

# Module Five

## The Cultural Context of Prevention

### Time

The anticipated time for this module is three hours.

### Learning Objectives

Participants will be able to:

- Understand key definitions related to culture and diversity
- Share parts of their own culture and learn about parts of other participants' cultures
- Discuss the dominant cultural values and beliefs in U.S. society that both encourage and discourage alcohol, tobacco, and other drug (ATOD) use and abuse
- Discuss dimensions and elements of culture and diversity and their relationship to prevention planning through the Strategic Prevention Framework (SPF)
- Describe why and how prevention professionals should be knowledgeable about and committed to addressing issues related to diversity
- Describe why and how prevention programs should be responsive to the diverse needs, histories, cultures, and strengths of all groups that the program serves
- Describe key skills and practices that utilize diversity as an asset in prevention program planning and implementation

### Materials and Preparation

1. Prepare an overhead projector or LCD Projector with the appropriate slides.
2. Be ready to use the following information and work sheets:
  - **Some Elements of Culture**
  - **Key Definitions in Diversity Work**
  - **Similarity and Diversity**
  - **Values of Dominant U.S. Culture**
  - **Our Files**
  - **Adultism**
  - **Requirements of a Culturally Effective Prevention Professional**
  - **Building Culturally Effective Prevention Programs**
  - **Where to Go to Find Information about Communities**
  - **Assess Your Own Organization**
3. Prepare blank colored paper for each participant and colored markers for each table.
4. Make copies of the U.S. values signs for posting around the room.

### Format of Facilitator Notes

Trainer instructions are in *italics*. Suggested narrative is in normal font.

### **Integrating the SPF throughout the SAPST**

*Cultural competence, along with sustainability, underscores the SPF. Without understanding and attending to the needs of the communities, prevention strategies implemented will not be successful. If people's needs are not met, if they are not actively engaged in the development, implementation and assessment of interventions, they are not likely to be invested in efforts. Community investment in prevention efforts is a key to long-term success, changes in population level outcomes and the sustainability of these outcomes.*

## Unit 1: Culture and Diversity (20 minutes)

### Slide 1

*Introduce facilitators and make opening statement about this module.*

I am really excited about the opportunity for us to go through this module together today. This module is a little different from the other parts of the SAPST training. No matter how much experience you have in prevention, we all have a lifetime of experience living in a culture or cultures, so it is likely that we will have personal feelings about this topic. This module is about asking you to do some work to translate your personal knowledge about culture into some skills that will help you to increase your competence in your specific role as a prevention practitioner.

*Depending on the dynamics of the group you may want to review the ground rules from Module 1, as well as ask for and make additions as necessary.*

### Slide 2

*Show slide, **Expectations**.*

What do you think of when you hear the word “culture”?

When we say that we are going to talk about culture, what are your expectations? What words, topics, and/or information do you expect to hear?

*Record participant responses on chart paper or white board.*

### Slide 3

*Show slide, **A Definition of Culture**.*

The important thing to remember about culture is that it is collectively agreed upon and that it is something that is learned. There are many different dimensions along which groups may vary. This variety may be indicated through external signs or symbols, behavior or practice, or written or spoken communication. Some elements of culture cannot be expressed in words/intellect but can only be known through feeling.

*Refer participants to the worksheet, **Some Elements of Culture**.*

### Slide 4

*Now expand the discussion to the topic of diversity. Show slide, **Dimensions of Diversity**.*

What does diversity mean?

*Elicit some responses from participants.*

Diversity is defined as differences in qualities, attributes, or conditions that are **socially defined as significant**. For example, skin color may be seen as significant in our society, but whether or not you have detached earlobes is not. Even though we may use the terms interchangeably,

diversity is different from culture in that culture is collectively agreed upon, learned, and inherently meaningful to its members. On the other hand, categories of diversity may be imposed from outside of the group itself and may not necessarily have a collectively agreed-upon inherent meaning for group members. At the same time, these categories of diversity may have real social and political consequences for their members.

*Refer participants to **Key Definitions in Diversity Work**. Ask them to consider the following questions in pairs or trios:*

Review the definitions and answer the following questions: Which definition or definitions are most relevant to your current work in prevention? Which definition or definitions do you want to learn more about in order to be more successful as a preventionist?

*Ask for a few examples from the groups, answering any questions about the definitions. Many of these definitions are derived from recent developments in the study of culture, identity, and social inequality. Reference materials for facilitators can be found in the resources section of the participant materials and at the following websites:*

*<http://www.unlearningracism.org/writings.htm> and <http://www.newsreel.org/films/Race.htm>.*

## Slide 5

*Show slide, **Why Study Culture and Diversity?***

Why would we, as prevention specialists, study culture and diversity?

*Look for participants to emphasize the following points:*

- *To most effectively assess community needs*
- *To increase the resources available*
- *To plan effectively to meet community needs*
- *To implement strategies appropriate to the community*
- *To better evaluate the effects of the prevention effort*
- *To empower community members to sustain prevention efforts*

The study of culture and diversity allows us to explore both similarities and differences that exist within a community. This is not about learning the “right” facts about certain groups. Even though we may identify specific groups within a community, it is likely that there will be as much difference within an identified group as between groups. The goal is to learn how to continually build our ability to learn about and use similarities and differences as assets in prevention work.

*Refer to the information sheet, **Similarity and Diversity** and encourage participants to use it as a resource.*

**Unit 2: Self Awareness: Our Cultures, Our Society, Our Profession (60 minutes)**

## Slide 6

You will now have an opportunity to share with each other some pieces of your own culture's beliefs and expectations about health and wellness. You will do this by making a group quilt.

*Show slide, **Quilt Activity Instructions**. Provide each person with a quilt square (a blank piece of colored paper). Place several different colored markers at each table. Have participants draw a picture or write words to depict a value or belief of their own culture that relates to health and wellness. They are to write their names on their quilt square if they are willing to answer questions about their picture and leave their names off if they want their picture to stand without explanation. Allow 5 minutes drawing time.*

*Have participants tape their squares into columns and rows on the wall.*

Would anyone like to describe his/her quilt square?

*After about 10 minutes of sharing ask the group:*

What common themes do you see?

How might you use this type of activity in your work with communities?

### **Slide 7**

In addition to all of the cultures with which we may identify and the messages that we get from those cultures about substance use, prevention efforts in the United States are framed by the larger context of values prevalent in the U.S. We get many messages about substance abuse from U.S. culture, some of them conflicting. One participant in a past SAPST training made a quilt square that is a great illustration of these contradictory messages.

