

# RTR/ Project 4PLAY (4 County Prevention and Leadership for Asian and Pacific Islander Young Adults): Final Report

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## I. ASSESSMENT

### *Brief Description of Proposed Grant*

Using the Strategic Prevention Framework (SPF), Asian American Recovery Services, a program of HealthRight 360 (AARS/HR360) and our local collaborators developed and Implemented a comprehensive multi-county, multicultural approach to dealing preventatively with co-morbid conditions of Substance Abuse (SA) and HIV/AIDS among Asian Americans, Native Hawaiians and Pacific Islanders (AANH&PI) in the San Francisco Bay Area, targeting the needs of limited English-speaking immigrants, and other high risk individuals (i.e., men who have sex with men (MSM), LGBTQ, and those reporting substance use or misuse). In 2005 Asian American Recovery Services in partnership with Asian and Pacific Islander Wellness Center (APIWC) was one of eighty recipients of Substance Abuse and Mental Health Administration (SAMHSA)'s Minority AIDS Initiative (MAI) grants. Project 3-3-3 (P 3-3-3) which was funded in Cohort 6 originally served Vietnamese, Filipino, and Chinese clients in one or more risk groups in three northern California counties: San Francisco, San Mateo, and Santa Clara. With the success of the P 3-3-3, AARS/HR360 and APIWC drew from their substantial program experience to service one of SAMHSA's newly identified subpopulations of focus, young adults 18-24. Project 4PLAY (4 County Prevention and Leadership for Asian and Pacific Islander, Young adults) also known as P4P is housed at the AARS office in South San Francisco (1115 Mission Road South San Francisco) expanded its ethnic focus from the three groups mentioned above to all AANH&PI and expanded services into 4 northern California counties: San Francisco, San Mateo, Santa Clara, and Alameda.

Currently, a very limited number of SA/HIV prevention efforts targeting AANH&PIs young adults exist in the San Francisco Bay Area. Many Asian Americans who are new immigrants to the U.S. face many formidable cultural and linguistic barriers. Even among American-born AANH&PI, there is a lack of peer and community support for sexual and racial diversity which contributes to low self-esteem and negative self-identity. Shame and denial, related to AANH&PIs cultural values pose significant barriers to accessing services. Access to current, appropriate, and accurate information has long been recognized as a key component of successful prevention programs. This is especially challenging when serving AANH&PIs communities, which have over 40 distinct languages and cultures.

Despite the excellent educational work done in recent years by the AANH&PI community based organization (CBOs), many from these communities continue to believe they are not at risk for HIV infection, resulting in low HIV testing rate. The San Francisco Department of Public Health has cited AANH&PIs need for comprehensive data on HIV infections, disaggregated by national origin or ethnicity, in part to illustrate the real scope of the problem. The proposed SPF project will help meet this need through a focus analysis and consensus interpretation of the current epidemiological profile available to each county we will work in and by working in partnerships with government agencies, CBOs and other community representatives to enhance outreach, prevention, and testing.

This program proposed to serve 250 unduplicated individuals in four Bay Area Counties (San Francisco, Alameda, San Mateo, and Santa Clara Counties) over the five year life of the grant. The prevention program's curriculum is adapted from 2 evidenced based interventions Cannabis Youth Treatment Motivational Enhancement Treatment/Cognitive Behavior Therapy (MET/CBT 5) Model, a recognized SAMHSA evidence-based approach and 3MV (Many Men Many Voices), a CDC evidenced based intervention, both were adapted for cultural appropriateness and the language needs of the population of focus. Exceeding an average exit and follow – up retention rate of 80%, 248 Project 4PLAY participants enrolled into and completed the seven week intervention. In addition to maintaining a high retention rate, Project 4PLAY expanded its reach into Alameda County working closely with Community Health for Asian Americans (CHAA), Asian Health Services (AHS), Korean

Community of the East Bay (KCCEB), and the Office of AIDS located within the public health department in Alameda County. In addition to new partnerships in Alameda County, Project 4PLAY was introduced to the Pacific Islander community more specifically the Samoan and Tongan sub groups through partnerships with the Samoan Community Development Center (SCDC) and The United Territories of Pacific Islanders' Alliance (U.T.O.P.I.A). With support from the above listed community based organizations, Project 4PLAY completed two focus groups one in the Korean and another in the Pacific Islander communities. Despite challenges implementing workshops in the Korean and Pacific Islander communities, Project 4PLAY was successful in collecting the Risk Behavior Screening Survey (RBSS) expanding its ethnographic data for these new sub-populations.

### ***Description of Implemented Program***

*The Intervention.* Project 4PLAY (4 County Prevention and Leadership for Asian and Pacific Islander Young Adults) delivered a seven-week group level intervention program that was a culturally adapted evidence-based intervention designed to provide prevention messages and basic life skills to provide participants with tools to remain HIV free.

To establish the intervention framework, Project 4PLAY utilized the Substance Abuse Mental Health Administration Service's (SAMHSA) program-building model of Strategic Planning Framework (SPF). This process involved an adaptation method that addressed five key steps of Assessment, Capacity, Planning, Implementation, and Evaluation. As a result of the assessment and planning phases, Project 4PLAY selected Project 3-3-3 (Cohort 6 – P3) intervention which adapted two evidence-based interventions (EBIs): Motivational Enhancement Treatment/Cognitive Behavioral Therapy 5 (MET/CBT 5) Sessions and Many Men, Many Voices (3MV). After adaptation of the EBIs, basic culturally appropriate changes to the original curriculum were implemented and included distribution of translated reading materials (i.e., program activity handouts, consent forms, surveys) for limited English speaking individuals who could read Chinese, Tagalog and Vietnamese; employing personnel who came from the target population and/or represent the target ethnicities and speak their languages; recreating a safe communal atmosphere through meals and alternative positive social activities; and ensuring privacy and confidentiality (workshop facilitators building trust and rapport with and between participants by fostering group cohesion in pre-meetings and workshop modules).

The seven session group level intervention were delivered by Project 4PLAY staff. The sessions included: 1. Relationship between Identity and risk behaviors; 2. Health (focus on HIV); 3. Communication; 4. Social Support; and 5. Problem Solving & Review. In addition to the five core workshop modules participants were invited to a welcome social/informational meeting. The final module was a two part activity which included a celebration and an opportunity for participants to receive a free anonymous HIV test on-site.

To increase participation from AANH&PIs, more unique and advanced cultural adaptations (derived from focus groups and additional evidence-based activities supported by current literature review) were necessary and implemented. For participants' time in Project 4PLAY, incentives were provided at the end of each module and completed surveys.

### ***Evaluation Rationale***

The main hypothesis guiding the evaluation design over the tenure of the program was that individuals exposed to the culturally-specific intervention, such as Project 4PLAY, would demonstrate a reduction in SA/HIV risk behaviors over time or three-months after exposure to programming.

