall health and wellness of our racially and ethnically underserved community and assisting individuals to access effective and compassionate care, behavioral health services with equity is of paramount importance to our center center. Our efforts at increasing access to behavioral health care, decreasing barriers to care, and thereby improving healthcare outcomes are demonstrated through these engagement strategies that we've implemented. And as Dr. Wright had mentioned, we are located on a lovely, beautiful location and throughout our health center there are beautiful and serene walking trails and scenic spots that patients have the opportunity to explore and enjoy. There's a farmer's market and a restaurant at the main campus Waianae location. We also offer exercise fitness programs at our own fitness center. We provide onsite transportation to and from buildings for those patients who have mobility constraints and may have multiple appointments during one visit to the health center. Transportation to and from a patient's home to the health center is also available.

Dr. Hsin-Tine (Tina) Liu-Tom:

The patient assisted services staff are available to individuals needing assistance in understanding and applying for medical insurance, sliding scale fees, SNAP benefits, and other related topics. The case management department coordinates care for our patients with careful attention paid to high risk cohorts. We also offer interpreter services to our patients who encounter language barriers and we offer closed captioning on Mend, which is our telehealth platform for services offered at the center. I myself speak Mandarin Chinese and have conducted individual therapy sessions with Mandarin-speaking patients. And these strategies align with the National Standards for CLAS, culturally, and linguistically appropriate services.

Dr. Hsin-Tine (Tina) Liu-Tom:

Additionally, Waianae Coast Comprehensive Health Center is a major economic provider in the community employing over 500 individuals, the majority of whom reside on the Waianae Coast. This innovative strategy of employing staff providers and trained interns who are familiar with and reside within the community allows the local community to feel a sense of safety and trust in their providers, staff, and the system. Many of our [Hawaiian 00:41:02], or students, are homegrown and locally trained

and have the opportunity to gain employment at the health center after their training duration in our programs, and our health center was developed by the community for the community.

Dr. Hsin-Tine (Tina) Liu-Tom:

Housed within Waianae Coast Comprehensive Health Center are our two departments, Malama Recovery Services and Ho'okuola Hale. Our innovative integrative and holistic team-based model of care in both departments contribute to the effectiveness in engaging our community. Weekly clinical review meetings at Malama Recovery Services monitor clients' progress and challenges in sustaining the four pillars of recovery, health, home, community, and purpose. Our trained counselors and certified substance abuse counselors teach and empower our clients through the sharing of their personal lived experience.

Makani Tabura:

Sorry, Dr. Liu-Tom, we got about two minutes.

Dr. Hsin-Tine (Tina) Liu-Tom:

Okay. Weekly pain management, treatment, team meetings, facilitate care coordination across specialty and providers. Our program offers access to behavioral therapy, group counseling, native Hawaiian healing teachings, and a cultural curriculum developed by Makani, physical therapy, medication, assisted treatment. In an effort to expand our services beyond our main campus in Waianae, we have several other satellite clinics on Oahu, including Kapolei, Ewa Beach, Nanakuli, and Waipahu, which also provide behavioral health services at these locations. And in addition to the clinics on Oahu, we have made recent efforts of targeted outreach to neighbor islands and the US territory of Guam in order to provide substance use disorder, opioid use disorder, and mental health services on these islands as they are also underserved and under-resourced racially and ethnically diverse communities.

Dr. Hsin-Tine (Tina) Liu-Tom:

Throughout the month of March of this year, needs assessment partnership meetings were conducted by me and our chief financial officer, Cindy E. through tele-video and telephone sessions. We met with the key stakeholders of federally qualified health centers, other medical facilities and academic institutions. And we established eight partnerships with the islands of Molokai, Hawaii Island, Maui, Linai, Kauai, and Guam. The outreach-

Makani Tabura:

Sorry, one minute.