*Show slide, **Conflicting Messages about Substance Abuse**.*

### **Slide 8**

*This next activity can be viewed as a counterpoint to the quilt exercise where participants explored the values that are most relevant to their own cultural context. It is also a preparation for the exercise which follows when participants are asked to generate values specific to the prevention field. Because, in these activities, participants talk about the ways that these values can both promote and discourage substance abuse, we get to talk as a class about how these values may not work for different cultural groups. Since participants are not at all asked to accept this list as values that they find personally meaningful, open discussion is facilitated which typically defuses potential resistance to this list.*

We are going to take a minute to discuss these contradictions further by looking at some values prevalent in the United States and the ways in which they both encourage and discourage substance use and abuse. Through multiple studies over many years, social scientists have found that there is a core set of values present in the dominant U.S. culture. This list of values comes out of one of the most widely used Introduction to Sociology textbooks, authored by John Macionis, and is a compilation of a volume of different research done over the past few decades. They are values of and largely benefit the dominant U.S. culture. These values are expressed regularly in many of our social structures, media, etc. Although we all exist within this cultural influence, we negotiate or interact with these values in many different ways. Not all of these values are meaningful for all individuals or groups. However, living in the U.S. and working in

the field of prevention in the U.S., especially with U.S. federal funding, these values are present in and around the work we do. As you look at these values, begin thinking about how they support or discourage substance use.

*If participants ask for a definition of Group Superiority, explain that this is the idea that some groups are inherently better than others. Acknowledge that we see this play out in all kinds of discrimination that is institutionalized in our culture - racism, sexism, etc. Participant responses to this value can open the door for us to acknowledge the presence of discrimination in the US.*

*Show slide, **Values of Dominant U.S. Culture** and refer participants to the information sheet of the same name.*

### Slide 9

In this next activity, when we talk about substance use we may be talking about problematic behaviors like drunk driving or healthy behaviors like using prescription medication appropriately.

*Show slide, **U.S. Values Activity Instructions**. Post the values signs around the room, with one of the U.S. values on each sign. Give participants a minute to review these posted values signs, and then ask participants to go stand by the value that they feel most **encourages** substance use or abuse and then to discuss their choices with the other participants who have chosen the same value. Ask for reports from each group about why they chose a particular value. Now ask participants to go stand by the value that they feel most **discourages** substance use or abuse and then to discuss their choices with the other participants who have chosen the same value. Ask for reports from each group about why they chose a particular value. Ask participants to return to their seats.*

### Slide 10

We have moved from discussing the values and norms that are most specific to us as individuals, to discussing dominant societal values that we all interact with to some degree. Now we are going to discuss the culture of a group to which we all belong. We all are members of the culture of substance abuse prevention practitioners. Membership in this group carries with it its own set of rules, values, expectations and norms.

Think back to the information in Module 1, the Historical Overview of Prevention, and the exercise covering the various “Viewpoints of Prevention” that you were asked to role play.

*Show slide, **Viewpoints of Prevention**.*

Can you think of any other viewpoints or roles we should add to this list? *Write additional viewpoints on easel paper.*

What are some examples of these viewpoints in action?

Since communities with which we work are probably also aware of these and other examples of these viewpoints in action, what assumptions might they have when we come to them and say “Hi, we’re here to do a substance abuse prevention program”?

*Look for the following points:*

- *Various individuals and communities may assume that they will be treated negatively or have assumptions made about their substance abuse patterns by prevention practitioners based on past/present treatment of their group.*
- *Viewpoints/practices may be seen as coming down from powerful political or intellectual players in the prevention field*

As we talk about the assumptions that individuals and communities may make about us as preventionists, we can now also start talking about the assumptions we may make about the individuals and communities with which we work.

## **Slide 11**

*Show slide, **Our “Files”** and refer participants to the information sheet of the same name.*

All of the assumptions, beliefs, knowledge and values that we have acquired about substance use and abuse, from our families, our own cultural groups, the dominant culture of our society, and our profession combine to create a “file,” or “record” that constantly plays in our head and influences our decisions and behavior as preventionists. The important thing to remember about these files/records is that everyone has them, they can’t be avoided. However, it is our responsibility as we work to become effective prevention practitioners, to be aware of and actively manage these files/records. The following exercise is an opportunity to further explore how we can discover and effectively manage these files/records.

Many of us in helping professions work really hard to suppress negative, discriminatory, or prejudiced attitudes we have heard or seen, especially as they concern the clients or communities with which we work. Sometimes, however, it is important to take a closer look at these files/records in order to improve our ability to manage them effectively.

We are going to practice examining our files/records about a group that receives a lot of focus from the prevention field (*don’t name the group yet*). I am going to read some different names used to identify this group. Please write down the first word that comes to your mind when you hear each name. You will not be asked to share your specific responses.

*Read the following list:*

- Young people
- Juvenile
- Youth
- Children
- Adolescents

*Many participants feel uncomfortable about what they feel is deliberately making assumptions, so it is important to acknowledge this discomfort and to remind them again that we ALL have files/records, although we may have already become pretty good at managing some of them. However, because self awareness is a never ending process this type of exercise is one way to go back and re-inventory these files/records and to learn even a little more about ourselves.*

Reviewing your list of reactions, what impressions that come to mind in regard to them?  
Were your first reactions either all positive or all negative?  
Can you identify the source of some of your first reactions?  
What are some things that you already do to manage your files/records?

### Slide 12

*There is a concept that is useful for summarizing the negative records that exist in our society about young people. Show the slide, **Adultism**. Refer participants to the information sheet, **Adultism** and briefly review its contents.*

What are some examples of the most extreme disrespect and devaluation of young people? (child abuse, child slave labor, child soldiers)  
What do you find useful or interesting about this concept?  
What do you find troubling or problematic about this concept?

### Slide 13

*Show slide, **Interrupting Adulthood Activity Instructions**.*

Divide into pairs/trios and think of at least one example of Adulthood, preferably in prevention work. You may be expected to do a short role play of this example for the class.

*Give groups about 5 minutes. Ask for one or two groups to volunteer their role play for the whole class. Give preference to groups that have examples that actually involve substance abuse prevention work. After the role play, ask participants to problem solve ways that we as prevention professionals can better manage our files/records about this group and could help other prevention professionals to do the same thing. Suggestions may include:*

- *Examining the specific personal experiences we had that created these files/records*
- *Working to have as many positive experiences as possible with as wide a variety of people as possible*
- *Listening to other people's stories about how other's files/records have affected them*
- *Seeking out skills that will improve your communication skills with different groups of people, instead of feeling guilty about having certain files/records*
- *Working to build bridges and create allies*
- *Assuming nothing – asking questions instead*

Our culture's assumptions about youth and substance abuse issues can also work to obscure legitimate needs for prevention programming for other age groups. The Strategic Prevention Framework emphasizes the importance of prevention programming across the life span and the prevention field (and funding) seems to be moving in this direction. What groups at higher risk for substance abuse might we miss when we assume that only youth abuse substances?