**Measurable Outcomes.** The initial evaluation used the following established program goals to guide the evaluation for Project 4PLAY:

1. Provide culturally competent HIV testing services.
2. Develop and implement evidence-based activities to reduce the incidence and impact of substance abuse and HIV.
3. Contribute to environmental strategies that result in changes in health policy and distribution of resources in service to the population of focus for HIV and S.A. prevention.
4. Contribute to capacity of community health care systems to deliver services through professional development and dissemination of prevalence and incidence data.

**Evaluation Plans.** Using the aforementioned objectives, the evaluation utilized qualitative and quantitative methods, incorporating three evaluation components: formative, process, and outcome. The evaluation also integrated GPRA requirements for SAMHSA performance data collection and reporting, including the National Outcome Measurement Survey (NOMS).

- **Formative Evaluation Approach or Program Implementation:** Program implementation methods were assessed through two major components: (1) program fidelity; and (2) community response and involvement. This component measured whether the program performed and or was implemented as originally planned. Specifically, this component involved assessing whether recruitment and outreach measures were met and whether the development of the expanded curriculum occurred. This portion of the evaluation used qualitative measures to document Program Goals 1-4.
- **Process Evaluation Approach:** Assessment of the process evaluation approach allowed for documentation of program description detailing: (1) Who (program, staff) provided what services (modality, type, intensity, duration); (2) To whom (individual characteristics); and (3) In what context (system, community). This portion of the evaluation used qualitative and quantitative measures to document Program Goals 1-4.
- **Program Outcomes:** Baseline, program-exit, and follow-up NOMS were administered to program participants to determine whether individuals exposed to the culturally-specific SPF intervention curriculum demonstrated a reduction in SA/HIV risk behaviors. Prior to receiving the NOMS, all potential and participating respondents received the Risk Behaviors Survey (RBSS) as part of the intake process. This portion of the evaluation used quantitative measures to document Program Goals 1 and 2.

## II. CAPACITY BUILDING

### Introduction

Project 4PLAY adopted a series of key practices that proved to be crucial to the successful functioning of the intervention. We highlight several key practices, amongst a host of other: carrying out a Strategic Planning Phase, which entailed conducting a Needs Assessment; Convening and maintaining a Community Advisory Board; pilot testing survey instruments; translating materials in to relevant languages; culturally tailoring the intervention; and establishing and maintaining monthly meeting for program staff and evaluation team.

Thought not initially included in the original proposal, Project 4PLAY spent the first year of its existence developing a strategic plan and conducting a needs assessment. This broad ranging endeavor sought to establish exactly what/was HIV/AIDS and Substance abuse educational and prevention needs in the San Francisco, Alameda, and San Mateo and Santa Clara counties amongst high-risk AANH&PI young adults 18-24 years of age. Project 4PLAY staff members showed flexibility in adapting their original plans to adopt procedures mandated by SAMHSA. It is the hallmark of a good intervention when practitioners are able to refine, modify and alter course and *still* deliver the proposed intervention.

### Strategic Prevention Framework

The Needs Assessment was part of a larger model building approach called the “Strategic Prevention Framework” (SPF). This process involved five key steps of Assessment, Capacity, Planning, Implementation, and Evaluation as shown in Figure 1. The figure below was borrowed directly from SAMHSA Minority AIDS Initiative/Project 4PLAY’s Strategic Plan, since it graphically depicts important components of the programs implementation.

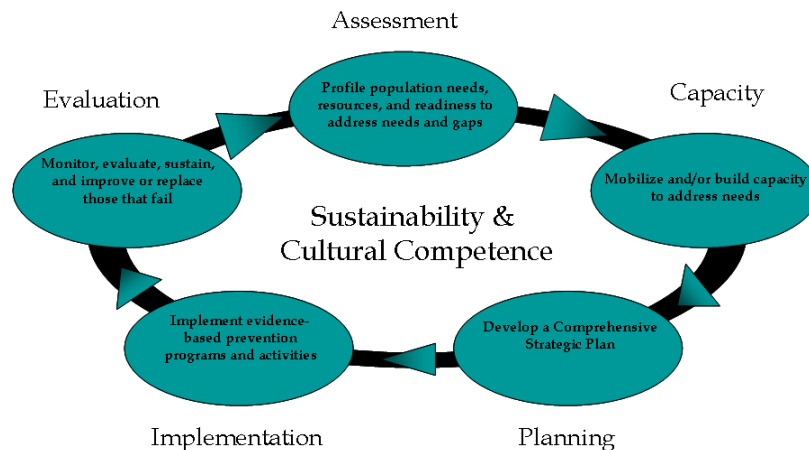


Figure 1. Strategic Prevention Framework from the Substance Abuse and Mental Health Service Administration/Center for Substance Abuse Prevention

In the SPF, the Assessment phase required Project 4PLAY to create a HIV/AIDS, and Substance Abuse needs assessment of the target population. The Needs Assessment included a literature review of the target population’s risky behaviors and protective factors; establish disease prevalence/incidence data; identification of determinants of risky behaviors; and used formative evaluation strategies by convening focus groups; and key informant interviews. The focus groups and the key informant interviews were essential to determine the health priorities, risky practices, and cultural requirements needed to be addressed in the intervention. However, before turning to these practices, Project 4PLAY undertook some important and necessary capacity building work.

## Capacity Building

Central to the Capacity Phase shown in the diagram above, was the creation of a Community Advisory Board (CAB). This board consisted of representatives from target communities, including department of public health officials, community based organization representatives, community stakeholders and unaffiliated community members. Once participants were identified and convened, this body met periodically throughout the entire 5 years of the project. The CAB's main purpose was to ensure and assist in the cultural adaptation of the intervention, including the curriculum.

These community stakeholders provided recommendations on addressing HIV/AIDS and substance abuse amongst the targeted communities' in the four target counties. The CAB also helped the program determine risk factors, identify appropriate community assets and resources, and point out gaps in current services. They reviewed materials for cultural appropriateness as well as the geographic scope of neighborhood outreach. Their expertise proved beneficial to tailoring and refining the proposed intervention.

### Listing: Project 4PLAY Community Advisory Board.

Luke Tao, Epidemiologist San Francisco Department of Public Health

Lorna Sumaraga, Santa Clara County HIV Prevention Community Planning Group

Raj Gill, Santa Clara Valley Health & Hospital System; Public Health Department; HIV/AIDS Prevention & Control

Maharlika Aguirre, Santa Clara HIV/STD Prevention & Control

Clara Boyden, San Mateo County Department of Health; Alcohol & Other Drug Services

Jennifer Nakamura, Counselor, Santa Clara AARS

Koji Sakakibara, Asian Health Services. Oakland CA

Lorenzo Hinojosa. HIV Testing Coordinator. Alameda County Office of AIDS

Malaya Arevalo, Program Manager Asian Americans for Community Involvement (AACI).

Ethan Giang, Program specialist Asian Americans for Community Involvement (AACI).