Dr. Hsin-Tine (Tina) Liu-Tom:

Okay. The outreach strategies were initiated with these Polynesian islands in order to disseminate an array of behavioral health treatment strategies, which have been successful at our health center and treatment, and to increase equitable access to behavioral health services based on the needs of each of these sites. And all of the collaborating islands have wholeheartedly welcomed the substance use, opioid use disorder and mental health treatment interventions. And the partnerships with the University of Hawaii at Hilo's Masters of Counseling Psychology program has already begun referring students to our training program. And this partnership will help create a pipeline of mental health professionals

trained in behavioral health treatment services. And I think that we're going to turn it back real quickly to Makani to talk a little bit about some of the lessons learned.

Makani Tabura:

We'll call it that. We've got about 30 seconds left. I just want to leave this with you folks. One of our elders said this, "By doing things Hawaiian, you begin to understand how our Hawaiian ancestors worked and thought, and you gain appreciation for our native traditions and indigenous practices." So whatever ethnicity, whatever blood, whatever culture runs through your veins, we make sure we make an effort to understand and celebrate their land, their people, and their culture. Mahalo.

Dr. Hsin-Tine (Tina) Liu-Tom:

One more last point is that we would like to also acknowledge being able to partner with the Asian American Native Hawaiian Pacific Islander Ohana Center of Excellence funded by SAMHSA. And with this partnership and increased relations offers an opportunity for us to strengthen our partnerships with the state and national level agencies to impact policy and reduce persistent racial and ethnic disparities. So again, these innovative strategies provided by Waianae Comprehensive Health Center have been implemented to ensure an advancement in behavioral health equity in a racially and ethnically underserved community. Thank you very much. Sorry to run over time.

Cori Cafaro:

No, thank you so much doctors Tina Liu-Tom and Niki Wright. Yeah. It was a wonderful presentation and I wish we could keep hearing from all the presenters today because there's just a wealth of knowledge and experience. And Makani as well, thank you so much for your words. I'd now like to transition over to South Central Foundation, Brandy Gallagher and Rachel Franzen, excuse me, will be presenting their winning strategy in the treatment category.

Brandy Gallagher:

Hello, my name is Brandy Gallagher, I'm the program manager of Benteh Nuutah Four Directions outpatient treatment center. We are one of the about 100 departments at, or clinics, at South Central Foundation. And Benteh Nuutah means, "Among the lakes, among the islands." In Ahtna and Dena'ina language. And I'll let Rachel Franzen introduce herself.

Rachel Franzen:

Hi, I'm Rachel Franzen. I'm the clinical supervisor and Brandy and I share operations. We have a joint operational structure, and so we oversee the program. Our program is an outpatient substance use treatment facility that serves individuals in the Alaska community. But I'll let Brandy take back over.

Brandy Gallagher:

Thank you, Rachel. So to start, we'll begin with South Central Foundation's vision and mission. So our vision is a native community that enjoys physical, mental, emotional, and spiritual wellness. Our mission is working together with the native community to achieve wellness through health and related services. Slide. So for our organization, health equity is about access and access and services that can address the whole person and is culturally appropriate and respectful for the individual. SCS Founding mission is based on health equity for services and programs provided over the last 40 years. South Central Foundation opened in 1982, so we just recently last year celebrated our 40-year anniversary. South

Central Foundation has four major components in which our services are based on and ensuring operational excellence is shared responsibility, commitment to quality, family wellness and operational excellence.

Brandy Gallagher:

SCS's measurement for success goes beyond the individual. It includes whole families and whole communities and towards multidimensional wellness or whole person wellness. The improvements that we carry now and the voices, the feedback that we receive now, they're given back to the community and improved at South Central Foundation for generations to come. So we really value that family is the heart of the native community. The heart of our system or our approach to care is called the Nuka system of care. So this is primarily based on Alaskan native values and traditions. The methods and models that we employ highlight and bring ancient traditions forward in practices like storytelling, frequent gatherings, learning circles, whole person care and environmental responsibility.