## Unit 3: Valuing Culture and Diversity in Prevention (60 minutes)

### Slide 14

*Show slide, **Cultural Competence for Prevention Professionals.***

As prevention professionals we act on the assumption that all communities have cultural elements that act as protective factors against substance abuse.

*Refer participants to the information sheet, **Requirements of a Culturally Effective Prevention Professional.** These requirements are some additional ways that you as a prevention specialist can effectively manage your records. Circle those requirements you think you meet fairly well. Then make a check mark next to the elements in which you would like to increase personal skill. Is anyone willing to share some of their thoughts?*

### **Slide 15**

*Show the slide, **A Culturally Effective Prevention Program.***

We have discussed how prevention professionals can become more aware of diversity and culture. Now we are going to examine how prevention programs can become more adept at effectively managing issues of culture and diversity as part of prevention planning.

### **Slide 16**

In Module 3 we discussed the Strategic Prevention Framework (SPF).

*Show slide, **Strategic Prevention Framework** and review the steps.*

*Illustrate how culture influences the implementation of the SPF by sharing an example from a community with which you are familiar, or by sharing the following example: Let me share an example from one community.*

*Assessment: In this community, there was a history of data being used to reinforce cultural stereotypes and focus on negative norms and behaviors. Trust in assessment processes and recorded data had been compromised. Community members were willing to discuss concerns, but resisted data publishing. Traditional scientific quantitative assessment was not culturally congruent. So discussion groups were held by respected community leaders, and focus group data was collected and recorded orally. The data was archived and accessible through a coalition of these community leaders. Community strengths and needs were published with an emphasis on strengths and solutions.*

*Capacity Building: Decisions were made in this community by broad community involvement and consensus with emphasis on community, rather than individual, health. Resources were informal and shared. Human resources were ample, financial resources were shared, and technology resources were limited. Capacity building efforts focused on formalizing existing resources and mobilizing technology skills of young people.*

*Planning: The community's group orientation drove the development of a community plan to select culture-based environmental strategies that addressed community norms for prevention.*

*Implementation: Skeptical of evidence-based, dominant culture programs, the community implemented a culture-based environmental strategy program which had demonstrated effectiveness in evaluations in a similar community and which included parent, youth education and skill-building, culture-based activities, and community policy components.*

*Evaluation: The community hired an evaluation consultant experienced in culturally competent evaluation methods to design a participatory evaluation which was guided by the community*

coalition. The evaluation combined quantitative methods with video documentation, story-telling, written story boards, and focus groups discussing behavioral and policy changes resulting from program components.

## Slide 17

Show slide, **SPF Activity**.

Ask participants to get into their case study groups. Assign one step of the SPF to each group. Referring to their case study community, have participants brainstorm ways they would need to consider culture and diversity in their assigned step of prevention planning if they were working in this community. Allow 15 minutes for small group discussion. Refer participants to the information sheet, **Building Culturally Effective Prevention Programs** as a resource for this exercise. Have table groups take turns briefly reporting on their discussion (maximum 5 minutes each step).

Look for some of the following points in each group's report, and make some of these points yourself, if necessary:

### Assessment:

*Involve respected, influential, formal and informal key community leaders and those who have a stake in preventing substance abuse to provide information about the community's views of substance abuse issues in their community, views of prevention, motivations to change, preferred communication methods, methods for gathering information in the community, and the natural allies in the community. Examine how the community shares information and statistical data, who holds and has access to data, acceptable methods of asking for information and analyzing information, issues of trust, turf protecting the community image, and language.*

### Capacity Building:

*Allocating sufficient time to the process, examine how decisions are made, what the existing priorities are, how individual vs. group values are addressed, and the likelihood of affecting identified risk factors. Look at who has information about formal and informal resources, who the support people are in the community, who holds the purse strings, what the most acceptable method of assessing services is, and priorities for desired resources that exist.*

### Planning:

*Examine how individual vs. group orientation, generational interrelations and spiritual orientation may affect which population or type of service on which to focus.*

### Implementation:

*Have evidence-based programs been used or evaluated with your focus population? Do evidence-based programs need to be adapted to be culturally relevant, culturally specific, or linguistically specific while maintaining the core components of the program?*

### Evaluation:

*Ask how questions can be asked – orally, written or demonstrated – to discover changes in knowledge, attitude or behavior? Who can ask these questions, in what languages, and are the evaluation measures themselves appropriate to the community?*

### **Slide 18**

There are several resources remaining in your manual. We have already discussed gathering information about the community as a key to developing a culturally effective prevention program. *(This should have been mentioned in the report out for the Assessment group.)*

*Show slide, **Gathering Information about a Community**, and review the points. Refer participants to the information sheet, **Where to Go to Find Information about Communities**.*

### **Slide 19**

*Show the slide, **Assess Your Own Organization** and refer participants to the information sheet of the same name. Review the main points and ask for some examples from the group of ways that their programs are successful in these areas.*

*Refer participants to <http://www.omhrc.gov/CLAS/> to access “A Practical Guide for Implementing the Recommended National Standards for Culturally and Linguistically Appropriate Services in Health Care,” a publication for the Office of Minority Health, Public Health Service, and U S. Department of Health and Human Services which includes material on institutional cultural self-audit, strategic planning, materials development, community interfacing and evaluation.*

### **Slide 20**

*Have participants form their case study groups. Show the slide, Case Study Activity, and refer to the information sheet, **Culturally Competent and Inclusive Organizations**. Have participants use the worksheet, Case Study Application to discuss what an ORGANIZATION would need to do to be culturally competent in their case study community.*

### **Slide 21**

*To wrap up this section ask the class as a whole to come up with the ultimate goal (utopia) of a culturally effective prevention program. Look for answers that summarize the idea that the program must be ultimately by, of, and for the community.*

### Some Elements of Culture

**Culture** is the collectively agreed-upon knowledge, experience, values, ideas, attitudes, skills, tastes, and techniques that are passed on from more experienced members of a community to new members. Language is a major transmitter of culture. Carriers of culture include families, religious organizations, peer groups, neighbors, and social groups.

Continuous interplay between individuals, their perceptions, attitudes, assumptions, and behaviors, and their environment and social institutions creates dynamically evolving cultures and subcultures, where the whole is more than the sum of its parts. That is, groups are bound together by the interactions of their members, as well as by their similarities to each other and differences from other groups. Culture is not static; it is constantly changing in response to the internal interaction of its members, to interaction between different cultural groups, and to the needs and threats experienced by group members. There is often a difference between the ideals put forth by a culture and the way that the culture is expressed in daily living. In addition, an individual can be identified in a number of ways that are independent of each another. This enables a person to participate in more than one culture simultaneously.