## Collaborative groups and Referrals

In addition to working with Project 4PLAY CAB members, project supervisor and project staff also participated in two collaborative groups focused on HIV/AIDS in the AANH&PI community. The first collaborative based in Santa Clara County, Asian and Pacific Islander's for HIV/AIDS (AHAC), was housed at Asian Americans for Community Involvement (AACI) in San Jose. HIV/AIDS for Asian and Pacific Islanders (HAAPI), second collaborative group, was housed at Community Health for Asian Americans (CHAA) in Oakland and supported programming and services in Alameda County. Both collaborative groups included members of community based organizations that worked with the AANH&PI community and or worked with issues concerning HIV/AIDS prevention, county public health departments, and a federal representative from the Office of Minority Health. As a member of HAAPI and AHAC, Project 4PLAY staff shared relevant data, announced upcoming project related events, collaborated on HIV/AIDS testing events in the community, and developed infographics and reports to share with local and state officials. Project staff also worked closely with members of the collaborative to refer

individuals who were eligible for Project 4PLAY, and refer individuals to resources within their own counties, and share resources to improve programming for the AANH&PI community.

### **Focus Groups**

Focus groups were conducted as part of the SPF Needs Assessment process, and served to inform P4P about HIV and SA prevention issues and needs. Findings from the focus group guided the development of prevention materials for the implementation phase. Focus groups involved six groups with two being ethnic specific, gender mixed (Korean and Pacific Islander), and four being MSM specific and ethnically mixed.

Findings from the focus group include:

Participants' perceptions of risk for HIV were low. While they understood there is risk, there was a notion that Asians are at low risk, so the concern was minimal. Several of the participants did discuss negotiating condom use, yet some admitted they were not as consistent with following the negotiation practices as they should be given they eventually felt that everyone else was being "safe," therefore they would be safe in not following safety practices with every encounter.

There was recognition of the role of ATOD play in sex, with many recognizing it lowers inhibitions or "increases your ability to talk to someone." With this recognition, participants also realized how this lowered inhibition can backfire, both in practicing safe sex and how one might come across to people when drunk.

Access to alcohol played a big part in drinking for both those under and of the drinking age. More people reported gaining access to alcohol from friends at house parties, and among the MSM this was more commonly reported than for the two ethnic-specific groups that discussed venues (clubs).

Substances of choice appeared to be alcohol, marijuana, and "Mollie" (ecstasy or some derivative of it); there were only a few participants mentioned having the witnessed cocaine use and there were no mention of prescription drug use among this group.

### **Pilot Testing, Translations, and Cultural Tailoring**

The Implementation phase entailed pilot testing and the cultural tailoring of the P4P curriculum to meet the needs of the target population. Along with the focus groups, these above mentioned preparatory steps were necessary for successful program implementation.

Pilot testing was conducted to ensure that the intervention was culturally appropriate for the targeted populations. Based on this work, additional adaptations were made to the P4P curriculum. In addition the curriculum was also adapted to incorporate language/slang utilized by young adults.

Another aspect of the cultural tailoring was the creating of a safe communal atmosphere, primarily through shared meals and social activities that provided alternative spaces/activities beyond the "bar scene," most commonly found in the LGBTQ community. In order to build trust and rapport between staff and intervention participants, program staff communicated with potential participants via social media and text messages leading up to the first meeting and continued showing their support via social media presence through the duration of the sessions. Project staff instituted many cultural adaptations through activities, including icebreakers, role playing skits and open discussion and assessment about the actual workshop content at the conclusion of a given workshop.



**Monthly Meetings**

Often overlooked in Program Implementation is the Monthly Coordinating Team meetings. For Project 4PLAY, these became critical meetings that reviewed and assessed the status of each component of the work. In the first year of the project, a weekly review of the strategic plan and needs assessment took place. Similarly, during the first year, the hiring of translators, the development of informed consent forms, and IRB approval dominated many meetings. The modification of the Risk Behavior Screening Survey (RBSS) survey instrument, used to identify potential participants, and the pilot testing of it and the National Outcome Measurement System (NOMS) were all-important topics. The RBSS was adapted from California's Department of Public Health's HIV/Hepatitis Counseling and Testing Risk Assessment Form, to include information on specific ethnicity, language spoken at home, with whom do you live with, educational level to better document the diversity within this group.

However, the real value of the monthly staff meetings was that a unity was forged amongst program staff on the one hand and the evaluation team on the other. Even though there was much turnover of personnel early on in the project, the Principal Investigator, Daniel Toleran, the Project Coordinator, Shristi Reddy, MPH, the lead evaluator Dr. Robynn Battle and co-evaluator Dr. Phillip Gardiner were consistent for the entire 5 years of the project. The evaluation perspective became a key ingredient in the monthly meetings and there was always a part of the agenda to discuss findings as well as discussion of current journal articles relevant to the topics addressed by Project 4PLAY. Indeed, the monthly meetings of the Project 4PLAY led to the conceptualization, discussion, and writing of several manuscripts based on data from Project 3-3-3 as well as continued funding of SAMHSA CBI grant in FY 2015-2020.

### III. STRATEGIC PREVENTION

The strategic prevention portion of P4P included outreach, recruitment and the implementation of a 7-module workshop providing culturally-relevant HIV and substance use prevention information to AANH&PI in the Bay Area, targeting the needs of limited English-speaking immigrants, and other high risk individuals (i.e., men who have sex with men (MSM), LGBTQ, and those reporting substance use or misuse) age 18-24. Monitoring of the strategic intervention who (program, staff) provided the services (modality, type, intensity, duration); and to whom (individual characteristics) the services were provided. Additionally, over the tenure of the grant, outcome measures (see Section V. Evaluation) were monitored to inform staff on progress and impact of Project 4PLAY programming.

#### Methodology and Tools

Methods used to monitor strategic prevention efforts included qualitative and quantitative methods. Qualitative methods included observation notes of monthly meetings, ethnographic notes from the intervention workshops, community presentations, Community Advisory Board meetings, and professional meeting presentations. Additionally, qualitative efforts included review of meeting minutes and personal communication with Project 4PLAY staff. Qualitative tools included written documents, notes and focus group and key informant interview transcripts.

Quantitative methods included review of attendance counts, program participation counts, and recruitment counts (dosage data). Quantitative tools included tracking data as well as NOMS and RBSS data.

#### Results

Program Staff – Over the tenure of the program, Project 4PLAY was implemented through the efforts of one principal investigator (AARS), one program supervisor (AARS) and two health educators (one from AARS and one from APIWC). Additionally, APIWC’ Deputy Director of Community Health served as part of the team, providing feasibility direction and input as it related to services delivery, particularly for HIV testing and Hepatitis screening.