Brandy Gallagher:

South Central Foundation recognizes that multidimensional wellness is most successful in a relationship-based system, so we take a relationship-based approach. Every employee at South Central Foundation goes through a three-day training. That's called Core Concepts, and that is about creating relationship with the... We call them customer owners instead of patients. And working with each other as employees and as a work team in support of the customer owner and their healthcare. Go to the next slide, please.

Brandy Gallagher:

So as an overview, south Central Foundation provides primarily healthcare and behavioral healthcare. We also have specialty services such as optometry, dental, neuropsychiatry, and traditional healing. It serves over 65,000 Alaskan Native and American Indian people to all those who qualify. We also have multiple rural clinics in the villages, and we do also see a handful of the clinics also service everyone in the community, so not just Alaska Native and American Indian people. So South Central Foundation is a tribally owned and managed healthcare system. As I said, we have over 100 departments and our department specifically... This information is on the right. So our community specifically is in the Matanuska-Susitna borough. It's the size of West Virginia, so very large for the area itself. It's a widespread with low transportation, or low public transportation, so we'll get to that here soon.

Brandy Gallagher:

Oh, sorry, go back one more. So a lot of the residents in the community come from across Alaska. The borough that we live in is gorgeous, has a lot of fishing and hunting land in comparison to some of the larger cities nearby. So with that space comes lack of jobs in the area as well. So median income for an individual is 30,000, and the cost to live in this part of Alaska, really all of Alaska, is pretty high for shipping food and utilities, the cold weather we get and all of those things. And go to the next slide.

Brandy Gallagher:

So some barriers to engaging in treatment, we are... I guess we'll back up just a little bit. We have been open for almost two years at this clinic specifically. So we opened November 2021. Prior to this, the Matanuska-Susitna borough residents here who were Alaska Native, American Indian, would have to travel an hour to receive substance use treatment. So that was a huge barrier. So trying to get over that, we opened up this clinic November 2021, and we have been growing since. What we've noticed in our

community is inadequate or lack of childcare to come in. Maybe a lack of finances to pay for childcare, lack of housing or a stable environment, lack of transportation, lack of public transport. Some have no licenses or no vehicles or no gas money, and it is a very widespread area. Many people also have no health insurance, lack of basic needs such as medical care, healthy food, basic housing.

Brandy Gallagher:

There's also the stigma that comes with substance use treatment sometimes is that fear of judgment or stigma, having family or friends find out, potentially they're worried about losing their jobs. There can also be language or cultural barriers. And then ensuring that we're keeping the cultural relevance for participants. And just a lot of other unknowns or other fears, or the unknown. What's it like? Maybe their support system or their friends are... That's just what they do, and so they don't want to give up the thing that is their social connection. So those have been the barriers that we've seen here and we have been working on a handful of ways to address that. So language and cultural barriers, we have access to an interpreter that can help with any communication barriers that we have here.

Brandy Gallagher:

We also have an employee who works specifically on helping people sign up for health insurance if they do not have any health insurance. We also offer a sliding fee scale and the amount goes all the way down to zero if they qualify. And if they're Alaska Native or American Indian, we are a IHS facility, and so they can come here at no cost for any of our services. We also have case managers who help with public transportation if needed. We work on Medicaid cab vouchers, but we also have a vehicle here if that's something that they maybe barely qualified for as Medicaid. And before I get into more of the details, we'll go to the next slide and Rachel will share a more thorough approach on our treatment. So with that I hand it over for Rachel on treatment creates or negates access.

Rachel Franzen:

Yeah, so the idea for this is that the way that we structure our treatment program, we were incredibly thoughtful in ways to ensure that we were creating access, not negating or not preventing access. So on the next slide we can move to. So essentially reducing barriers to treatment begins with us and we hold a philosophy or a core assumption that nothing needs to be a barrier or nothing should be a barrier. So ways that this can look will be we don't require an invasive assessment to start. We offer a consultation without commitment, meaning that people can come in and have a brief intervention and we'll get more into the nuts and bolts of the program, but they can start off with a licensed mental health clinician and make sure this is a good fit. Maybe they're here because they have to have an assessment and they don't need treatment, or maybe they do or maybe they're not quite sure.