Listed below are some of the many elements that are defined by a person's culture(s).

- **Aesthetics** (attitudes and behaviors related to literature, music, dance, art, architecture)
- **Ceremony** (attitudes and behaviors related to what a person should say and do on particular occasions)
- **Communication forms** (attitudes and behaviors related to personal space, greeting, voice tone, eye contact, touch, smiling, facial or emotional expression, gestures, humor)
- **Ethics** (attitudes and behaviors related to honesty, fairness, principles)
- **Folk myths** (attitudes and behaviors related to heroes, traditions, legendary characters, superstitions)
- **Formality versus informality** (attitudes and behaviors related to ways members address each other)
- **Gender roles** (attitudes and behaviors related to expectations of people based on their sex)
- **Generational interrelationships and kinship patterns** (i.e., independent, interdependent, dependent, extended, augmented)
- **Grooming and presence** (attitudes and behaviors related to physical appearance, such as hairstyle, cosmetics, dress)
- **Health and medicine** (attitudes and behaviors related to wellness, sickness)
- **Individual orientation versus group orientation** (attitudes and behaviors related to whether the welfare of the individual or the unity of the group takes precedence)
- **Language and linguistics** (language, wording, and structure of speech)
- **Recreation** (attitudes and behaviors related to how people spend their leisure time)
- **Relationship focus versus goal focus** (attitudes and behaviors related to whether the

maintenance of interpersonal relationships or the achievement of goals is more important)

- **Relationships** (attitudes and behaviors related to connections between family members, friends)
- **Rewards and privileges** (attitudes and behaviors related to motivation, merit, achievement, service)
- **Rights and duties** (attitudes and behaviors related to personal obligations, voting, taxes, military service, legal rights)
- **Sex and romance** (attitudes and behaviors related to courtship, marriage)
- **Spirituality** (attitudes and behaviors related to spirituality, prayer, purpose in life, the possibility and type of afterlife)
- **Status** (attitudes and behaviors related to people of different rank, e.g., age, wealth, office, fame)
- **Subsistence** (attitudes and behaviors related to providing for oneself and providing for the young and the old, also related to who protects whom)
- **Taboos** (attitudes and behaviors related to doing things against accepted norms)
- **Time** (attitudes and behaviors related to being early, on time, or late; concepts and relational nature of past, present, future)
- **Values** (attitudes and behaviors related to what is desirable or good)
- **Values inherent in symbols, numbers, colors, directional orientation**

Gonzalez, V.M., Gonzalez, J.T., Freeman, V., & Howard-Pitney, B. (1991) Health Promotion in Diverse Cultural Communities: Practical guidelines for working in and with diverse cultural communities. Health Promotion Resource Center, Stanford Center for Research in Disease Prevention in cooperation with the Henry J. Kaiser Family Foundation.

## INFORMATION SHEET

### Key Definitions in Diversity Work

The following list of definitions provides a basic vocabulary of terms that are central to understanding and discussing issues of culture and diversity.

<b>Adulthood:</b>	The belief that adults are better than young people and are entitled to mistreat and disrespect young people simply because they are young.
<b>Ageism:</b>	The belief that persons of any age are less important and valuable than other age groups.
<b>Ally:</b>	A member of a historically more powerful group who speaks out against discrimination and prejudice directed at “minority” groups.
<b>Culture:</b>	The collectively agreed-upon knowledge, experience, values, ideas, attitudes, skills, tastes, and techniques that are passed on from more experienced members of a community to new members.
<b>Cultural diversity:</b>	The shared values, beliefs, and norms that vary between groups.
<b>Cultural competence:</b>	The understanding and appreciation of cultural differences and similarities within and between groups. A willingness and ability to draw on community-based values, traditions, and customs and to work with knowledgeable persons of and from the community in developing prevention strategies. (CSAP 1994).
<b>Disability:</b>	A limitation, difference, or impairment in one’s physical, mental, or sensory capacity or ability.
<b>Discrimination:</b>	A society-wide, systematic manner of treating individuals differently due to their status or membership in a particular group.
<b>Diversity:</b>	Differences in qualities, attributes, or conditions that are socially defined as significant.
<b>Ethnicity:</b>	Membership in a group of people sharing learned culture and language.
<b>Gender:</b>	Cultural concepts about the behaviors and attitudes that are appropriate for each sex (i.e., what is considered masculine and what is considered feminine).
<b>Heterosexism:</b>	A societal or community bias whereby cultural institutions and individuals are conditioned to expect others to live and behave as heterosexuals.
<b>Historical trauma:</b>	The cumulative effects of emotional and psychological wounding over a person’s life span and across generations, emanating from massive group trauma experiences (e.g., slavery, the Holocaust during World War II or the forced relocation of Native peoples during the 1800s). Individuals and communities may be at risk for trauma-related effects even if they did not personally experience the related events.
<b>Inclusion:</b>	The practice of intentionally working to ensure the right of all of a community’s diverse populations to participate fully and equally in decision-making, policy development, and implementation of programs, policies and practices.

<b>Minority:</b>	The smaller in number of at least two groups. In this context, “minority” refers to groups with less power and fewer opportunities. Although commonly used, this term is starting to be seen as derogatory.
<b>National origin:</b>	The country in which a person was born.
<b>Prejudice:</b>	A belief that someone deserves more or less access to resources based on their membership in a certain group.
<b>Race:</b>	Membership in a group of people sharing inherited physical characteristics that are socially and politically defined as significant.
<b>Racism:</b>	The belief that some ethnic or racial groups are inherently superior to others.
<b>Sex:</b>	One’s biological status as male or female.
<b>Sexism:</b>	The belief that one sex is innately superior to another.
<b>Sexual orientation:</b>	Describes the sex(es) of people toward whom one feels romantically or sexually attracted (i.e., heterosexual, bisexual, gay/lesbian).
<b>Socioeconomic status:</b>	One’s social position related to economic and lifestyle characteristics and created by income, education, profession, etc.
<b>Stereotype:</b>	A highly simplified conception or belief about a person, place, or thing, based on limited information.

Center for Substance Abuse Prevention. (1994, September). Following specific guidelines will help you assess cultural competence in program design, application, and management. /CSAP Technical Assistance Bulletin. /Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration.