#### Outreach and Cohorts –

- Outreach. Targeting several types of outreach sites based on staff experience and Community Advisory Board suggestions, Project 4PLAY staff made an estimated 4000 unduplicated contacts with individuals that could potentially qualify for the intervention. Sites were based on the notion that individuals from the program’s targeted risk groups frequented these spaces and or events. The six types of sites included: (1) bars and clubs (nightlife venues); (2) ethno-cultural events; (3) gay community events; (4) street outreach; (5) other, which included social media venues such as Facebook and Craig’s List and social media applications (such as Grindr, Jack’d, Adam4Adam, Manhunt); and (6) HIV testing sites (individuals appearing at testing van in Alameda, Santa Clara, San Mateo, and San Francisco Counties). Specifically, spaces and events were targeted where a majority of the participants or clientele was AANH&PI and or AANH&PI MSM or places known as with possible substance use can occur. For example, for MSM, in both San Francisco and Santa Clara counties, certain gay bars or clubs held monthly dance events that targeted Asian MSM. In other cases, ethno-cultural events included large community cultural events such as Chinese New Year, Tiet (Vietnamese New Year) or Pistahan (an annual Filipino cultural event). Project staff also collaborated with community based organizations at HIV awareness events such as World AIDS Day.

- Cohorts.** During outreach efforts, all contacts were given prevention information about HIV and substance use. Potential participants for Project 4PLAY, however, were determined through a screening process where the health educators used a series of questions where potential participants were screened to determine if they met the criteria for participation. These criteria included: (1) being one of the targeted ethnic and risk populations; (2) self-report alcohol or substance use in the past 30-days; (3) live in or frequent one of the four-targeted counties; and 4) reporting having had unprotected sex in the past two years. If the individual met the first criteria in addition to a combination of the remaining three criteria project staff collected contact information and potential participants were invited to participate in the 7-week prevention program where they were given an adaption of the California's Department of Public Health's HIV/Hepatitis Counseling and Testing Risk Assessment form called the Risk Behaviors Survey (RBSS) to complete. In addition to collecting RBSS from participants who came to the welcome/informational session, project staff also collected RBSS at all outreach venues mentioned above and followed up with potential individuals who expressed an interest in learning more about Project 4PLAY or participating in the workshops. As a result of efforts to collect RBSS at as many outreach venues as well as part of the intervention a total of 595 RBSS forms (95 more than expected) were collected. Demographics of individuals completing the RBSS can be found in Table 2. Section IV includes more detailed results from RBSS.

Given the pan-Asian population targeted by P4P, participants represented 17 specific ethnic groups (see Figure 1), with the majority of participants being Chinese (19%), Filipino (23%), Vietnamese (16%) and MER (multi-ethnic/racial) (24%). This unique MER group had over 40 multi-ethnic or racial combinations with the top 11 found in Table 1. Ethnic groups with one to two individuals were calculated as "0%" given their percentages were below 1%. For the purposes of analysis, the largest ethnic groups were used and are shown hence forward in all data tables.

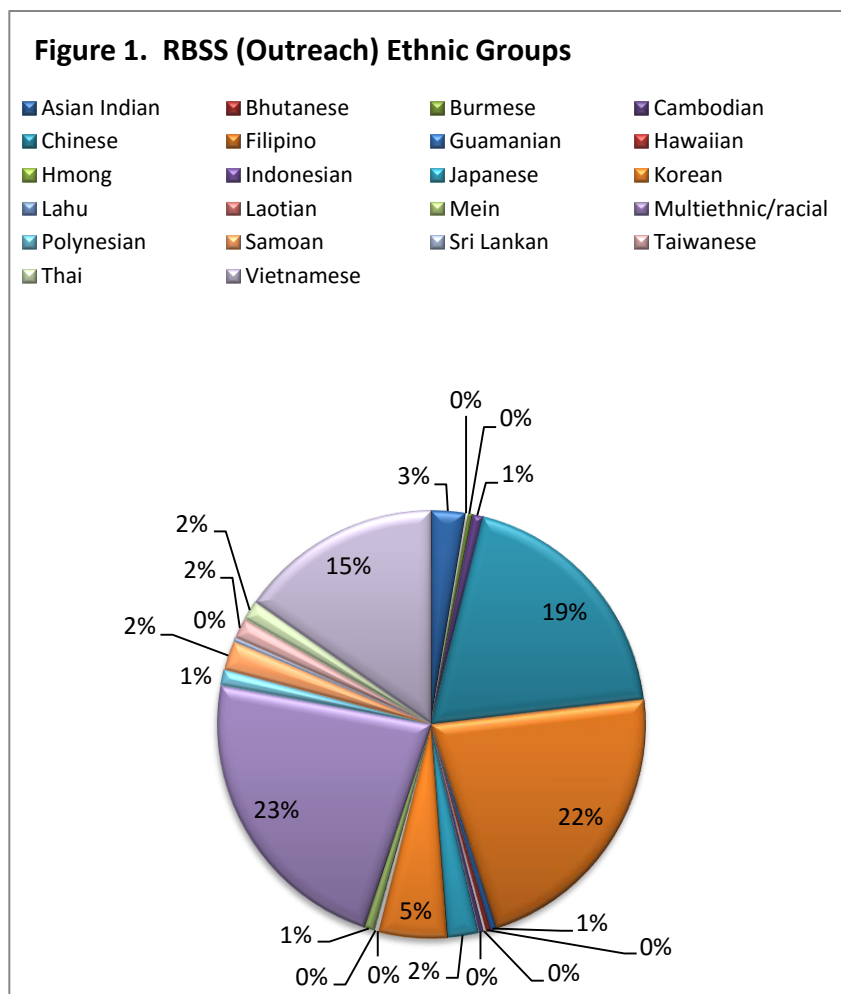


Table 1. Top 11 MER Groups

<b>Top 11 MER Groups</b>	<b>% of Reported MER</b>
Chinese-Vietnamese	18
Burmese-Chinese	6
Filipino-Hawaiian	4
Filipino-Japanese	4
Polynesian-Samoan	4
Filipino-White	4
Vietnamese-White	4
Cambodian-Chinese	3
Chinese-Indonesian	3
Chinese-Japanese	3
Japanese-White	3

For program participant demographics, see Table 2. A majority of the participants were from Santa Clara County, followed by Alameda. Most were of Multi-Ethnic/Racial descent, followed by those of Chinese or Filipino descent. Breakdown of ethnicity by county was significant ( $p=.00$ ), with Alameda County having the most MER, San Francisco County having the most Chinese, San Mateo County having the most Filipinos, and Santa Clara County have the most Vietnamese. About three-fourths of the participants were born foreign born, while 76% reported their primary language to be English. No statistical significance was seen between ethnicity and place of birth or primary language.

Table 2. Demographics of Project 4PLAY Program Participants

<b>County of Participants</b>	<b>Chinese N (%)</b>	<b>Filipino N (%)</b>	<b>Vietnamese N (%)</b>	<b>MER N (%)</b>
<i>Alameda (N=48)</i>	16 (34)	7 (16)	5 (14)	20 (43)*
<i>San Francisco (N=37)</i>	12 (27)*	11 (25)	5 (14)	9 (19)
<i>San Mateo (n=24)</i>	4 (9)	15 (34)*	2 (5)	3 (6)
<i>Santa Clara (N=62)</i>	12 (27)	11 (25)	24 (67)*	15 (32)
<b>Place of birth – Foreign born</b>	18 (78)	29 (83)	16 (76)	20 (74)
<b>Primary language – Non-English*</b>	34 (76)	35 (76)	27 (73)	39 (80)

\* $p=.00$  Difference observed between ethnic groups.