Rachel Franzen:

We also offer case management without commitment. So we start with brief intervention and case management services, not only to help people with getting the things they need to come to treatment, but also getting the things need in life like housing, and food stamps, and other resources that will make them more successful in treatment. We've offered, as a result of COVID, telehealth now. So when transportation is a barrier, when someone can't take off the half hour to drive here from work, telehealth services are also a way of meeting people where they're at. It's also a way of trying treatment without showing up. Alaska is a small community and we're across from the bowling alley. People will see your car in the parking lot, those kinds of things.

Rachel Franzen:

As well as transportation support. So when it's an important assessment, when it's time for an assessment, if we need to pick you up, we can pick you up. If it's time to go to detox, we can pick you up. We also try to do flexible scheduling and individualize the program and then do financial assistance when needed. So if somebody really needs their license. We also don't require sobriety. So moving to the next slide that use needn't be a barrier. Because of our programs view that nothing should be a barrier and we want to meet people where we're at, I used to think of it as harm reduction, we're really life promotion. So life promotion and that idea is what we've integrated into something what we call the Path to Healthy Living Program, or Path to Healthy Living model. It's strengths based and it's culturally focused and tailored. It respects and responds to the individual person in the context of their health, their needs, their values, their community, family. And the central philosophy is that use is a symptom, not a problem.

Rachel Franzen:

It can become a problem over time because anyone addicted to substances relies on it as a primary coping tool at some point. And what we as providers must do is recognize that before we take away that substance or before we even begin to talk about taking away that substance, we have to work on the things that will address that underlying issue. So we start focusing on goals. So our Path to Healthy Living program is individually tailored. It infuses motivational interviewing, solution focused therapy, cognitive behavioral, some other integrative techniques along with an indigenous model of wellness. So going to the next slide, a little bit more about path to healthy living. We recognize that treatment is scary, that sobriety is scary, and substances serve a purpose to people.

Rachel Franzen:

So while traditional approaches might have people have to stop first or hit rock bottom, we are not going to require that and then hope that they simultaneously create their life. We will help them to create a life worth being sober for. And that then helps them to be able to have things that are meaningful that naturally are times where they're more sober in life. And we hope, and often what I find, is that participants learn through that that they want to be sober for that, they want to moderate their use. But the goal is never about moderation or abstinence, it's wellness as the individual defines it, where the person no longer needs to escape life or use in order to experience life.

Rachel Franzen:

So if we look at the next page, it shows our Path to Healthy Living model. And so if you look on the right side of the screen, the detours, that's essentially traditional relapse prevention. These are my detours, these are my triggers, these are the way they show up, and these are my coping skills at the bottom, the tools to returning to your path. And what we do is we don't focus on that side. We focus on the left side first. What are your goals? What are you already doing that's creating meaning? And what are your values? Because values we can use to leverage change, right? Oh, go back. Yeah. Values will leverage change. I may not want to go to the gym, but if I think about going to the gym because I want to spend time with my family and actually be able to run around with my three-year-old, I'll go to the stupid gym, right? Because wellness is a goal if I think about my family.

Rachel Franzen:

So our focus is over and over really focusing on goals and when detours come up, figuring out is the detour behavior the substance use? What's the underlying detour, is it pain? And the tools to return us

to our path are not focused on just reducing detours, but really getting people back, moving towards their goals, the things that create meaning in life. Now go to the next slide. So this is a treatment roadmap. So as I mentioned, they started a first session. It's no referral, no paperwork. It's the expert model of care. We focus on increasing readiness. We give them some drop-in group, case management needs, anything that helps them get ready. When they're ready and they're willing and they're interested, we'll do an assessment. They'll start working on their goals as soon as they come in, but we really start working on it a lot in phase two. They address their mental health needs, they can do trauma work, EMDR, all of the evidence-based treatments.