### Similarity and Diversity

Our relationships with others require a constant balancing act between our differences and similarities. All people everywhere share much in common. In some ways we are more similar than different. We all have the same basic needs. Biologically, we are all the same species. We have generations of families, heritage and history, relationships with friends and others, values that direct our lives, spirituality, beliefs, patterns and habits, traditions, hopes, and dreams for ourselves and for our world. We seek meaning and harmony in our lives and connectedness in our relationships. We eat, work, rest, play, wear clothing, express creativity, laugh, give, and receive. The specifics of how we manifest these things and the differences in the attributes of the persons performing these manifestations create the diversity in our world today.

Any given community contains varied ways of thinking, believing, and acting that represent the many cultures and diverse groups that exist within that community. Although communities have unique cultural profiles, all communities are communities of diversity. Each individual within that community has multiple characteristics and possibly multiple cultures with which they identify and that shape their specific experience within that community.

Appreciating and understanding diversity, cultural sensitivity, and culturally appropriate prevention programming for individuals and communities is an ongoing and ever-changing process that requires continual effort and patience.

The study of culture and diversity allows us to explore both similarities and differences within a community. This is not about learning the “right” facts about certain groups. Even though we may identify specific groups within a community, it is likely that there are many differences among members of the identified group. The goal is to learn how to continually build our ability to learn about and use similarities and differences as assets in prevention work.

## INFORMATION SHEET

### Values of Dominant U.S. Culture

Within any society, values people hold are likely to vary according to many factors, including age, sex, ethnicity, religion, race, and social class. However, every society has a set of core values and beliefs that surround and contain the members of that society and that are upheld by the members of that society who hold the most resources and privilege. But the values that dominate a society can also contain contradictions.

Prevention efforts in the United States are framed by the larger context of the values of the dominant U.S. culture. The communities with which we work receive many different messages about substance use and abuse from these values, some of them conflicting. To examine these contradictions, it is important to take a look at dominant U.S. values and the ways in which they both encourage and discourage substance use and abuse. Through multiple studies over many years, social scientists have found that there is a core set of values present in the dominant U.S. culture. The values listed below act as standards by which American social institutions, media, and others define what is desirable or undesirable, good or bad, beautiful or ugly (Macionis, 1991).

- Individualism
- Activity and work
- Material comfort
- Science
- Achievement and success
- Freedom
- Group superiority
- Equal opportunity
- Progress
- Practicality and efficiency

The U.S. way of life is based on the rights of the individual; the political system hinges on the idea of free elections, with each person expressing his or her views; and the economy is focused on meeting the varied needs of selective, individual consumers. U.S. culture celebrates the accomplishments of people who get the job done and who control their own fate through activity and work. Activities that generate money and create material comfort are highly valued, especially those that utilize practicality and efficiency to do more with fewer resources. Americans are confident that science can effectively address problems and improve lives. There is a strong belief that each person receives achievement and success through competition and personal merit. There is also a belief that freedom is essential so that personal goals may be pursued and that everyone should have an equal opportunity to get ahead. In contradiction to the belief in freedom and equality, personal worth is often also linked to social categories based on social class, race, ethnicity, and sex. There is also a strong belief in progress and the promise that the future will be better than the present (Macionis, 1991).

Macionis, John. (1991). *Sociology*. (3rd ed.) Prentice Hall.

## INFORMATION SHEET

### Our Files

All of the assumptions, beliefs, knowledge, and values that we have acquired about substance use and abuse—from our families, our own cultural groups, the dominant culture of our society, and our profession—combine to create a “file,” or “record” that constantly plays in our head and influences our decisions and behavior as preventionists.

The important thing to remember about these files/records is that everyone has them—they can’t be avoided, and simply having them does not make us less valuable as individuals. However, it is our responsibility as we work to become effective prevention practitioners to be aware of and actively manage these files/records.

Many of us in helping professions have worked really hard to suppress negative, discriminatory, or prejudiced attitudes we have heard or seen, especially if they concern the clients or communities with which we work. Sometimes, however, it is important to take a closer look at these files/records to improve our ability to manage them effectively.

Files

- are acquired from many sources,
- influence behavior and decision making, and
- are unavoidable, BUT
- are manageable.

To manage files, we must

- commit to the hard and ongoing work of embracing diversity,
- examine the specific personal experiences that create undesirable files/records,
- work to have as many positive experiences as possible with as wide a variety of people as possible,
- listen to other people’s stories about how others’ files/records have affected them,
- seek out skills that will improve our communication with different groups of people,
- work to build bridges and create allies rather than feel guilty for having certain files/records, and
- assume nothing—ask questions instead.

## INFORMATION SHEET

### Adultism

Excerpts from Bell, J. (1995). "Understanding adultism: A key to developing positive youth-adult relationships." Available at <http://freechild.org/bell.htm>.

Most of us are youth workers because we care about young people. Personally we want to both be effective and have good relationships with young people. We are satisfied when things go well. We feel bad when our relationships sour. Sometimes we scratch our heads in dismay when, despite our best efforts and concern, we find ourselves in conflict with young people we work with. We sense that some larger dynamics are at work that we can't quite see.

To be successful in our work with young people, we must understand a particular condition of youth: that young people are often mistreated and disrespected simply because they are young. The word *adultism* refers to behaviors and attitudes based on the assumption that adults are better than young people and entitled to act upon young people without their agreement. This mistreatment is reinforced by social institutions, laws, customs, and attitudes.

### *The Heart of It*

The essence of adultism is disrespect of the young. Our society, for the most part, considers young people to be less important than and inferior to adults. It does not take young people seriously and does not include them as decision makers in the broader life of their communities. Adults have enormous importance in the lives of almost every young person. This fact may make it difficult to understand adultism. Not everything the adult world does in relation to young people is adultist. It is certainly true that children and young people need love, guidance, rules, discipline, teaching, role modeling, nurturance, and protection. Childhood and adolescence are a steady series of developmental stages, each of which has a different set of needs, issues, and difficulties. For example, a 3-year-old needs a different amount of sleep than a 15-year-old, or what works to physically restrain a 7-year-old will not work with an 18-year-old, or how you explain conception and birth to an inquisitive toddler will be quite different from how you explain these to a sexually active teenager.

The point is that no one act or policy or custom or belief is in itself necessarily adultist. Something can be labeled adultist if it involves a *consistent* pattern of disrespect and mistreatment.

Certainly disrespect and mistreatment do not stem from adultism alone. Other factors, like sexism, racism, poverty, physical or mental disability, and so on, may also contribute to these results. But systematic disrespect and mistreatment over years simply because of one's young age are major sources of trouble.