Those who expressed interest in participating in the intervention or learning more about Project 4PLAY were contacted by project staff largely via text as that was the preferred method over email or phone calls. During the invitation, individuals were provided the dates, times, place of the upcoming meetings and incentive schedule for the workshop series.

Through efforts of interested individuals, Project 4PLAY recruited and administered the program to 32 cohorts (see Table 3) serving 248 individuals. Of the 32 cohorts, eight took place in San Francisco County, ten took place in Santa Clara County, five in San Mateo, and nine in Alameda. Due to staff change over, competing priorities, and lack of interest Project 4PLAY struggled to outreach and enroll participants in San Mateo and parts of Alameda County, mainly the Tri-City area (Union City, Newark, and Fremont).

Of the 32 cohorts, fifteen were targeted just towards MSM, and the remaining 17 towards individuals who identified used substances and or also identified as MSM. AARS/HR 360 renegotiated the number of individuals to be served by the intervention of the tenure of the grant to 250 after reviewing challenges and staff support for the project. On average participants attended three out of five of the core workshops/interventions.

Table 3. Cohort Types and Number of Participants

Cohort			County & Type		
Cohort			County & Type		
1	6	ALA MSM	17	6	ALA MSM
2	12	SM MSM	18	10	SC MSM/DU
3	6	ALA MSM	19	7	SF MSM/DU
4	10	SC MSM	20	5	SC MSM/DU
5	7	SF MSM	21	5	ALA MSM/DU
6	7	SF MSM	22	8	SF MSM/DU
7	7	ALA MSM	23	4	SM MSM/DU
8	8	SM DU	24	11	SC MSM/DU
9	7	SJ MSM	25	9	SC MSM/DU
10	0	SSC Girls	26	10	SF MSM/DU
11	6	SM MSM	27	10	ALA MSM/DU
12	14	SF MSM	28	8	SC MSM/DU
13	9	ALA MSM	29	9	ALA DU/MSM
14	9	SC MSM	30	12	SC MSM
15	7	SM MSM	31	5	SF MSM/DU
16	5	SF MSM/DU	32	9	ALA DU
N = 248					
Average group size = 7.75					
Average # of Interventions Attended = 3.64					

Project 4PLAY had a total of 248 participants at Baseline and was able to retain 228 or 92% of the participants at Exit. Thus, the program exceeded its 80% Baseline to Exit retention rate by 12%. At Follow-up, the program was able to retain 200 participants or 88%. The Baseline to Follow-up retention rate was 81% for the total program. The program exceeded its 80% Baseline to Follow-up retention rate for the overall program by 1%.

## IV. IMPLEMENTATION

**Accomplishments.** The overall goal or focus for Project 4PLAY was reduce the incidence of HIV and substance use among Asian American and Pacific Islander young adults in the SF Bay Area through a comprehensive multi-county, multicultural approach to prevention services addressing co-morbid conditions of HIV/AIDS and Substance Abuse.

Numbers achieved –NOMS & RBSS. After the third year of the grant, a thorough review of performance to date was conducted, Asian American Recovery Services, a program of HealthRight 360 (where Project 4PLAY is housed) discussed and came to an agreement with SAMHSA through its Program Officer to reduce the numbers served by the intervention to a more feasible number. With the re-established new number of 250, Project 4PLAY was successful in recruiting and intervening with 248 individuals over the course of the grant period and maintaining the grant required 80% retention rate. Findings from both data collection instruments have served in documenting disaggregated risk behavior information among AANH&PIs young adults as well as information adaptations of the P 3-3-3 curriculum.

- Numbers achieved - Outreach numbers. It was proposed that Project 4PLAY would provide outreach to 250 individuals a year totaling 1,000 persons over the life of the project. This number was exceeded each year with the program outreaching to an estimated average of 300 – 600 individuals from the targeted ethnic groups, counties and risk behavior groups.
- CAB effectiveness. The community advisory board proved effective given their input and guidance for recruitment ensured that the right strategies and sites were used for outreach. Their guidance also proved useful in adapting the P 3-3-3 curriculum to meet the specific cultural needs of the targeted populations. Project staff also participated with two collaborative groups with overlapping membership with the project CAB, HAAPI (HIV/AIDS for Asian and Pacific Islanders) in Alameda County and AHAC (Asian Americans for HIV/AIDS Collaborative) in Santa Clara County. Partnership with HAAPI and AHAC not only supported Project 4PLAY in meeting program objective, but allowed for opportunities to sustain Project 4PLAY in the community. Additionally, relationships were built with several community-based partners, which helped in gaining entry into the different “communities” (MSM and close knit ethnic communities such as the Korean and Samoan community) within the targeted counties and ethnic groups.
- Capacity building efforts. One of the goals for Project 4PLAY was to contribute to capacity of community health care systems to deliver services through professional development and dissemination of prevalence and incidence data. Project 4PLAY offered trainings to interns to assist with facilitation and outreach efforts. In addition, project staff completed a community report back in the four counties the project was implemented. The report back was held at the conclusion of the program in Year 5 with presentations tailored to specific and relevant data to ethnic groups and trends within that particular county. The Project also disseminated copies of the 2 journal articles published based on the data collected by P-3-3-3 (Cohort 6).

- Building rapport crucial / peer support and involvement. Project 4PLAY knew that it would be challenging to establish and maintain rapport with a population that is rarely targeted with the type of information the program was attempting to disseminate. Through diligent efforts and innovation with adaptations of the curriculum, however, strong rapport was built. Results of this work were shown by the continued interest of participants once a cohort was completed where several participants helped with program recruitment and implementation through referrals and word of mouth. In addition, Project 4PLAY was successful in hiring two former Project 4PLAY participants as Project Assistant later in the grant period who highlight their stories as a means of building rapport with potential participants especially using social media hook-up apps (i.e. Grindr, A4A, Jack'd).
- Data supporting future grants. Documentation of disaggregated AANH&PI risk behaviors proved fruitful, with the data being used to establish need and drive new programs for future programs. Use of this data resulted in the Asian American Recovery Services receiving SAMHSA funding to programming targeting 18-24 year old AANH&PI
- Submission of manuscripts / abstracts to professional conference for presentation (posters and oral). As part of Project 4PLAY's effort to disseminate program results, findings were presented over the five-year tenure at professional meetings (American Public Health Association [APHA] [5 posters, 1 oral presentation] and SAMHSA as well as University of Californian, San Francisco webinars). Additionally, project staff and evaluation team members are in the process of submitting manuscripts from P 3-3-3 data as well as newly collected data from focus groups and Project 4PLAY.