Rachel Franzen:

When they have a path for wellness, their Path to Healthy Living plan is complete, they'll present it. It's a group model of care and they'll present it and they'll pass, and they go into phase three where they transition their recovery to the community. So then they bridge, we don't call it graduation, we call it bridging because we believe that you don't graduate from addiction. You have times where you might struggle a little bit more and times where you don't. And if you're struggling, you can just bridge back in. All right, next slide.

Cori Cafaro:

And I'll just jump in real quick. Rachel, we've about one minute left, so we'll wrap up as much as possible. Thank you.

Rachel Franzen:

So our outcomes are really about self-discovery, trying to help people experience life and experience wellness. And through experiencing wellness and having that positive connections and relationships, they're actually able to avoid use of substances while not even focusing on that as the focus of treatment and developing those skills necessary to achieve goals long after treatment. So next slide. So other innovations we've done are outreach and engagement. So we've met with individuals in the community, other substance use providers. We've offered Narcan kits at tattoo parlors and wound clinics, sought out needle exchanges. We also offer a craft style group called Family Supporting Change. That's for family members who have a loved one who's struggling with substance use. It's completely free, no commitment. It helps them to reconnect with their loved ones, and it also gives them support as well as tools that increase the likelihood of that person will engage in treatment, but it really is for that loved one.

Rachel Franzen:

Then lastly, for me, helping stay engaged. So we commit to participants through a contingency management program for the first 16 weeks of treatment. Next slide. So that offers incentives, things like toys, coloring books, fishing gear. It's not abstinence based. We don't do UAs really, unless people want one. It's attendance based. We're trying to get them here. We're trying to help them show up. When they show up, they get a point, and if they spend and they get a reward, then they get some stuff and then they can internalize that over time. And then again, we also help with transportation beyond just Medicaid vouchers. We'll drive someone to the DMV or help them get into the dental clinic that they've been scared of. Things that are going to become a barrier to them, we'll commit to helping them stay and helping them get what they need, and get jobs and all those pieces. So lastly, let me turn over really quickly to Brandy to measure our efforts.

Brandy Gallagher:

Yeah, I know we're at time. Just a quick overview is looking at our retention rate, learning circular group attendance, looking at our appointments and schedules and just how much more filling we might be. We also look at a lot of feedback, customer owner feedback and employee feedback. We do an annual employee survey and we do customer owner surveys as much as possible. It can be on a specific person, it could be after a group. So that's really measuring how their success here. So if the customer owner succeeds here, then we are happy because it is customer owner focused treatment and I'm just hoping that they can help spread the word out as a newer clinic for just under two years. And with that, thank you all for your time and presentation.

Cori Cafaro:

Thank you so much. And we have our final presentation today, Paul Smokowski of North Carolina Youth Violence Prevention Center, and they are winner in the mental health category. Oh, hi Paul. I think we've got you muted at the moment.

Paul Smokowski:

There we go. There, thank you. I'm Paul Smokowski and executive director of the North Carolina Youth Violence Prevention Center, and we want to express our gratitude for SAMHSA's... And this award, being able to also be integrated in this webinar. Thank you so much. Next slide. We're also working with a really very unique community context, like my colleagues. In the lower 48, we're one of the most ethnically diverse counties with a diversity index of 73.5. The other 14 counties that are more diverse are actually in Hawaii and Alaska. So we are a very large rural county in North Carolina. It's the historical home of the Lumbee Indian Tribe, which is not a federally recognized tribe, but has very strong cultural lineage and roots in history within this area. The area unfortunately also struggles with high levels of violence and crime that are connected to high rates of poverty. So these are some of the statistics with violent as well as property crime. Next slide.