Other "isms" like racism and sexism are well established and accepted as realities. They each have a huge body of literature and research documenting the effects and history of the oppression. There are novels, movies, media presentations, political organizations, and social movements devoted to illuminating and eliminating the "ism." Although there is certainly much research and literature on children and youth, very little of it concludes that young people are an oppressed group in our society, with parallels to other such groups. Yet, there is abundant evidence that points to the reality of adultism.

There are numerous examples of disrespect toward young people. Of course, there is the obvious oppressive treatment: physical and sexual abuse of young people. Official reports of child abuse reached 2.7 million cases in 1993. There is also a whole range of nonphysical punishments or

threats: being routinely criticized, yelled at, invalidated, insulted, intimidated, or made to feel guilty, with the effect of undermining a child's self-respect. If young people protest against their mistreatment, they are often subjected to more punishment. Young people are denied control and often even influence over most of the decisions that affect their bodies, their space, and their possessions. For example, most adults seem to think they can pick up little children or kiss them or pull their cheeks or touch their hair without asking.

Most young people know that in a disagreement with an adult, their word will not be taken over the adult's. Most adults talk down to children, as if children could not understand them. Adults often talk about a young person with the young person present as if he or she were not there.

Adolescent young people are frequently followed by security guards in stores, passed over by clerks who serve adults in line behind them, chased by police from parks or gathering places for no good reason, or assumed by passing adults to "be up to no good." The media often promote negative images and stereotypes of them, especially of urban youth and black youth.

An institutional example is the absence of socially responsible, productive, and connected roles for young people in most societies. Certainly in the United States, young people find few jobs, no real policy-making roles, no positions of political power, and no high expectations of young people's contributions to society. On the other hand, the youth market is exploited for profit, as the manufacturing and entertainment industries manipulate styles, fads, popularity, and all other aspects of mass culture.

### ***The Emotional Legacy***

They say that the emotional legacy of years of this kind of treatment is a heavy load, which can include any or all of the following: anger, feelings of powerlessness, insecurity, depression, lack of self-confidence, lack of self-respect, hopelessness, and feeling unloved and unwanted.

What are some possible results of such feelings on young people's behavior, especially as they reach adolescence and early adulthood?

- Some act "out" by bullying, being prone to violence, rebelling against the "norm," leaving home early, and so on.
- Some act "in" by becoming self-destructive: suicide, alcohol and drug abuse, depression, and so on.
- Some gain a sense of belonging or safety by joining a gang, a clique, a club, or teams.
- Some isolate themselves, become lonely, don't ask for help, don't have any close relationships, and don't trust others.

Again, adultism is not the only source of such behaviors, but it surely plays a major role.

### ***A Link to Other Forms of Oppression***

There is another important reason for understanding and challenging adultism. The various ways we have been disrespected and mistreated have, over time, robbed us of huge amounts of our human power, access to our feelings, confidence in our thinking and ability to act, and enjoyment of living. The pain we experience as young people helps condition us to play one of two roles as we get older: to accept further mistreatment as women, as people of color, as workers, etc., or to

flip to the other side of the relationship and act in oppressive ways toward others who are in relatively less powerful positions than ours.

A simple illustration might help make this clear. Picture this: a sixth grader is humiliated by the teacher in front of the class for not doing the math problem at the board correctly. The recess bell rings. He is fuming. He feels disrespected. He goes outside and picks on someone to get his feelings out. Whom does he pick on? Someone smaller and often someone younger. And so it goes: the sixth grader picks on the fifth grader. The fifth grader turns and knocks down the third grader. The third grader hits the first grader. The first grader goes home and picks on his little sister. The little sister turns and kicks the cat.

We can observe in a group of children how mistreatment is passed down among them. It is passed down the line of physical power—bigger to smaller and often older to younger.

The significance of this early experience becomes clearer when it is generalized to other forms of the abuse of power. Men, for example, who were routinely beaten as little boys grow up to be wife beaters. This is a clinical truism. Similarly, white people, disrespected as children, turn the same attitude, embellished with misinformation, on people of color.

This is one of the pervasive and lasting effects of the mistreatment of young people. Bullies have been bullied. Abusers have been abused. People who have been put down put others down. If a person had not been disrespected and mistreated over and over as a child and young person, that person would not willingly accept being treated that way as he got older, nor would he willingly heap disrespect on others.

Adultism, racism, sexism, and other “isms” all reinforce each other. The particular ways young people are treated or mistreated are inseparable from their class, gender, or ethnic background. However, the phenomenon of being disrespected simply because of being young holds true across diverse backgrounds.

Adultism is a pervasive and difficult form of mistreatment to identify, challenge, and eliminate precisely because every human being has experienced adultism, whatever the degree of severity or cultural variety, and because much adultism is considered natural and normal by most people.

### ***Implications for Our Work With Young People***

The set of behaviors, attitudes, policies, and practices that we have labeled adultism gets in the way of more effective youth-adult partnerships. It is useful to reflect on our interactions with young people for signs of unintended disrespect in tone, content, or unspoken assumptions.

Those of us who work in youth programs must re-examine the program practices, policies, and power relationships with the lens of adultism and make adjustments.

A few general guidelines might improve our relationships with young people:

- Listen attentively to young people. Listen when they talk about their thoughts, experiences, and feelings about being young.
- Ask questions. Ask what they think about everything.
- Lie back. Curb the inclination to take over. Support the initiatives of young people.
- Validate their thinking. Welcome their ideas.
- Allow them to make mistakes. Putting their ideas into practice will bring mixed results. They will learn. We need to support the process of their taking leadership.

- Change the power relationships wherever appropriate. Consider when adults can refrain from using authority, from making the final decision, from being the “real power” behind youth leadership.
- At the same time, do not thrust young people into decision-making and leadership positions without training, practice, and understanding of their responsibilities. Otherwise, we set them up for frustration, confusion, possible failure, and humiliation.
- Always respect all young people, no matter what their ages, and expect them to respect each other, at all ages. This is the starting point for reversing the internalized disrespect.
- Have high expectations of their potential, and positively assess their current abilities. Never sell them short and always be prepared to lend a hand with a difficulty.
- Do not take out your anger about them on them. They get this from adults all the time. It only adds more hurt. We need to take care of our upsets about them some other way.
- Give young people accurate information about the way the world works, our experiences, relationships and sex, the contributions of young people to humankind, and other issues that interest them. Never lie to them.
- Be patient with yourself when you unconsciously slip into old adultist habits. It will take time to undo them. Always appreciate how well you are doing.