2015 accepted abstracts for the APHA meeting include (click to follow link or copy and paste to URL):

2035.0 Sexual Practices of San Francisco Bay Area Asian & Pacific Islander Young Adults: Who is at Risk?

2059.0 Alcohol, Tobacco, and Other Drug Use Among Asian American Young Adults ages 18-24 living in 4 Counties bordering the San Francisco Bay

2073.0 "Hookin' Up": Dating preference and sexual practices of San Francisco Bay Area API Young Adults

Two journal articles were published with data from the previous grant data P 3-3-3. Journal of Ethnicity in Substance Abuse ( Substance use among Chinese, Filipino, and Vietnamese adults living in San Jose, Daly City, and San Francisco and its implications on ATOP Prevention Services, 2012); and the second in AIDS Education and Prevention (Correlates of HIV and HCV risk and testing among Chinese, Filipino, Vietnamese Men who have Sex with Men and other at-risk men, 2013).

**Lessons Learned.** Through trial and effort, the following lessons were learned.

- Importance of disaggregated risk-behavior profile. One of the program goals was to compile a risk behavior profile for the target AANH&PIs that had a sample size that is significantly larger than those in comparable earlier studies. Project 4PLAY was able to meet this goal and learned that

there were differences in the targeted groups in terms of risk behaviors and substance use. Particularly, the program was able to see which groups “stood out” the most, thus determining that disaggregating sub-ethnic groups demonstrates sub-populations that require targeted outreach and prevention efforts.

- Importance of working in a culture-appropriate and language specific environment (staff and community). Project 4PLAY learned the importance of using staff that were bilingual/bicultural (Chinese, Vietnamese, Filipino, Multi-Ethnic/Racial) representative of the young adult community. Using this approach enabled the staff to communicate with participants in the program and through the NOMS (which was translated in to three targeted languages Chinese, Vietnamese, and Tagalog). Additionally, it allowed the staff to build a rapport due to similar cultural experiences, but also as peers.
- Importance of working with community partners (CBO's). A large part of Project 4PLAY's success comes from collaborative efforts with other community based organizations (CBO's). With the extension of services into Alameda County where AARS/HR 360's Project 4PLAY does not have an office space programming relied heavily on support and collaboration with CBO's with a similar mission and vision as AARS/HR 360 and Project 4PLAY. Community partners allowed Project 4PLAY to be implemented within their organization providing not only space but referrals and resources to participants who resided in Alameda County.
- Importance of addressing MSM and youth population and having young MSM on the team. Similar to working in a culture-appropriate and language specific environment, Project 4PLAY learned the importance of using staff that were from not only the MSM community but the young MSM (YMSM) community. Having staff that met these characteristics allowed the program to identify current trends in the YMSM community and explore current methods of hooking up such as online hook-up sites and apps (i.e. Grindr, Adam 4 Adam, and Jack'd). Identifying this group ensured that Project 4PLAY addressed certain risk behaviors needs within the realm of its intervention.
- Program feedback through monthly coordination meetings. Often times, evaluation results are reported back to the program at the end of the tenure of the program or perhaps at the end of each fiscal year of the program. In the case of Project 4PLAY, the program learned that inclusion of the evaluation team in its monthly coordination meetings proved useful, as it helped to assess current outreach efforts, measurement instrument concerns, and overall program progress. By doing this monthly, ensured that the program could make programmatic adjustments were fit and maintain program integrity.
- Importance flexibility and adaptation. Because of SAMHSA changes in the direction of programming across all its grantees, Project 4PLAY was forced to adjust its programmatic approaches (example, data collection tools, cross site evaluation reporting). Project 4PLAY staff learned that by being flexible and having a willingness to adapt, that it was still able to provide and effective program within the new boundaries. The program also worked with what was available to it, utilizing partnerships to help compensate for lost access or opportunities, such as the case when AARS merged with HealthRight 360. Through strong relationships with community partners, Project 4PLAY was able to keep outreach and implementation efforts moving. Additionally, through monthly reviews of the program's efforts, Project 4PLAY was able to adjust, to some extent, program procedures to address program needs while still maintaining the EBI's fidelity that it set out to implement.
- Organization must support new approaches and innovation of program. Project 4PLAY learned that having a grant within a large organization sometimes results in becoming invisible to agency administration. The lack of focus or priority in prevention services, leads to miscommunications



and in some case not understanding what the program is attempting to do or how the program wishes to proceed in the future.

**Challenges.** Although successful, Project 4PLAY was not without challenges - - some were easily addressed, while others were not resolved within the timeframe of the grant. These challenges served to inform both staff and evaluators as well as and moved them to strategize and identify alternative responses in the future.

- Recruitment of high risk individuals. One of the program goals was to compile a risk behavior profile for target AANH&PIs that had a sample size that is significantly larger than those in comparable earlier studies. Although Project 4PLAY was successful in collecting from some ethnic groups (Chinese, Vietnamese, Filipino, and Multi Ethnic/Racial), overall the project staff had a difficult time outreaching and retaining high risk participants. High risk where those individuals who are well on their way to becoming chronic substance users or currently use other illicit substances which the literature have cited previously, namely those who use methamphetamines, regular users drugs such as spice (non-plant based marijuana derivatives) or injection drug users. The challenge was identifying where to outreach for these high risk participants. Project staff exhausted former participant networks and their program social media presence when attempting to outreach online. Collecting ethnic specific data from specific ethnic groups has proved advantageous for generating data on a larger sample size however in the future a specific focus on high risk individuals will be helpful in understanding risk with the AANH&PI young adult community.
- Anecdotal data and NOMS responses. Through ethnographic notes and anecdotal data, it was learned that the more comfortable Project 4PLAY participants became with the program and its staff, they revealed more about their past and current substance use and sexual behaviors. There is evidence of rapport being built through the socials pre- and post-intervention with staff gaining knowledge of participants revealing true information later in the program (usually in the last one to two workshops) suggests that individuals may not have accurately reported their behavior with the Baseline NOMS. This suggests that maybe some of the participants answered survey questions as they perceived “it was expected.”
- Challenges with collection of information. Participants may have experienced survey “fatigue” as they were asked to complete both the RBSS and NOMS. Given the questions on both instruments were similar, some of the respondents felt like the same questions were being asked repeatedly. Additionally, the length of the NOMS proved a challenge, even after it was translated into specific targeted languages. Finally, there seemed to be limited usefulness of NOMS tool for identifying important population based characteristics. For example: (1) ethnic specific information, such as ethnicity, language spoken at home (Asian is not a language), nativity, immigration time frame; and (4) identification of protective factors.

## V. EVALUATION

### Methodology and Tools

Once P4P staff selected and adapted two evidence-based curricula, both the National Outcomes Measures (NOMS) and Risk Behavior Screening Survey (RBSS) were pilot-tested. Table 4 presents what program questions could be answered by the surveys.