Paul Smokowski:

Great. So this is just visually, you can see the blue line is Lumberton, North Carolina, the only metro area in this 900 square mile radius county. And Lumberton would be the 7th highest level of violent crime per thousand residents in the country. So you can see on the left-hand side, some rural areas are markedly struggling with crime and violence. Next slide. So in 2018, I want to shout out to our team. I'm the grant writer, but this team makes this work that I'm going to tell you about actually. So successful, Martica Ballao is our Director of Victim Services, Ashley Prows-Beard, Brianna DeDeaux, Stephanie Edwards, Emily Locklear, and many partners. Those are our therapists, our trauma-based therapists, and we call our program the Victim Education and Empowerment Project. Next slide.

Paul Smokowski:

Great. So in 2018, in order to counter the high levels of violence and crime, we received a state grant to provide free mental health services for victims of crime. And we did all the things that are in the literature to do. We hired social workers from the county. We were ethnically, racially reflective of the community and we built this strong program and we still struggled with referrals. Like Pastor Williams had said, there's high levels of mistrust in our community, a great deal of stigma against mental health and behavioral services. So over the past five years, we've created a multi-tier program of supports in order to try and bring folks further into, warm them up into working with us for behavioral health equity. Next slide.

Paul Smokowski:

This is what the three tiers look like. The first one is Mental Health Literacy Training, which is in the community. We're doing events in the community to raise awareness of the signs and symptoms of youth mental health problems. The second tier has to do with a less traditional approach. We turn to the expressive arts to try and engage kids at a high level in order to make those relationships that would then lead them to trust us enough and their families to be invested in bringing them and trusting us to be able to serve them with trauma-focused psychotherapy, which is our highest level of services for youth in need. Next slide. This is simply the Youth Mental Health First Aid model. We won't talk about that very much. It's to raise awareness of mental health symptoms and how do you engage youth in talking about crises that they might be going through. Next slide.

Paul Smokowski:

We also augmented that or complimented it with the Community Resilience model. That model has more content on trauma and adverse childhood experiences and the stress response, and it gives six very simple skills on how youth can help themselves when they're feeling the stress and triggered. Next slide. So these are just some basic satisfaction numbers. I'm not going to read them, but you can see 96% of those who participated in this training said it better prepared them for their work with youth. At the beginning, 85% really didn't feel comfortable talking with youth, but after the training, 100% said that they would be confident in being able to engage youth in these discussions. Next slide.

Paul Smokowski:

Now, one of the innovative outreach approaches that we did was called Paint Parties. This is not art therapy, it's a positive youth engagement enrichment community event where youth come together and each month we have a life coach, who's also an artist, who will facilitate the group and we have therapeutic themes that they will focus on in creating their paintings. So I've given you a lot of pictures as examples of youth who, during this activity, they're very proud of what they're creating and they really enjoy bonding with each other while doing a really creative expressive activity. Next slide.

Paul Smokowski:

There we go. So the themes that you do each month, we tailor those to both cultural and contextual issues. So for example, owls and other animals as protective creatures, they might paint an animal that they have particular synergy with. Or at Mother's Day we bring mothers and their children to paint together. In the spring we might do buds and blossoms. What do you want to grow within yourself, within your community? And they create these paintings based on these therapeutic themes. Next slide. We did this virtual during the pandemic. So that broke down the geographic barriers that my colleagues were also mentioning, and it let youth in their bedrooms or in at the kitchen table be able to connect and get outside of that isolation that we saw during the pandemic. Next slide.

Paul Smokowski:

What we found in our satisfaction surveys is that 97% of youth enjoyed being part of this group experience. Next slide. And here you can see some examples. Youth, 94% said the facilitators were encouraging and creative. And this is really key because those were the same facilitators who would nurture them into trauma-focused treatment if they needed it. Next slide. So 97% of our youth found the themes that we created for the paint parties, they enjoyed the themes. Next slide. And they found this experience very relaxing. So it really helped with the trauma and stress in their nervous systems for this to be able to give them an outlet, a release for all that pent-up stress. Next slide. So we had a

second program. We wanted to also go into the school district and have larger groups of kids. So we created what we call SEE IT, which is Student Expression and Empowerment through Interactive Theater.