### ***Good Policy***

In our efforts to create solid relationships with young people, we inevitably come up against adultism: theirs, ours, or society’s. Program staff in youth programs need to avoid two extremes. One is the permissive attitude that says, “Anything the young people want is OK.” The mistreatment of and disrespect for young people have left them, to varying degrees, with irrational feelings, misinformation, and tendencies to act out their hurts. Adult staff must not abdicate their responsibility to provide effective leadership and good policy. The other extreme is for the adult authority to run the show. Adults, likewise, have their share of irrationality, which is often the legacy of the adultism visited upon them as youth. The young people need policies that protect them from adultist leadership.

### ***Envisioning a World Without Adultism: A Final Comment***

It is inspiring and sobering to ask young people to imagine a world in which they were completely respected and never suffered from mistreatment because they were young: Inspiring because they talk about how education would be more related to them as learners, how they would help hire teachers and develop curricula, how they would use schools as community centers to provide services and opportunities for others, how they would treat their siblings and friends with much more care, how they would feel smart and effective, how they would feel part of their community, how they would help decide how things got done, how they would have numerous open and trusting relationships with adult family members and others, how they would feel confident and loved, how they would help end conflict between racial and cultural groups, how they would be leaders. Sobering because present reality is so far from that. However, each of us, in our individual relationships with young people and in our programs, can help create the

conditions that help young people develop their vision, practice decision making, exercise judgment, and grow in leadership.

### Requirements of a Culturally Effective Prevention Professional

1. Recognize the influence of your own social position, values, perceptions, opinions, and knowledge on your interactions with others.
2. Provide and promote an atmosphere in which similarities and differences can be explored and understand that this process is not only cognitive, but attitudinal and affective, as well.
3. Draw upon the experiences of members to include diverse perspectives in any given curriculum, practice, or program.
4. Encourage and accommodate a variety of learning and participation styles, building on community members' strengths.
5. Be skeptical about the validity of diagnostic tools applied to people who are culturally different from those on whom the norms were calculated.
6. Understand, believe, and convey that there are no culturally deprived or culturally neutral individuals or groups and that all cultures have their own integrity, validity, and coherence and deserve respect.
7. Learn to embrace new, ambiguous, and unpredictable situations and be persistent in keeping communication lines open when misunderstandings arise.
8. Help expand other people's knowledge of your own culture and affirm and legitimize other people's cultural perspectives.
9. Encourage community members to see themselves in a multicultural perspective, and encourage skill building in cross-cultural communication and interaction.
10. Learn to be an ally to groups that experience prejudice and discrimination in your community. Help others learn to be an ally to your own group.

## INFORMATION SHEET

### Building Culturally Effective Prevention Programs

Cultural competency is at the center of the strategic prevention framework (SPF). The Substance Abuse and Mental Health Services Administration's (SAMHSA's) Generic Logic Model: Cultural Competence in Proficient Prevention Service Delivery lists five stages of the SPF as they relate to cultural competency: (1) formulate culturally-based assumptions of change; (2) build collaborations; (3) select "best-practice," "evidence-based" components; (4) document, review, and improve the quality of program implementation; and (5) adapt and revise "best-practice," "evidence-based" components (SAMHSA, 2005).

The following is a list of dimensions to consider in each stage of prevention program development. Many of these dimensions can be considered in more than one stage of the SPF.

#### **Assessment**

- **Community priorities:** Consider differences in opinion both within and between communities about the nature of the problems, including substance abuse, in the community. Other problems may be perceived as more serious than substance abuse.
- **Views of substance use, misuse, and abuse:** Consider differences in opinion both within and between communities about the risks, benefits, acceptability, and social sanctions related to substance use and abuse.
- **Experience with prejudice and discrimination:** Consider both past and current experiences by individuals, families, and communities and the costs associated with and coping mechanisms developed in response to these experiences.

#### **Capacity Building**

- **Views of wellness and keepers of wellness:** Consider community use of both alternative and traditional healing practices.
- **Historical circumstances:** Consider personal, familial, and community histories, especially as they relate to inter- and intra-group interactions and access or lack of access to resources, institutions, power, and authority.
- **Organizational leadership:** Consider whether board and other agency leadership are willing to invest both time and resources in building the capacity of the staff to work effectively with diverse populations. Does the board have a policy on nondiscrimination that it effectively communicates to all staff?

#### **Strategic Planning**

- **Problem-solving strategy styles (hierarchical versus participatory):** Consider differences in structures used for defining authority and making decisions in the family or community and whether the organization has an effective plan for the involvement of all segments of the community at multiple levels of the organization.
- **Service-provider expectations:** Consider the presence or absence of high expectations and

positive attitudes by the program staff, administrators, and board members toward all clients, regardless of their culture or group membership.

- Organizational culture: Consider whether staff hiring and promotion practices, program publications, volunteer policies, and board member recruitment reflect a commitment to diversity.

### **Implementation**

- Scheduling and timing: Consider strategies for expanding or condensing the format in which information is provided. Consider community expectations around timelines, deadlines, and punctuality.
- Materials: Consider community-accepted meanings attached to symbols, numbers, colors, directional orientation, and other components related to the development of materials and visual aids and whether materials reflect the experiences, needs, and perspectives of the groups being served.
- Teaching style: Consider whether the teaching styles used by facilitators match the learning styles of the participants.
- Language and terminology: Consider the multiple meanings associated with words and terms and the potential for loss of meaning when slang, jokes, and analogies are translated or used out of their cultural context and whether the organization (board, facilitators, evaluators, etc.) shows respect for the participants' first language and dialects.

### **Evaluation**

- Evaluation: Consider whether the assessment and evaluation procedures used in the program are culturally relevant.
- Written, oral, and demonstrative communication styles: Consider different strategies for gathering, recording, interpreting, and reporting information; for asking questions; for giving negative responses; and for self-reporting. Also, consider whether the materials used in program events and publications reflect the diversity of the community or client base.
- Views of prevention, health, and illness: Consider community-accepted definitions of health and sickness.

Gonzalez, V.M., Gonzalez, J.T., Freeman, V., & Howard-Pitney, B. (1991) *Health Promotion in Diverse Cultural Communities: Practical guidelines for working in and with diverse cultural communities*. Health Promotion Resource Center, Stanford Center for Research in Disease Prevention in cooperation with the Henry J. Kaiser Family Foundation.

Substance Abuse and Mental Health Services Administration. (2005). *Generic logic model: Cultural competence in proficient prevention service delivery*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration.

## INFORMATION SHEET

### Where to Go to Find Information About Communities

#### *Start by Consulting the Experts*

You will want to consult experts who know the community best and can provide you with a valuable perspective on the community.