As the NOMS (the required GPRA data collection tool) served to address standardized substance use and HIV knowledge and risk; the California's Department of Public Health's HIV/Hepatitis Counseling and Testing Risk Assessment form which was adapted to become the RBSS served to document more in-depth information regarding risk behaviors and HIV testing history. Additionally, it collected detailed information about participants' ethnicities, allowing Project 4PLAY to disaggregate the different ethnic groups to determine if certain groups were more at risk than others. This survey strategy was done with the hypothesis that when aggregating groups under "ASIAN," certain ethnic groups exhibiting more high-risk behaviors are masked. For the program goals, the two surveys addressed two of the four goals (See Table 4).

Table 4. Program Goals as Evaluation Measures & Survey Correspondence

SAMHSA/CSAP Program Questions	Survey Variables Used For Measurement
1. Provide culturally competent HIV testing services.	NOMS Q# 39-44, 120 RBSS – HIV Testing History
2. Develop and implement evidence-based activities to reduce the incidence and impact of substance abuse and HIV	NOMS Q# 19-44, 57-70, 76-103 RBSS – All questions

### Selected RBSS Results

As part of the SPF and Project 4PLAY to document and compile a risk behavior profile of the targeted populations, Project 4PLAY administered the RBSS during outreach efforts to all potential participants. Additionally, all individuals who participated in the prevention program completed the RBSS and these participants are included in the 595 RBSS forms collected.

Given the pan-Asian population targeted by Project 4PLAY, participants represented 20 specific ethnic groups, with the majority of participants being Chinese, Filipino, Vietnamese, and MER (multi-ethnic/racial) individuals. For the purposes of analysis, the largest ethnic groups were used in all data tables.

**Substance Use.** The most commonly reported substance used in the past 30 days was alcohol followed by hookahs for all four ethnic groups (see Table 5). Filipino and MER respondents reported

the highest rates of alcohol, hookah, e-cigarettes, and blunt use. Filipinos reported the highest rate of ecstasy use. Although there were no statistically significant differences between ethnic groups for use for alcohol, blunts, marijuana and ecstasy use, significance was observed for use of hookah use ( $p=.02$ ) and e-cigarettes ( $p=.01$ ).

Table 5. Substance Used in the Past 30 Days (RBSS)

Reported Substance Use: N = 76	Chinese (%)	Filipino (%)	Vietnamese (%)	MER (%)
Hookahs*	33	63	33	45
e-Cigarettes <sup>+</sup>	4	38	0	26
Alcohol	60	71	62	72
Blunts	11	13	8	22
Marijuana	11	5	17	16
Ecstasy	5	10	6	2

\* $p=.02$  between ethnic groups

+ $p=.01$  between ethnic groups

**Sexual Behaviors.** The average number of sexual partners reported was 1.28 persons. Those who reported protective oral sex, less than a quarter of participants reporting use of a condom, while one-third to half of those reporting anal insertive (38%) or anal receptive sex (52%) used a condom all of the time (see Table 6). No statistically significant differences were seen between ethnic groups, although Vietnamese had the highest rates of condom use for oral sex, Chinese and Filipinos for anal-insertive sex, and Chinese and Vietnamese for anal-receptive sex. Although very few individuals reported sex while under the influence of a substance, this finding needs to be viewed with caution, since earlier focus groups findings and in a workshop activity “circle of secrets” these behaviors were disclosed.

Table 6. Use of Barriers During Sexual Encounters (RBSS)

In 30 day during sex with partner <u>ALWAYS</u> used a barrier for:	Used Barrier w/ Partner - Always			
	Chinese (%)	Filipino (%)	Vietnamese (%)	MER (%)
• Oral	6	5	21	4
• Insert (Anal)	42	45	33	31
• Receptive (Anal)	56	44	67	47

**HIV Testing.** Table 7 includes reported HIV testing history. About two-thirds (60%) reported having ever tested, while 46% of these individuals reported being tested in the past six months. There were no statistical differences between ethnic groups and being HIV tested for lifetime or in the past six months. Among those who tested on-site during the last workshop 23% were first time testers.

Table 7. Lifetime HIV Testing

Have you ever been tested for HIV?	Chinese (%)	Filipino (%)	Vietnamese (%)	MER (%)
Yes	52	65	54	64
No	48	35	50	36

### Comparison of NOMS Data across Data Collection Periods (Baseline, Exit, and Follow-Up)

Substance use among Non-users. Usage rates were assessed by analyzing those who reported use of ATOD at baseline and reviewing reported behavior at the end of the intervention through exit survey data. Substance categories were mutually exclusive, and not all participants were users of all substances. The most commonly used drugs were alcohol and marijuana followed by cigarettes (see Table 8).

Table 8. Past 30 Day Non-User Stability (NOMS)

Substance	% of Non-Users at Baseline	% of Non-Users at Exit	% of Non-Users at Follow-up	Direction of Change from Baseline to Exit	Direction of Change from Baseline to Follow-up
Alcohol*	14	22	25	↑	↑
Cigarettes	75	77	71	↑	↓
Other Tobacco*	92	93	86	↑	↓
Marijuana*	75	78	68	↑	↓
Cocaine or Crack*	98	96	90	↓	↓
Methamphetamine*	98	99	91	↑	↓
Prescription Drugs without doctors' orders*	95	96	90	↑	↓
Injected Drugs *	99	99	92	↔	↓

\*p&lt;.05

**Baseline N = 244, Exit N = 228, Follow-Up N = 191**

Rates for non-users was high (86% or more non-users) for all substances with the exception of alcohol, cigarettes, and marijuana, and remained high at Exit and Follow-Up suggesting abstinence while involved with and after participation in Project 4PLAY. From baseline to follow-up, statistically significant increase in non-users for alcohol occurred ( $p < .05$ ). Additionally, the slight decreases in non-users for other tobacco, marijuana, cocaine/crack, methamphetamines, prescription drugs, and injection drugs were all statistically significant. Such a shift may represent experimentation of substance use, a behavior common among this age group. Encouraging, however is the shifts were minimal, and overall, individuals reporting none use of substances overall is still high.

Protective sex across time. Barriers or protective sex rates were assessed by analyzing those who reported protective sex with the last time they had a sexual encounter and reviewing reported behavior at the end of the intervention through exit and follow-up survey data (see Table 9).

**Table 9. Protective Sex Across Time**

Substance	% of Reporting Barriers at Baseline	% of Reporting Barriers at Exit	% of Reporting Barriers at Follow-up	Direction of Change from Baseline to Exit	Direction of Change from Baseline to Follow-up
Oral Sex w/ Barrier*	12	18	26	↑	↑
Anal Sex w/Barrier	61	70	68	↑	↑

\* $p = .00$

Across time, reported protective sex increase for both oral and anal sex, with reported oral sex protection being statistically significant ( $p = .00$ ).

**Health Knowledge and Health Services**

Part of the P4P was to provide information about challenges associated with substance use, and general knowledge about HIV, available local treatment services and HIV testing. Participant data was analyzed to determine if there was any change over time in perceptions and knowledge.