Paul Smokowski:

We started with bullying prevention because that's such a large youth violence issue for us. So we would have actors that you can see in this picture, members of my team, and they would go in, we would get the content from the audience of youth and they would suggest characters, conflict situations, the setting. We would act it out. And the key here is that we would stop at different times and they would give what happens next. So then they would have to use problem solving to move through the narrative that they were creating. Next slide. And here you can... Well, the previous slide. I just want to mention, here's the last two things with this. 87% of kids told us that, SEE IT taught them how to solve problems, and another 86% said it was helpful in teaching them how to handle conflicts. Those were key outcomes within our community. Next slide.

Paul Smokowski:

So the last or highest tier, I'll just go through this very quickly because people are very familiar with it. We would bring kids in for trauma-focused psychotherapy such as TFCBT, and we would try and infuse this evidence-based treatment with as much creativity as possible based on our other programming. Next slide. And here's some examples of youth actually drawing where they felt stress in their bodies and then working through that with their counselor. Next slide. And this is the triangle that everyone knows with thoughts, feelings, and actions. They would be analyzing their situations with that. Next slide.

Paul Smokowski:

And it would all build into a trauma narrative, similar to the SEE IT scenarios that we would do. This is having them individually now work through their own trauma situations and try and come to some coping and resolution. Next slide. We're going to go very quickly. Each summer we have a Colors of Life summer camp where we take all of these activities together. Next slide. And we put all of these therapeutic activities for kids at no charge, bringing them into a setting where they can bond with each other, make relationships, and again, that idea of life promotion that my colleagues talked about. That's what we're trying to do here. Next slide. And we bring in leaders from the community to talk with them. Next slide. And we do special field trips. Sometimes they've never seen the ocean, but it's 45 minutes away. We'll take them to the beach, we'll take them to the county fair.

Paul Smokowski:

Next slide. And this is what I'm going to leave you with. Here is the major data. In 2018 when we started, we struggled. We had 20 clients and we were able to do 125 sessions with those 20 clients. Last year that ended last fiscal year, so June of 2023, we had 1,750 clients and we were able to do 2,341. So that is 18 times the sessions that we started with and 87 times the clients that we started with. And that I think I want to thank my team because that's enormously difficult work that they were able to really make this so successful. Thank you.

Cori Cafaro:

Thank you so much, Paul. Now we'll go to Q&A. I know that we have about nine minutes left, which is kind of a short time for Q&A, but we did get some good questions. I want to make sure the panelists

have a chance to answer. I'll also recommend that if the panelists would like, they can drop their contact information into the chat box, making sure it's directed to everyone who's participating, so that way folks can send follow-up questions if they wish. Okay. So the first question we have, and this is for everyone who's in participation, or everyone who presented today, is about the national culturally and linguistically appropriate services.

Cori Cafaro:

So these are our end CLAS Standards, which might be new for a lot of folks, but we'll drop a link into the chat momentarily to give you more information about what they are. The question is, to any of the panelists, "What percentage of your efforts relied on the implementation of the National CLAS Standards internally within your individual organizations?" The person's interested in knowing if this was an aspect to your success or something you considered. And if you didn't use them, then that's helpful information as well.

Paul Smokowski:

Cori, I'll defer to others because we really weren't using those standards at the time.

Cori Cafaro:

Yeah, I appreciate that. Anyone else want to jump in? Okay, I will go ahead and jump to the next question. And I think this one will definitely tie into a lot of the work people are doing. So we had a question about youth. Is there a youth component to your programs? Clearly, Paul, yours is all about youth. But the follow-up question is, "Are there any youth led aspects of your programming for any of the panelists? How are the youth programs implemented?" We could gear this to the other panelists who haven't spoken much about youth as much.