1. **Individuals and groups from the focus community:** These people will often be your first contacts in the community. Through them you will learn more about the community in a more direct way than just by reading or hearing about it. These people can also work with you as partners and consultants to create or adapt the program to the various groups within the community. However, seek out community contacts carefully and be cautious of people who claim to be “experts” and to speak for a whole group of people. Look for leaders of community institutions like religious congregations, civil rights groups, and arts organizations. Poorly or hastily selected people can cost you the accuracy of your information, as well as the trust of the community in later program-building efforts.
2. **Helping professionals or other persons working in similar communities or with similar problems:** These people may be found in local, regional, or national organizations (e.g., major minority health organizations or voluntary health agencies). These organizations often have accumulated relevant information based on their experience with various diverse communities throughout the country. Such people can provide you with more specific information about the problem as it is experienced by the different cultural groups. People in local organizations can also give you pointers on how to work in and with the community, sharing with you some of their own experiences (i.e., what is appropriate, what does or doesn’t work well, and whom you might contact in the community to begin your planning).
3. **Academicians:** These are the people in academic research institutions or government agencies who have done research in your areas of interest or have personal, sociological, or historical knowledge and experience with specific ethnic or subcultural groups. They can help you interpret and clarify the findings from your library search or direct you to the most recent and relevant research.

#### *Library Search*

Although you should spend most of your time in the community, it is important to devote some time to library research so that your approach in the community is an informed one. The following are the types of literature you will want to review. Remember that most information from these sources is likely to cover a much broader population than you intend to work with; be prepared for significant local and regional differences.

1. **Census data, maps, and other government documents, reports, and statistics:** Such information identifies who and where the focus community is, as well as what problems and needs exist in comparison with the general population.
2. **Medical and public health references, specifically epidemiological and health intervention articles related to the health problem(s) you want to address in a**

**program:** These provide the latest information on the scope of the problem, on trends in different populations, and on previous approaches taken to mediate the problem. This type of information can give you ideas on how you might approach the problem in your focus community.

3. **Behavioral and social science literature:** Review intercultural and ethnic studies literature because this often includes a collection of psychological, sociological, and anthropological references specific to **different** racial, ethnic, or cultural groups. Such information can be extremely useful in providing you with a general understanding of different cultures' values, beliefs, practices, and historical experiences in the United States.
4. **Local newspapers:** Both the major dailies and smaller neighborhood newspapers, including the various ethnic or cultural publications, are a good source of information about a focus community. The local news **and** editorial sections often provide some specifics about a community's or group's controversies (i.e., their most pressing issues, concerns, or problems). These newspapers also provide listings of current or upcoming community events. Such information not only gives you some insight into the social and political "climate" in that community but can also help you identify people, places, and events to visit when you begin exploring the community.

If you feel time is too short to gather this type of extensive information, go back to the drawing board and reassess your timeline. It will take you MUCH longer to repair the damage done by a negative first impression or an ineffective or offensive program than it will to do your homework before you begin.

Gonzalez, V.M., Gonzalez, J.T., Freeman, V., & Howard-Pitney, B. (1991) Health Promotion in Diverse Cultural Communities: Practical guidelines for working in and with diverse cultural communities. Health Promotion Resource Center, Stanford Center for Research in Disease Prevention in cooperation with the Henry J. Kaiser Family Foundation.

## INFORMATION SHEET

### Assess Your Own Organization

The first step in the process toward developing a more culturally effective prevention program (a step that is important but often forgotten) is assessing your own organization.

#### 1. *Organizational diversity*

- Have members of your staff had experience working with diverse communities and with your focus population?
- What is the range of cultural values, beliefs, and knowledge within your staff? How are they different from the focus community's?
- How do these beliefs influence your staff's attitudes about different cultural groups?
- Does your organization have policies and procedures that address diversity in management structure and program delivery?

#### 2. *Community interfacing*

- Does your organization collaborate with other community organizations? Are staff members involved in supportive relationships with other community groups?
- Is your organization seen as a positive community partner with other community organizations and community members?
- What opportunities have you created to empower community members and organizations to become involved in both leadership and support roles?
- Is your organization and staff based in the community—or are you coming from the outside? If you are coming from the outside, how have you shown the community that you are the most appropriate organization to be leading this work?

#### 3. *Capacity for investment*

- Is your organization willing to commit the resources necessary to building or strengthening relationships with groups and communities?
- Is your organization able and willing to utilize outside resources if the needed knowledge and abilities are not present in the organization?

#### 4. *Appropriateness of materials and process*

- Are audiovisual materials, public service announcements, training guides, print materials, evaluation instruments, and other materials to be used in the program linguistically appropriate for your focus community?
- Are program processes culturally appropriate for your focus community?

## **CULTURALLY COMPETENT AND INCLUSIVE ORGANIZATIONS INFORMATION SHEET**

The first step in the process toward incorporating culturally competence and inclusion into prevention programming is planning for a culturally competent and inclusive prevention organization. A culturally competent and inclusive prevention organization:

### **1. Continually Assesses Organizational Diversity**

There is a regular assessment of the experiences organization members have had working with diverse communities and with focus populations?

There is a regular assessment of the range of values, beliefs, knowledge, and experiences within your organization that would facilitate working with focus communities.

### **2. Invests in Building Capacity for Cultural Competency and Inclusion**

Your organization has policies, procedures, and resources that facilitate the ongoing development of cultural competence and inclusion.

Your organization is willing to commit the resources necessary to building or strengthening relationships with groups and communities?

Your organization members are representative of your focus population.

### **3. Practices Strategic Planning that Incorporates Community Culture and Diversity**

Your organization collaborates with other community organizations and organization members are involved in supportive relationships with other community groups.

Your organization is seen as a positive community partner by other community organizations and by community members.

### **4. Implements Prevention Strategies Using Culture and Diversity as a Resource**

Community members and organizations have had an opportunity to create and/or review audiovisual materials, public service announcements, training guides, printed resources, and other materials to be ensure that they are accessible to and appropriate for their community

### **5. Evaluates the Incorporation of Cultural Competence and Diversity into Prevention Strategies**

There is a regular forum for a wide variety of community members to provide both formal and informal feedback on the impact of prevention strategies in their community.

Read over your case study and think about what would be ideal for your community as you answer the following questions.

1. What is the range of culture and diversity within an organization that would best serve this community?
2. How could the organization collaborate with other community organizations?
3. What opportunities could you create to empower community members and organizations to become involved in both leadership and support roles in this community?
4. How could you ensure that community members have an opportunity to create and/or review audiovisual materials, public service announcements, training guides, and other materials to be ensure that they are accessible and appropriate for this community?
5. Who could you consult in order to get feedback on your prevention efforts in this community?

# **Achievement/ Success**

# Individualism

# Activity & Work

# Science

# Material Comfort

# Freedom

# Group Superiority

# Practicality & Efficiency

# Equal Opportunity

# Progress