Substance Use Risk. Participants were asked about the risk of the use cigarettes, marijuana, and binge drinking. Using analysis of variance to test scaled answers across time, responses were analyzed to see if perceptions of risk improved over time (see Table 10). Responses were measured by mean scores for each substance with scores ranging from 1 (“No Risk”) to 4 (“Great Risk”).

**Table 10. Mean Scores for Perception of Risk for Substance Use by Time**

Perception of Risk...	Baseline Mean Score (SD)	Exit Mean Score (SD)	Follow-Up Mean Score (SD)	Change from Baseline to Follow-Up
Cigarettes	3.6 (.69)	3.6 (.68)	3.6 (7.2)	↔
Marijuana*	2.5 (.87)	2.7 (.92)	2.7 (.9)	↑
Binge Drinking*	3.2 (.82)	3.3 (.87)	3.2 (.82)	↑

\*p=.04 for Baseline to Follow-Up

Overall, responses varied across time for perceptions of risk for the different substances. For example, for cigarettes, responses ranged between “moderate” and “great” risk score or a 3.6, while perceptions of risk for marijuana was between 2 and 3, and perceptions of binge drinking hovered around a 3 or “moderate” risks. With the exception of cigarettes, fluctuations in scaled answers were statistically significant for marijuana and binge drinking ( $p=.04$  for both), suggesting P4P materials had some influence or impact on how participants saw and or understood risk of the two substances.

**HIV Knowledge Scores.** Participants were presented with general HIV knowledge statements and asked to respond “True” or “False.” Responses were then summed to create a score for correct answers. Possible HIV knowledge scores were 0 to 6, with higher scores indicating more correct responses. Using analysis of variance, mean scores were tested for change across time.

Knowledge scores for HIV knowledge increased over time (3.1 at baseline to 3.2 at follow-up), and the increase was statistically significant ( $p=.04$ ). With a possible score range of 0-6, mean HIV knowledge scores indicate that NOMS participants’ scored about three or half of the statements correctly, and gave about one more correct responses and maintained information at follow-up.

**Health Services & HIV Testing.** Access to services was measured by analyzing what participants reported over time for recognition of access to health care and testing status (see Table 11).

**Table 11. Access and Knowledge to Healthcare Services**

Health Service	Baseline (%)	Exit (%)	Follow-Up (%)	Change from Baseline to Follow-Up
Have health insurance	81	83	87	↑
<b>Know where to seek health care services for:</b>				
HIV/AIDS or other STDs*	85	94	94	↑
Drug or alcohol problem*	70	86	87	↑

\*p=.00 for Baseline to Follow-Up

The percentage of NOMS participants who reported knowledge about available services for HIV testing and treatment, and drug and alcohol treatment consistently increased across time, with all

increases, being statistically significant ( $p=.00$  for all both services). Such changes indicate that participants acquired information and maintained this information over time. Knowledge of drug and alcohol problems services saw the largest increase.

Finally, NOMS participants reporting being HIV tested for saw a 21% increase with 70% reporting being tested at baseline to 91% reporting being tested at follow-up ( $p=.00$ ).

### **Summary of significant findings**

From baseline to follow-up, statistically significant findings include:

- 1) Increase in non-users for alcohol occurred ( $p<.05$ ).
- 2) Slight decreases in non-users for other tobacco, marijuana, cocaine/crack, methamphetamines, prescription drugs, and injection drugs were all statistically significant ( $p<.04$ ).
- 3) Reported use of protection for oral sex ( $p=.00$ )
- 4) Risk perception associated with various substances increased for marijuana and binge drinking ( $p=.04$  for both)
- 5) Knowledge of health care services increased for both HIV/AIDS or other STD's and Drug or Alcohol problem ( $p=.00$  for both)
- 6) Reporting HIV testing increased from baseline to follow-up 21% ( $p=.00$ )

## VI. RECOMMENDATIONS

Activity outcomes and evaluations findings indicate that Project 4PLAY was successful at various levels in designing and implementing a strategic prevention framework for addressing HIV and substance use prevention among underserved AANH&PI young adults in the Bay Area. Most importantly, strong community relationships and ties were established, ones that will contribute to future efforts in the prevention of HIV and the reduction of substance use among underserved AANH&PI communities. Additionally, the collection of disaggregated risk behavior data has proven invaluable, since recent data on disaggregated AANH&PI is limited or non-existent (Toleran, et al.). Finally, Project 4PLAY raised the awareness of community providers, locally and nationally, and the AANH&PI community alike, about potential risk behaviors for populations that are seen by many health care providers and society as “invulnerable.”

**Recommendations.** As the program moved towards ending, staff along with the evaluation team began to review the different outcomes of the program, both from the process and outcome perspective. Based upon this review the following recommendations are suggested.

- Continued building of rapport with potential and current participants. Through ethnographic notes and anecdotal data, it was learned that the more comfortable participants came with the program and its staff, they revealed more about their past and current behaviors. Although there is evidence of rapport being built through the socials pre- and post-intervention, knowledge of participants revealing true information later in the program (usually in the last one to two workshops) suggests that individuals need more time pre-program (particularly pre-Baseline NOMS) in order to provide responses closer to their behaviors. It is suggested future programming include more time for building rapport, or more specifically trust, with potential participants in order to ensure that they report true behaviors.
- Survey Changes. There seemed to be limited usefulness of NOMS/GPRA tool for identifying important population based characteristics. For example: (1) ethnic specific information, such language spoken at home (Asian is not a language), nativity, immigration time frame; and (2) identification of protective factors that may be culturally bound (whom do you live with, years of education). Given these weaknesses, the NOMS tool was not strength-based for Project 4PLAY’s culture-diverse population. Therefore, it is recommended that certain measures within NOMS be revised and included.
- Experience in the needs of linguistic and culturally diverse populations. Due to limited availability for concrete programmatic or field experience from Federal staff and their contractors to address the needs of linguistic and culture diverse populations, it is suggested that future SAMHSA technical assistance and training efforts to include individuals with this expertise as part of the technical assistance team.
- Translations for NOMS needed. Since SAMSHA does not provide consent forms and NOMS in various languages, Project 4PLAY had to engage an outside translation contractor, and to resort to in house back translation which were voluntary and completed only when individuals had time to dedicate to the task. This has posed challenges to programming when there are changes to the consent form and survey instrument that require an updated version. It is recommended that if SAMHSA wishes to have certain measurement tools available, that it supports grantees efforts to help them make these items available in different languages.
- Focus on at-risk Asian American, Native Hawaiian and Pacific Islanders. With the growing evidence that specific Asian ethnic sub-populations exhibit differing levels of risk behaviors,



continued prevention funding support must be available to address their needs. Further, per OMB Directive 15, mandating ethnic specific data be collected and reported for all racial groups. SAMHSA should identify and fund programs that address these diverse groups, and mandate all grantees to be compliant with this regulation in order to fully address the needs of all populations at risk for substance abuse and HIV.

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