Makani Tabura:

I want to share a quick story about youth. I was working with one of my youth clients and he came to me because he said he didn't want to be Hawaiian. It kind of broke my heart and I said, "What do you mean?" So he started to describe to me, he says, "Well, I see my dad. My dad is at the beach and he's buried in sand and something is going on with him and I think he uses drugs, and that's what it means to grow up being Hawaiian." So he correlated being Hawaiian to being addicted to drugs, he didn't know the difference. What I did with him, I took him in the back of my office. I have a lot of Hawaiian games, so I had him throwing spears and he started hitting the target and getting it. I said, "You know why you can do that? Is because you're Hawaiian." Something as simple as doing a cultural game or a cultural concept. Don't sit him down in the room and talk to him and try and explain to him, just take kids out and do what kids do.

Makani Tabura:

For so long as adults, we think we know what they're thinking. We don't. So if you just take them outside and say, "Hey, try this." So a lot of our programs, I work with youth, and this is going to sound really crazy, but a program I grew up doing, my mom, we would take... Kids at the time, we called them at risk. And we'd drop them off on our farm in the back of a valley and we'd just leave them there and we'd come back the next day. Anybody, any child, any person will change when they're in survival mode. So it's a little bit harsh, but sometimes we have to do it for today.

Cori Cafaro:

Thank you so much, Makani.

Carlton Williams:

For us with our youth, we had a special component of the Youth Mental Health First Aid training that we take the young people who were mature enough to go through and then they would become our ambassadors to facilitate the first aid mental health training to other youth. We also had youth do messages, the ones that were identified in their school settings and on social media as well.

Cori Cafaro:

Thank you. Any other presenters want to jump in before I move on to the next question? Okay. So our third question, and this is actually Pastor Williams, you're already on the screen, so it's great because it's about Mt Olive Baptist Church. So this audience member is asking, "Where did you start? How did you bring together so many organizations to offer services at one location? How did you compile all these resources at the very beginning?" And then they also said, "This can go out to other presenters as well after you've a chance to speak."

Carlton Williams:

Initially, it started with my work with the Urban League when we were doing some work. This is before the inceptions of One-Stops across the country. What we recognized and what they recognized is that if you could provide services to your clientele in one location, they were more apt to surrender themselves to the services as opposed to traveling all over town. So the Mt Olive One-Stop model is a direct result of the whole One-Stop concept where we just went out and we found people who provided the services that we didn't to see if they wanted to partner with us, maybe be housed in our location. Public health, we have a testing lab in the church, which is unheard of, but we were able to pull it off. And a lot of people come to the church for HIV testing, Hep C testing, other kinds of health screens. So it's just finding those community partners that are vested in community and are good, either corporate or community citizens, they'll partner with you. So that's where it started for us.

Cori Cafaro:

Thank you so much. And I know we heard from our folks from Hawaii, how their organization started, how they got the resources together. Any other presenters would like to speak up about this?

Makani Tabura:

I just want to add that I think the bottom line is don't wait for anybody. I'm going to use a very difficult topic right now that everybody's familiar with on Maui right now. We didn't wait for anybody. We had to do it ourselves. We have to do it ourselves. It sounds really weird to say, but a fire and destruction is no different than people in addiction. We can't just leave them and wait for somebody else, even without resources, it's possible. The question we always ask is, "What did our ancestors do? What did our ancestors do?" And I think that should be motivation enough just to do it. We have to demand it. Let's stop asking and let's just demand it. Mahalo.

Cori Cafaro:

What wonderful words to end these presentations on. Thank you so much, again. I'd like to thank all of the people in the audience who are seeing this live or a recording of the event. Thanks for joining us and we'll be sharing related resources, including the recording, once available, on the NNED share site. We'd

also like you to provide input on this event to help us plan for future NNED offerings. We're always trying to make improvements as we go along. And then lastly, on behalf of SAMHSA's Office of Behavioral Health Equity and the National Facilitation Center, we want to acknowledge and thank everyone for being here and thank all the challenge winners as well for sharing about their work today. You can learn more about the challenge winners at the link that's going to be provided in the chat. Okay, thank you.